The Priory Hospital North London

Quality Report

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

Ratings

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

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

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

Summary of findings

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.

Overall summary

We rated Priory Hospital North London as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.
- Staff assessed the physical and mental health of all patients on admission. They worked with patients to develop individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans for young people on the child and adolescent mental health wards were of a high standard and reflected all young people's needs.
- Teams included a range of specialist staff to meet the needs of patients. Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients and young people had good access to physical healthcare and supported patients to live healthier lives.
- Staff understood how to protect patients and young people from abuse and the service worked well with other agencies to do so.
- Staff involved patients in risk assessment and actively sought their feedback on the quality of care provided.
- Staff felt respected, supported and valued. They reported that the provider provided opportunities for career progression and they felt able to raise concerns without fear of retribution.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. Staff ensured that patients had easy access to independent advocates.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff assessed young people's competence using the Gillick competency, which they understood well.
- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients, young people and staff.

However:

- There were not always a sufficient number of nursing staff working on Birch Ward. This meant young people did not always get escorted leave from the ward. Staff were unable to always take breaks and staff supervision was not taking place.
- The child and adolescent wards only had adult size defibrillator pads in the resuscitation bag. On Oak Ward some items, such as disposable forceps, were past their expiry date.
- Although the hospital monitored restrictive interventions, it did not have a restrictive interventions reduction programme to think long term about how to minimise the use of restraint and rapid tranquilisation.
- Following an incident investigation, all patients in the hospital had their bedrooms searched twice per month. This was a blanket practice unrelated to individual patients' or young peoples' level of assessed risks.
- When patients decided to discharge themselves, medicines for the patient to take away with them did not come with important warning labels. This was not best practice.
- The vacancy rate for registered nurses on Lower Court was high at 43%. Long term agency staff were used to minimise the risks of inconsistent care, but further recruitment was needed.

Summary of findings

- Although staff on Lower Court discussed patients' potential risks regularly, changes to patients' risk levels were not always clearly documented in their care records.
- Staff prescribed sedative medication to help with sleep for clients having detoxification treatment, without exploring other options first. This was not good practice.
- Staff did not always clearly record when clients having detoxification treatment were offered relapse prevention medicines.
- The did not have ways for patients, young people, and carers to be involved in the operation of the hospital.

Summary of findings

Contents

Good

The Priory Hospital North London

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Hospital inpatient-based substance misuse services

Summary of this inspection

Background to The Priory Hospital North London

The Priory Hospital North London is a 49 bed independent hospital in North London which provides care and treatment for people with mental health problems and substance misuse problems. The services provided at the hospital are:

Lower Court - A 27 bed ward for male and female adults with acute mental health problems, obsessional disorders and substance misuse problems.

Birch Ward - A 13 bed ward for children and young people up to 18 years of age. The ward provides care and treatment for males and females with acute mental health problems.

Oak Ward - A nine bed ward for children and young people up to 18 years of age. The ward provides care and treatment for males and females with acute mental health problems.

The NHS commissions beds for adults and children and adolescents at The Priory Hospital North London. Clients at the hospital also have their care and treatment funded by insurance companies, or are self-funding.

The provider is registered to provide the following regulated activities:

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

Treatment of disease, disorder or injury.

There was a registered manager in post.

We have inspected Priory Hospital North London on four occasions since 2015. Our last comprehensive inspection of the hospital was in April/May 2018. At that time, we rated the hospital as inadequate for safe, requires improvement for effective, caring and well-led and good for responsive. We rated the hospital as requires improvement overall.

Following this inspection, we issued requirement notices on the provider concerning the following regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 9 – Person-centred care

Regulation 10 – Dignity and respect

Regulation 12 – Safe care and treatment

Regulation 17 – Good governance

Regulation 18 – Staffing

In October 2018, we undertook a focused inspection of the child and adolescent mental health wards, to check the provider had made the required improvements since the April/May 2018 inspection. Following this inspection, we issued a further requirement notice to the provider regarding Regulation 12 – Safe care and treatment. As it was a focused inspection, that inspection did not include any ratings.

Our inspection team

The Priory Hospital North London was inspected by a team including a CQC Inspection Manager, four CQC Inspectors and four specialist advisors, two of whom were registered nurses and two were consultant psychiatrists. The inspection team also included an expert by experience, who is a person who has used, or cared for someone using, similar services.

Why we carried out this inspection

This was an unannounced comprehensive inspection. We undertook this inspection to check on the quality and safety of the services and to check on improvements made since our inspections in May and October 2018.

Summary of this inspection

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients and young people
- spoke with the registered manager and all of the ward managers or acting ward managers
- spoke with the medical director and director of clinical services
- spoke with 24 other staff members; including doctors, registered nurses, healthcare assistants, ward clerks, a clinical psychologist (and therapies lead), an assistant psychologist, an occupational therapist assistant, a family therapist, a social worker, an activity coordinator, and a teacher
- spoke with five adults and nine young people using the services
- spoke with four parents or carers of young people using the service
- spoke with a young person's advocate
- looked at 19 care and treatment records of patients
- looked at 22 medicine charts
- looked at 21 staff supervision records
- attended three handover meetings, a community meeting, a therapy group and a substance misuse multi-disciplinary meeting
- carried out a specific check of the medication management on all three wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

On Lower Court, all the adult patients we spoke with said that staff members treated them with dignity and respect. Patients we spoke with said that they were able to contribute to their care plan and felt involved in their care. Two patients we spoke with said that there were a lot of therapy groups during the day but they felt that there were not enough activities in the evenings or at the weekend.

We spoke with nine young people on the CAMHS wards. Most young people we spoke with said that staff were kind, respectful and supportive. They said that the nurses and therapists were interested in working with them and they felt involved in care planning. Young people said they could have a copy of their care plans, and knew who their named nurse was. All young people we spoke with said that they had access to advocacy.

Young people on Oak Ward described more positive experiences than those on Birch Ward. Several young people on Birch Ward said that there had been times when they thought there were not enough staff on duty, particularly during incidents on the ward, when they had felt unsafe. They said that the nursing staff did not have a sufficiently visible presence on the ward. Young people described mixed experiences with agency staff, and some communication issues between staff working on the wards.

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:

- There were not always a sufficient number of nursing staff working on Birch Ward. This meant young people did not always get escorted leave from the ward. Staff were unable to always take breaks. The vacancy rate for permanent registered nurses on Lower Court was 43%. This was a high vacancy rate. Where possible, long term agency staff were used to minimise the risks of inconsistent care.
- The hospital did not have a restrictive interventions reduction programme. In the six months before the inspection there had been 99 incidents of patients being restrained. A restrictive interventions reduction programme is designed to minimise the use of restraint and rapid tranquilisation.
- Following an incident investigation, all patients in the hospital had their bedrooms searched twice per month. This was a blanket practice unrelated to individual patients' level of assessed risks.
- When patients decided to discharge themselves, medicines for the patient to take away were placed in standard boxes, but important warning labels regarding the medicines were missing. This was not best practice. The management team acted immediately to remedy this situation during the inspection.
- The child and adolescent wards only had adult size defibrillator pads in the resuscitation bag. On Oak Ward some items, such as disposable forceps, were past their expiry date.
- All wards were safe, clean, well-furnished and well maintained.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.
- Staff understood how to protect patients and young people from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. The provider had dedicated staff leads for safeguarding adults and children.
- Staff regularly reviewed the effects of medicines on each patient or young person's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers

Summary of this inspection

investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multi-disciplinary discussion and updated as needed. Care plans for young people on the child and adolescent mental health wards were of a high standard and reflected all young people's needs.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward teams included, or had access to, the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff explained patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. Staff assessed young people's competence using the Gillick competency, which they understood well.

However:

Summary of this inspection

- Clients having detoxification treatment were prescribed sedative medicine in their first three days of treatment to help with sleep. This was done before other sleep hygiene measures or other, non-addictive medicines were considered, which does not follow best practice guidance.
- Staff did not always record when they offered relapse prevention medicines.
- There was still work to do to ensure all care plans on Lower Court were personalised, holistic and recovery orientated.
- Nursing staff on Birch Ward did not always receive monthly supervision as planned.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported them to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

However:

- The provider did not have ways for patients and carers to be more involved in the operation of the hospital.

Are services responsive?

Good

We rated responsive as good because:

- Staff planned and managed discharge well. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- Staff facilitated young people's access to high quality education throughout their time on the wards.
- The food was of a good quality and patients could make hot drinks and snacks at any time.

Summary of this inspection

- The wards met the needs of all patients and young people who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider provided opportunities for career progression and felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in national quality improvement activities.

Detailed findings from this inspection

Mental Health Act responsibilities

As of September 2019, 78% of staff had received training in the Mental Health Act. Staff who were due to undertake Mental Health Act training had been booked onto the next available training day.

Staff explained to patients their rights under the Mental Health Act (Section 132 rights) in a way that they could understand. This happened on admission and was being repeated at regular intervals.

There was a record of each young person's capacity to consent to treatment. Patients were informed of their right to appeal under the MHA and this was recorded on patient files. These records confirmed that the patient had capacity to understand the information that was being explained to them.

At the focussed inspection published in December 2018, we found that staff did not always ensure that young people understood their status as an informal patient. At the current inspection, there was a poster explaining the rights of informal patients, which was on display in communal areas. Staff explained the rights of detained and informal patients at every community meeting on the wards. Young people told us that they understood what it meant to be an informal patient.

Administrative support was provided by the MHA administrator who was based at the hospital. The hospital managers carried out regular audits of statutory forms relating to the MHA.

An Independent Mental Health Advocacy (IMHA) service was provided by a local advocacy organisation. All detained patients were given information about this service. We were told that this service regularly visited the hospital, and patients had the opportunity to meet with an advocate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Eighty two per cent of staff had received training in the Mental Capacity Act 2005.

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

Staff understood the issues and complexities around competence, consent and capacity for under 18-year olds. They described how they had acted within the principles of the MCA when assessing and treating patients including making 'best interests' decisions. For young people under the age of 16, their Gillick competency was assessed. Staff had a good knowledge of the Gillick competency assessment.

Management were working to improve the quality of capacity and competency assessments by increasing the frequency of audits, and involving families, interpreters and speech and language therapists. They were clear about the need to ensure that capacity is reassessed whenever there is a change in the patient's presentation.

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	Good	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Requires improvement	Good	Good	Good	Good	Good
Hospital inpatient-based substance misuse services	Good	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

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

Good

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

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

Good

Safe and clean environment

Safety of the ward layout

Staff were aware of and managed the environmental risks on the ward. This included ligature risks and blind spots. Staff could observe all communal areas of the ward from the two nursing stations. Convex mirrors were also present to help mitigate blind spots.

During our last inspection in May 2018, a clear timetable was not present for the minimisation or removal of all ligature points. During this inspection, a risk reduction action plan was in place. The ward was in the process of having five safer bedrooms on the ward. These bedrooms had anti-ligature fittings and observation panels in the bedroom doors. The ward had a ligature risk assessment carried out in June 2019. Staff we spoke with were aware of the ligature points that were present on the ward and managed them through observation. The provider issued a bulletin on ligature points and choking risks. This bulletin identified new risks as learning from incidents in other services.

The ward complied with guidance on eliminating mixed sex accommodation. Although the ward was mixed sex, all bedrooms had en-suite facilities and a female only corridor and female only lounge.

Staff had access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well maintained. Domestic staff kept clear cleaning records that showed areas were cleaned regularly.

Staff adhered to infection control principles, including handwashing and wearing personal protective equipment such as disposable gloves. There were appropriate arrangements for clinical waste disposal, including sharps bins in the clinic rooms, which were dated on opening and not overfilled. Posters about infection control and handwashing techniques were present throughout the ward. Staff completed monthly infection control audits.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff completed a checklist of items in the emergency bag weekly.

Staff checked, maintained, and cleaned equipment. The clinic room cleaning record was fully completed for the three months before the inspection.

Safe Staffing

Nursing staff

The ward reported an overall vacancy rate of 43% for registered nurses as of 9 September 2019. This core service reported an overall vacancy rate of 15% for healthcare assistants as of 9 September 2018. The majority of vacancies were filled by long-term agency workers to ensure consistency of care for patients.

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

Good

A staffing calculator was used on the ward, this outlined minimum staffing levels. For example, when there were 24 patients on the ward the staffing calculator dictated that two registered nurses and four nursing assistants should be present during the day. Two nurses and three nursing assistants should be present during the night. Staffing rotas showed these establishment levels were met and were often exceeded.

The ward manager could adjust staffing levels daily to take account of the case mix. For example, when a patient required enhanced observations.

When necessary, managers brought in agency and bank staff to maintain safe staffing levels. Between the 10 June 2019 and 9 September 2019, the service used agency staff to fill 125 shifts.

When agency and bank nursing staff were used, they received an induction and were familiar with the ward. The ward manager had recently started using an agency staff profile document to ensure that all agency staff were competent and had received a full induction. The profile covered an assessment of competencies for administering medicines, a checklist to ensure staff were familiar with policies and procedures for the ward, and to ensure new staff were introduced to patients. Agency staff training compliance was also included in the agency staff profiles.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients we spoke with said that they had regular one-to-one time with their named nurse.

Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. None of the patients we spoke to said that activities or leave had been cancelled due to staff shortages.

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

Medical staff

Each of the wards had a ward doctor Monday to Friday during normal work hours. Outside of these hours, there was a doctor for the hospital that staff could contact. A doctor could attend a ward quickly in an emergency at any time of the day or night.

Mandatory training

Staff had received training and were up-to-date with appropriate mandatory training. The compliance for mandatory and statutory training courses at 9 September 2019 was 97%. All relevant staff had completed training in preventing and managing violence and aggression, breakaway techniques, basic and intermediate life support, and risk assessment.

Assessing and managing risk to patients and staff

Assessment of patient risk

During our last inspection in May 2018, patient risk assessments did not contain details of all patient risks. During the inspection, we saw this had improved. Staff did a risk assessment of every patient on admission and updated it when there were changes in the patient's behaviour or after incidents.

Staff had a good understanding of the potential risks associated with each patient and written records were up-to-date. Risk assessments highlighted specific risks for each patient such as the risks of suicide, self-harm, self-neglect and non-compliance with treatment. For all patients the progress notes were comprehensive and up-to-date.

Staff used a standard risk assessment tool for all patients. The risk assessment template prompted staff to include details of risks to the patient, risks the patients presented to other people and a history of risk related incidents. Staff were able to access historic risk assessments that had been completed during previous admissions to hospitals operated by the provider.

Management of patient risk

Staff created management plans for all identified risks. For example, where a patient was at risk of self-neglect, the patient was having daily physical health checks.

Staff discussed any changes in risk level each day at a handover meeting but did not always record the reasons behind this on the system in a timely way. In two out of five risk assessments we reviewed, it was not always clear why risk levels had changed. For example, a patient was identified as a high risk of physical health issues on admission, but medium risk two days later, with no rationale recorded.

Staff completed a five-point risk assessment for patients that had unescorted leave in the community. This took account of a patient's mental state, relational security and their compliance with their medication.

Every weekday morning the management team in the hospital met for a 'flash' meeting. This meeting was to review any concerns and to plan for the next 24 hours. The focus of the 'flash' meeting was to ensure effective communication in managing risks and staffing.

Staff followed good policies and procedures for use of observation and for searching patients or their bedrooms. The ward allocated an observation level to each patient depending on the level of risks. Patients that were higher risk would also have bedrooms closer to the nursing office. Searches of patients returning from leave were not routine for those on the general mental health and obsessive compulsive disorders treatment programmes.

Following an incident, all patients had their bedrooms searched twice per month. This was a blanket practice for all patients and was not related to individual patients' risks.

The only restrictions on visiting times for patient's visitors was that they could not visit after 9pm.

Each patient was able to use their own mobile telephone during their stay, unless there were specific risks identified with patients being in possession of their mobile telephones.

Staff implemented a smoke-free policy. All cigarettes and electronic cigarettes were banned in all hospital buildings. This meant that one method for clients to reduce or stop their use of cigarettes was banned in hospital buildings. This may have amounted to a blanket restriction and have been counterproductive.

Informal patients could leave at will and knew that. Aninformal patientis someone who has agreed to come into hospital for assessment and treatment of a mental health condition. All informal patients that we spoke with were aware that they could leave at any time.

Use of restrictive interventions

The service had 27 incidences of restraint (seven different service users) between 1 March 2019 and 11 September 2019. The service had four incidences of prone restraint between 1 March 2019 and 11 September 2019. This is where a patient is in a face down position. These four incidents involved administering medication. Episodes of restraint were recorded in detail in incident reporting forms. Details included the duration of each position of restraint, the type of restraint and which staff members were present during the restraint. The senior management team checked every month that all incidents of restraint and rapid tranquilisation had been recorded.

The service did not have a restrictive interventions reduction programme. This was not in accordance with best practice guidance (Positive and proactive care: reducing the need for restrictive interventions, 2014). However, the senior management team undertook an annual review of restrictive interventions.

Staff used restraint only after verbal de-escalation had failed. All clinical staff on the ward were trained in prevention and management of violence and aggression (PMVA). Staff told us that they would always try and de-escalate by talking to patients first. Staff understood the Mental Capacity Act definition of restraint and worked within it. Records showed that staff restrained the patients to prevent harm to the patient.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Patients that were given rapid tranquilisation were monitored at least every hour, or in some cases every 15 minutes in accordance with the guidance..

Staff did not seclude patients on the ward. There was no seclusion room at the hospital.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding referral, and did so when appropriate. Ninety-one per cent of staff in the hospital had received training in safeguarding adults and safeguarding children at the time of our inspection. Before the inspection, the provider did an annual survey of staff and patients to check their knowledge of safeguarding. It showed that the majority of staff and patients knew about safeguarding.

Staff could give examples of how they protected patients from harassment and discrimination, including those with protected characteristics under the Equality Act 2010.

Safeguarding concerns reported by staff included, financial, physical and sexual abuse. Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

The designated safeguarding officer was the hospital social worker. In addition, there were two safeguarding leads on Lower Court. These leads received specific safeguarding supervision, had a higher level of safeguarding training and had dedicated time to spend on this role. They supported and assisted other staff to consider safeguarding where appropriate.

There was a clear system for recording safeguarding referrals and for keeping track of progress of those referrals. Monthly audits were undertaken to identify any themes and trends, and these were reviewed in the clinical governance meeting. A yearly audit of safeguarding referrals was reviewed by the quality committee.

Staff followed clear procedures to keep children visiting the ward safe. Rooms were booked outside the ward for patients to meet privately with young relatives.

Staff access to essential information

Patient care records were stored on an electronic system. Staff used this system to record and access each patient's progress notes, care plan, risk assessments and other information relating to care and treatment. All clinical staff had access to the electronic system. Existing records were assessible to staff if patients were re-admitted to the service at a future date.

Medicines administration records and physical health monitoring records were completed on paper. Staff were not expected to record information on more than one system.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely and in well-organised cabinets and a medicines fridge and were disposed of safely.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicine.

The system for providing patients with medicines when they were discharged did not always meet best practice requirements. This was the case when patients decided to self-discharge and were not willing to wait. Medicines for the patient to take away were then dispensed by the ward doctor and a registered nurse. However, the medicine boxes did not have the required warning labels, such as for not operating machinery, or to be taken after food. This meant that the risks associated with medicines were not minimised. When we raised this with the management team, they immediately developed medicine information sheets for patients to be given out when this occurred. These included easy-read versions. They also planned to obtain the appropriate warning labels.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence (NICE) guidance. Physical health monitoring occurred daily for patients on high dose antipsychotic medication. Records of the storage and administration of controlled drugs were kept on each ward. The records showed that the service met legal requirements in relation to the monitoring and storage of controlled drugs.

Track record on safety

There had been no serious incidents on the ward in the year before the inspection. The threshold for the provider to classify an incident as a serious incident was lower than that in NHS services.

Reporting incidents and learning from when things go wrong

Staff reported all incidents that they should report. Staff across the hospital reported incidents such as medicines errors, patients going absent without leave and incidents of self-harm.

Staff understood the duty of candour. The duty of candour is a legal duty to be open and honest with patients or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future. The duty of candour was part of the incident reporting system. This was checked by the management team to ensure that the duty of candour was followed following incidents where it was required. For example, a member of staff had fallen asleep during a night shift. The patient involved received an apology the next day after the incident, from the hospital director. This incident was raised as a safeguarding with the local authority and the agency staff member was barred from working on the site.

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

Good

Staff received feedback from investigations of incidents, both internal and external to the service. Incidents were discussed in the monthly clinical governance meetings and lessons learnt group. Staff also discussed incidents and subsequent actions in ward business meetings. We saw an example of photographs highlighting risks in the environment, which had led to incidents in other hospitals. Serious incidents were also be discussed in monthly supervisions.

Staff were able to give us examples of changes which had been made following incidents from across the service. For example, a second door had been added to the entrance to the ward as patients were previously absconding via the single door. Before the construction of the second door a staff member had been placed by the ward entrance to try and prevent patients absconding.

Managers debriefed and supported staff and patients after any serious incident. Immediate debriefs took place following serious incidents. Sessions with counsellors and other necessary adjustments were made for staff who needed time to reflect following serious incidents.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Records showed staff completed a comprehensive mental health assessment of patients in a timely manner at, or soon after, admission.

During our last inspection in May 2018, the content of some patients' care plans was generic and lacked the necessary level of detail to ensure they were person-specific. During this inspection, we found this had improved, but there was more work to do to make sure this was consistent. Most care plans we reviewed were personalised, holistic and recovery-oriented. However, two out of five care plans reviewed still had some elements that appeared generic. For example, in one care plan it was not clear what techniques the patient should use to manage their anxiety. Each patient had four separate care plans in place entitled 'keeping me safe, keeping me connected, keeping me healthy and keeping me well'.

Staff assessed patients' physical health needs on admission and summarised these in the 'keeping me healthy' care plan. Initial physical health assessments included patients' height, weight, blood pressure and any existing physical health conditions.

Staff updated care plans where necessary. The care plans we reviewed had all been updated regularly.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence. Patients were assessed by a therapist on admission and a programme of therapies specific to their needs was put in place. The therapies included cognitive and dialectical behavioural therapies and family therapy. A range of therapy groups were available to patients such as anger management group, men's and women's groups. Two patients we spoke with said there was a lack of activities in the evenings and at weekends. Ward staff had recently introduced a quiz night and movie night in the evenings in response to patient feedback.

Chronotherapy was used to treat patients' depressive symptoms. Chronotherapy involves a variety of strategies to control exposure to environmental factors, which may influence depressive symptoms. This treatment is not widely available in the United Kingdom but has a strong international evidence base.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Patient records showed that staff supported patients to get access to specialist treatment. A patient had previously been supported to attend the local hospital for an electrocardiogram (ECG, to check the heart's rhythm) and a magnetic resonance imaging (MRI) scan. Staff also supported patients to attend local dental practices.

Staff assessed and met patients' needs for food and drink and assessed those needing specialist care for nutrition and hydration. Patient records indicated that staff referred patients to a dietitian when required.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients who wished to stop smoking were supported by staff to access nicotine replacement therapies. The service facilitated walks and exercise groups for patients. Staff helped visit a swimming pool in the local area.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used Health of the Nation Outcome Scales (HoNOS) to measure improvements in the health of all patients on admission and at the point of discharge.

Staff did care plan audits, pharmacy audits, safety check audits and security audits on a weekly basis. An admission assessment audit and rapid tranquilisation audit were conducted on a monthly basis. The medical director had taken on the responsibility of completing their own audits in relation to medicines management, in response to concerns being raised by the ward's pharmacist. There was a reduction in errors being noted since the introduction of the new audit.

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. The multi-disciplinary team included staff from a variety of professional backgrounds, including medical, nursing, psychology, occupational therapy, social work, and pharmacy. There was input from a range of professionals in patient care records.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Staff we spoke to were knowledgeable about the current patient group.

Managers provided new staff with a comprehensive induction, including a checklist of tasks to be completed over their first six months. New staff were provided protected time to become familiar with the policies of the ward and to complete the mandatory training. New starters worked the same shift pattern as their mentor or line manager for the first week.

Managers provided staff with supervision. The provider's target rate for supervision compliance is 85%. The clinical supervision rate was 89% between 1 August 2018 and 11 September 2019. Supervision was recorded on a standard template. Supervision sessions included discussions about the employee's wellbeing, safeguarding, complaints, compliments, details of 1:1 sessions with allocated patients and career development. Staff we spoke to said they felt well supported by their managers.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work. As of 9 September 2019, 70% of non-medical staff had received an appraisal. Seven staff had not had an appraisal in the last 12 months. The ward manager told us this was due to a change in the system that recorded appraisals. All doctors had undergone revalidation in the last 12 months.

Managers ensured that staff received the necessary specialist training for their roles. For example, some staff were phlebotomy trained.

Managers supported staff through periods of poor performance. Staff were monitored constructively during supervision sessions and accessed additional training.

Multidisciplinary and interagency team work

Staff held regular and effective multi-disciplinary meetings. Each consultant held a ward round once a week. Ward rounds were attended by a nurse from the ward and a member of staff from the therapy team. During each ward round, the consultant and a nurse met with the patient, reviewed the patient's progress and discussed any plans for the patient's discharge.

Effective multi-disciplinary handovers took place between each shift. During the inspection we attended one handover. Any significant updates from the previous shift were discussed.

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

As of September 2019, 78% of staff had received training in the Mental Health Act. Staff who were due to undertake Mental Health Act training had been booked onto the next available training day.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it.

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

Good

A patient advocate regularly visited the ward and contact details for the advocate were displayed on the ward notice boards.

Staff explained to patients their rights under the Mental Health Act (Section 132 rights) in a way that they could understand. This happened on admission and were being repeated at regular intervals.

A Mental Health Act (MHA) compliance audit was undertaken in April 2019 by the MHA administrator within Priory Healthcare. The MHA administrator who led on the MHA did regular audits of paperwork for compliance, and checked that rights were explained. These audits were discussed within the flash meeting every week but also within the monthly clinical governance meetings.

Good practice in applying the Mental Capacity Act

As of September 2019, 82% of staff had received training in the Mental Capacity Act within the service. Staff that were due to undertake this training were booked on the next available training day.

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

The ward managers undertook peer audits of each other's wards with regards to the completion of documentation around capacity to consent to treatment. These audits were reviewed in clinical governance meetings. They were also supplemented by the provider's internal compliance inspector, who reviewed the audits during visits.

There had been no Deprivation of Liberty Safeguards applications made for patients during the 12 months before the inspection.

Polices on the use of the Mental Capacity Act and Deprivation of Liberty Safeguards were available for staff to access.

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

Good

Kindness, privacy, dignity, respect, compassion 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 when they needed it. During the inspection we observed positive interactions between staff and patients. All the patients that we spoke to said that the staff members treated them with dignity and respect.

Staff supported patients to understand and manage their care, treatment or condition. Nurses met patients individually and patients were invited to attend weekly ward rounds with their consultant.

Staff directed patients to other services when appropriate and, if required, supported them to access those services.

Staff understood the cultural needs of patients. Staff would support patients to attend places of worship outside of the hospital when requested. A member of staff attended the equality and diversity group for the provider. The staff member was planning on setting up a specific lesbian, gay, bisexual and transgender (LGBT+) group within the service for both patients and staff.

Staff told us there was an open culture within the staff teams and they were confident in raising any concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences.

Staff maintained the confidentiality of information about patients. Patient information was displayed on a whiteboard in the nursing office. When the whiteboard was not in use staff lowered a blind over the whiteboard to cover the patient information.

Involvement in care

Involvement of patients

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

Good

Staff used the admission process to inform and orient patients to the ward and to the service. All patients were provided with a ward information pack. This pack contained information about the facilities on the ward, visitor information, complaints process and advocacy.

Staff involved patients in their care and gave them access to their care planning and risk assessment documentation. All the patients we spoke with said that they had seen their care plan and had contributed to it. Patients also said they felt able to contribute to discussions during ward rounds.

Staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. All patients we spoke with said that they understood their care plan. The ward manager would arrange a translator to attend ward rounds if a patient did not speak English.

The hospital did not have a range of initiatives to involve patients in the operation of the service. Other areas of work had been prioritised to improve care and safety on the wards. The service had plans to further develop the involvement of patients in the way the service ran in the months following the inspection.

Patients could give feedback on the service and their treatment and staff supported them to do this. Staff enabled patients to give feedback on the service they received during weekly patient community meetings. Previous community meetings could be found on the notice board on the ward. Patients were also provided with an end of treatment satisfaction survey in their welcome packs.

Staff ensured that patients could access advocacy. The service displayed contact details for the advocate on a notice board. All of the patients we spoke with said they knew how to contact the advocate.

Involvement of families and carers

Staff informed and involved families and carers appropriately and provided them with support when needed. Family and carers were invited to ward rounds with the patient's permission. Staff members would help support patients to go on home leave. Staff members that were trained drivers would drive patients to and from their carer's home. Patients were risk assessed before being driven by staff members.

Care records indicated that families and carers were involved where appropriate. For example, in one patient's care record it was evident that their mother was routinely updated following every ward round.

The hospital did not have a wide range of initiatives to involve families and carers in the operation of the service. Although attempts had been made to get some family members of patients to join clinical governance meetings, this had not happened. The service had plans to develop ways in which family members and carers could be involved with the operation of the service.

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

Good

Access and discharge

Bed management

Average bed occupancy on Lower Court between 1 March 2019 and 11 September 2019 was 79%. This included patients admitted for substance misuse treatment.

Beds were available for patients who went on overnight leave. Patients were not expected to move beds unless justified on clinical grounds.

If someone became very unwell, beds on a psychiatric intensive care unit were obtainable at a private provider a short distance away.

The average length of stay on Lower Court was 25 days between 1 August 2018 and 11 September 2019.

Discharge and transfers of care

Staff planned well for patients' discharge, including good liaison with care managers/care co-ordinators from community mental health teams in the patient's local area. Care co-ordinators were invited to attend ward rounds when a patient was nearing discharge.

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

discussed during ward rounds. Patients that were discharged received a follow up phone call from the ward two days after discharge. Staff would help support patients if they required treatment in an acute hospital.

Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Bedrooms were large, fitted with good quality furniture and had en-suite bathroom facilities.

Patients had somewhere secure to store their possessions. Patients could lock their bedroom doors to ensure their possessions were secure.

Staff and patients had access to the full range of rooms and equipment to support treatment and care. On the ward there was a clinic room, a lounge for all the patients and a female only lounge. Patients had their meals in a dining room shared by staff and patients from across the hospital. Therapy groups and sessions took place off the ward at the therapy department.

The ward had a quiet area and a room where patients could meet with visitors in private.

Each patient was able to use their own mobile telephone during their stay, unless there were specific risks identified with patients being in possession of their mobile telephones.

The hospital had large grounds that patients could access. Patients whose risks were perceived to be higher were escorted by staff when they accessed the hospital grounds.

All patients that we spoke to said that the food provided by the hospital was of good quality. We observed patients and staff eating the same food that was freshly prepared on-site.

A kitchen area was available on the ward for patients to freely access whenever they wished. They could store and prepare snacks and hot drinks in this area.

Patients' engagement with the wider community

Staff supported patients to maintain contact with their families and carers. Most patients maintained contact with their families throughout their admission. Family therapists supported patients and their families to gain the skills needed to support each other following discharge from the service.

Meeting the needs of all people who use the service

The service could support and make adjustments for people with disabilities. There was a wheelchair accessible bedroom and bathroom on the ward.

All patients we spoke with were positive about the therapy groups available. However, patients felt that there were not enough activities in the evenings or on weekends. Staff had recently started a quiz night during a weekday evening and a film night during the weekend to provide patients with activities outside of therapy time.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Patients received this information in their welcome packs, this information was also displayed on notice boards in the communal area of the ward.

Staff could make information leaflets available in languages spoken by patients if and when required. These leaflets could be sent for full translation into any language by the hospital admission team.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All food was prepared and cooked on-site and could be made according to specific needs and preferences.

Patients had access to spiritual, religious and cultural support. Staff told us they escorted patients to their local places of worship. Prayer could also be facilitated in quiet places on the ward when necessary.

There was no specific information, or specific activities, for LGBT+ patients. However, a staff member was planning a specific LGBT+ group in the hospital for patients and staff.

Listening to and learning from concerns and complaints

In the 12 months before the inspection there had been 31 complaints in relation to Lower Court. Following investigations, 17 were not upheld, five were partially upheld and nine were upheld. No complaints had been referred to the ombudsman.

Patients knew how to raise concerns. Patients could make complaints in writing, on the telephone and in person. They could also make complaints via their advocate. We also saw an example where nursing staff had raised a complaint on behalf of a patient.

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

Good

Staff knew how to deal with complaints and there was an established system for ensuring complaints were responded to. This included informing the person who had complained of the timescale when they would receive a response.

The hospital director wrote a response to patient complaints. These responses identified each area of complaint and whether this was upheld, partially upheld or not upheld. There was also a description of how the complaint had been investigated. When parts of a complaint were upheld, there was an apology and details of how the service would take action to reduce the chance of similar complaints in future.

The service clearly displayed information about how to raise a concern in patient areas. Staff provided patients with information about how to make a complaint when they were admitted to the ward.

When patients complained or raised concerns, they received feedback. Whenever possible, the ward manager dealt with informal complaints straight away and gave patients feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared in team meetings and during supervision.

The service used compliments to learn, celebrate success and improve the quality of care. The ward received 50 compliments in the 12 months before the inspection. Thank you cards were displayed on the wall in the ward managers office.

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

Good

Leadership

The senior management team had a good grasp and oversight of the services they managed. The new director of clinical services had been in post for three weeks at the time of the inspection. They had already made an impact and gained the trust and respect of staff. All of the senior leadership team were very experienced and had the knowledge and skills to undertake their roles.

Leaders in the service were visible and accessible to staff and patients. Staff spoke highly of the senior leaders in the service. Leaders in the service could describe how staff were working to provide safe, high quality care.

Development opportunities were available for staff in the service. A non-registered nurse had been sponsored to undertake education to become a registered nurse.

Vision and strategy

The provider had a clear vision to make a real and lasting difference to patients' lives by putting people first, being a family, acting with integrity, being positive and striving for excellence.

Bi-monthly employee awards recognised staff who achieved and demonstrated the provider's values. In addition, information on expected standards and behaviours were given to staff in the form of a 'credit card'. The value of being a family was also promoted by staff groups throughout the hospital providing feedback to the clinical governance meeting.

Culture

Staff were positive about working at the hospital and were very positive regarding the hospital director and new director of clinical services. Overall staff morale was high.

Efforts to improve staff morale had included providing gift vouchers for staff who had worked for the provider for five, 10 and 20 years. 'Surprise Fridays' included an ice cream van onsite for staff during hot weather or providing high quality donuts for all staff. There were also plans to fund a Christmas party for staff.

The staff survey the previous year had an overall response rate of 30%. At the time of the inspection, a staff survey had just started. In one week, 40% of staff had responded to the survey. This demonstrated there was already more engagement from staff before the staff survey had been completed.

When performance issues had been raised, the management team took action to address these. This

included suspending staff when necessary for an investigation to take place. Supervised practice, support and coaching were also used to assist staff in meeting expected standards.

Staff were aware of the provider's whistleblowing policy and told us that they would speak up about any concerns they had.

Governance

The governance system for the service had been reviewed and changed considerably in the previous year. The monthly clinical governance meeting included written reports from all staff groups, such as registered and non-registered nurses, and housekeeping staff. The clinical governance meeting reviewed a wide range of quality and safety information, including ward community meeting minutes, infection control audits, incident reports and complaints. The minutes of the clinical governance meetings were stored on the staff intranet so that all staff could access and read them.

The hospital quality and safety committee met every three months. This committee reviewed themes and trends from health and safety incidents, audits and other quality-focused work. The lessons learnt group looked at incidents, safeguarding matters and complaints to identify learning and put in place actions to minimise repetition.

At hospital and ward level, there were standard agenda items for team meetings. This ensured incidents, complaints, safeguarding referrals and learning from investigations were shared with staff. There were also senior management team meetings and heads of department meetings. These focused on overall quality and safety matters with the aim of improving communication across the hospital and between staff groups.

Management of risk, issues and performance

The hospital had a risk register which outlined the current highest risks in the service. These risks reflected those we found during the inspection and reported by staff. Staff could submit items to the hospital's risk register through the ward manager or they could speak directly to senior managers.

'Flash' meetings were held every weekday morning. These involved ward managers and senior managers. The purpose of these meetings was to predict any potential difficulties in providing safe and high-quality care for patients that day. This could involve staffing difficulties or particular clinical situations. The 'flash' meeting ensured that senior managers were aware of the potential difficulties and could take action to minimise them. This could include senior managers spending time on the wards to support staff.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for front line staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Staff said they had sufficient computers to carry out their roles.

Information governance systems included confidentiality of patient records. All computer systems were assessed by individual usernames and passwords.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to the relevant external bodies as needed. Staff sent notifications in a timely manner to the Care Quality Commission in relation to patients sustaining injuries, allegations of abuse and incidents reported to the police.

Engagement

Staff had up-to-date information about the service. They could access clinical governance meeting minutes and learned about developments in staff business meetings. The senior management team were clearly focused on improving engagement with staff and were visible and accessible on the wards. Staff could also access news items on the providers' intranet to learn of developments within the provider. Engagement with staff was further promoted by 'Surprise Fridays' and staff receiving various types of vouchers for their performance.

Patients were asked to complete a satisfaction questionnaire at the end of their treatment. This was in paper form or online. Feedback from patient satisfaction questionnaires was discussed in ward community

meetings, which members of the senior management team attended. This feedback had included more sports activities being available, and the service was working towards operating a gym on site.

The senior management team recognised there was more they could do to develop the engagement of patients and their relatives or carers. Attempts to have a patient attend the clinical governance meetings had not been successful. However, other plans included patients sitting on staff interview panels and developing a carers group to obtain feedback.

Learning, continuous improvement and innovation

The hospital management team were clearly committed to continuous improvement of the service. There had been a focus on staff inductions, the required standards and behaviours of staff and on staff morale and engagement. The hospital also had a quality improvement facilitator to support staff with identifying and implementing ways of working to improve the quality of care to patients.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

Overall, both wards were safe, well equipped, well furnished, well maintained and fit for purpose.

At the focussed inspection in October 2018, we found that the provider should ensure that they met timescales for the minimisation or removal of all ligature points on the child and adolescent mental health (CAMHS) wards to create a safe environment. During the current visit, we found that the provider had refurbished young people's bedrooms, removing ligature anchor points. They had also addressed concerns about poor lines of sight to observe patients due to the layout of the environment. They had installed further convex mirrors to address blind spots, including those in bedrooms, and could also observe particular areas through the use of closed-circuit television. New, sturdier furniture had been provided on the wards. In addition, staff observed patients assessed to be at risk of self-harm in accordance with the provider's policy for close observation and made regular checks of the location of all patients within the building. With permission from patients, staff were also using a monitored system of closed-circuit television cameras (CCTV) in some bedrooms to monitor patients at high risk of self-harm.

The provider had made a detailed risk assessment of all parts of the building, including ligature risk assessments. This was completed in September 2019 and included all the ward areas. The audits clearly identified all anchor points/risks and what was in place to mitigate them. For example, young people were only able to access the lounge with staff supervision. Further plans were in place to upgrade some of the windows on the wards, and for four more bedrooms to be fitted with desks.

The provider issued a staff bulletin on ligature points and choking risks. This bulletin identified new risks following learning from incidents in other services. The bulletin included pictures to assist staff in identifying and managing these risks.

Both wards could accommodate male and female young people. There were no seclusion facilities at the hospital. Situations involving heightened risks to patients were managed by increasing the levels of observation.

We observed a swift but calm response to alarm calls on the wards. The provider regularly tested response times to emergency alarms and call buttons and had a rolling programme of emergency scenario drills. Staff discussed the learning from each scenario to improve their response in a future emergency.

Maintenance, cleanliness and infection control

Overall, the wards were clean, well maintained and appropriately furnished. Domestic staff kept records on the cleaning tasks they carried out. Each day, a member of staff was assigned the responsibility of checking the ward for any cleaning or maintenance issues. Staff logged and reported any maintenance issues and signed any issues off once completed. Staff tested alarms weekly to make sure they were working correctly. Staff told us they were aware of safe handwashing practice and infection control protocols and had training on this.

We observed that the kitchen areas for young people's use only had one sink, instead of separate sinks for food preparation and handwashing, which would have been good practice. We also found a small number of out of date food items in the refrigerators on Oak Ward. Staff addressed this promptly.

Some patients told us that the carpets on the ward were not always as clean as they would like. One of the ward managers told us that they were looking at the possibility of changing or removing carpets on the ward.

Clinic room and equipment

The clinic rooms were clean, tidy and organised and equipment was maintained and calibrated. Although audits were regularly undertaken, there were a small number of disposable medical items which were past their expiry date and there were no child size pads for the defibrillator.

At the focussed inspection in October 2018, we found that the provider did not have robust systems in place to ensure all clinic room items were within their expiry date, and the clinic rooms were cleaned regularly. At the current inspection, we found this had mostly been addressed. The clinic rooms on Oak and Birch wards were clean, tidy and organised with records in place to demonstrate regular cleaning. We found a small number of items in the emergency bag that were out-of-date on Oak Ward, including disposable forceps, which expired in February 2019. Staff advised that an external pharmacist came in weekly to audit the clinic room, and staff completed their own audits, but these issues had not been picked up. However, as soon as we raised the issues, staff took swift action to rectify them.

Equipment, such as blood pressure monitors, a mobile electrocardiogram, and scales were serviced regularly. Emergency equipment included a 'grab bag', defibrillator, oxygen cylinder, suction machine, first aid box and ligature cutters. Records showed staff checked the equipment daily and the contents of the grab bag once each week. Emergency medicines were in date. However, there were no child size pads, for young or low weight children, available for the defibrillator. There were no young or low weight children on the wards at the time of the inspection.

Safe Staffing

Nursing staff

The service did not always have enough nursing staff who knew the patients and could provide the care and support patients needed.

Patients on Birch Ward told us that there were times when they felt unsafe due to insufficient staff and a high reliance on agency staff. They also told us that there were times when they were unable to take their escorted leave. This was usually due to an incident on the ward. However, there had been a large number of incidents in recent months. Patients said that the nursing staff did not have a sufficiently visible presence on the ward and were often either in the office or clinic room or on one-to-one duty with another patient. Staff confirmed that a significant

number of vacancies for registered nurses and subsequent use of agency staff, combined with a very unsettled period on Birch Ward, supporting patients with a high level of needs, had impacted on patient care and staff morale.

Staff and patients described Birch Ward as sometimes being chaotic. Staff had raised concerns in their team meetings about not being given breaks from one-to-one duties for extended periods and were advised that management were attempting to address this. They also described times when there were not enough staff on duty, due to a sudden increase in the levels of patient observation needed. There had also been recent incidents during which staff had been injured at work.

Between 1 August 2019 to 9 September 2019 turnover across the wards was 28% on Oak Ward and 20% on Birch Ward. Staff sickness was 1.9% on Oak Ward and 1.7% on Birch Ward over this period. The establishment was 7.7 registered nurses on Oak Ward and 10.3 registered nurses on Birch Ward. At the time of the inspection there were 50% registered nurse vacancies across both wards, of which 6.5 whole time equivalent (WTE) vacancies were on Birch Ward, and 3.7 WTE vacancies were on Oak Ward. The provider was looking to promote recruitment to registered nursing posts by offering an increment in pay to suitable new staff.

At the time of inspection, staff said they were relying on regular use of agency nurses, although they used locum staff (agency staff who worked regularly on the wards) as much as possible. Some permanent staff worked additional shifts as part of the hospital's bank of staff. In the three months from 10 June 2019 to 9 September 2019 bank and agency staff had been used to cover 202 shifts on Birch Ward and 145 shifts on Oak Ward. Ward managers said that

they attempted to include regular bank and agency staff in team meetings and provide supervision, but due to a high number of staff required to conduct patient observations, this was not always possible.

For non-registered nurses, the establishment was 13.1 on Oak Ward, and 15.8 on Birch Ward, with no vacancies at the time of the inspection. Although there were no vacancies for non-registered nurses at the time of the inspection, their high turnover was recognised as a challenge for the wards, with new staff taking time to get to know patients and become familiar with the wards.

Two registered nurses were scheduled to be on duty on each ward at all times. The number of non-registered nurses varied according to the number of patients, and the number of patients requiring enhanced observations. This level of staffing was determined by a staffing calculator that was used across the Priory Group. Ward managers were able to adjust the level of staffing on the ward according to needs and the number of patients who were admitted.

Staff told us that there were some occasions when only one registered nurse was on duty during the day shift, due to late sickness or absence, and failure to obtain agency cover. Staff reported these as formal incidents. The provider increased the number of non-registered nurses during these emergency situations.

Medical staff

The consultant psychiatrists were supported by a ward doctor on each ward. An out of hours doctor was also available on site outside of normal office hours.

There were three child and adolescent mental health consultant psychiatrists covering the two wards, each working four days a week. There was also input from a consultant specialising in obsessive compulsive disorder as needed.

Each of the wards had a ward doctor on weekdays during normal working hours, one of whom was a long-term locum. Outside of these hours, there was a resident doctor for the hospital, and a CAMHS consultant psychiatrists' rota, meaning a doctor could attend a ward quickly in an emergency at any time of the day or night.

If a patient had a physical health problem which required further medical assessment they were taken to the general hospital nearby.

Mandatory training

A range of training was available for staff, including CAMHs specific training and reflective sessions. Across the hospital over 90% of staff had completed all mandatory training.

Information submitted to the CQC prior to the current inspection indicated a high level of compliance with staff mandatory training across the hospital. Across the hospital, 91% of relevant staff had completed appropriate training in safeguarding children and safeguarding adults. All relevant staff had completed training in preventing and managing violence and aggression, breakaway techniques, basic and intermediate life support, and risk assessment.

Staff told us that they had access to the training they needed, and also attended CAMHS training days approximately every quarter to look at specific topics. Most recently the training day focussed on reviewing emergency drills, risk assessments and fire safety. There were fortnightly reflective sessions for staff to cover specific topics. However, staff said that they could not always attend these due to the staffing needs on the wards.

Assessing and managing risk to patients and staff

Assessment of patient risk

Risk assessments for patients were undertaken on admission and were updated frequently. Patients' risk assessments were comprehensive, specific and detailed and led to the development of patient-centred risk management plans.

We reviewed the records of nine patients across the two wards and found that detailed risk assessments had been carried out on admission by a registered nurse or the ward doctor. These assessments were frequently updated and included clear information about current risks. A wide range of actual and potential risks were recorded including those relating to self-harm, suicidal thoughts, absconding, self-neglect, and inappropriate sexual behaviour. Risk management plans included details of how these risks were to be managed in a way that was specific to the individual needs and preferences of the patient.

Management of patient risk

Individual patient risks and overall systems to minimise patient risks were managed well.

Good

Child and adolescent mental health wards

Every weekday morning the management team in the hospital met for a 'flash' meeting. This meeting was to review any concerns and to plan the next 24 hours. The focus of the 'flash' meeting was to ensure effective communication in managing risks and staffing.

Staff on the CAMHS wards carried out simulations of emergency scenarios twice monthly. Staff told us that following training, they were far more aware of the whereabouts of all young people on the wards to ensure their safety. We observed swift but calm staff responses to alarms on the wards.

Staff told us that they were conducting more targeted searches of young people's belongings than previously and had introduced a cupboard for parents/visitors to store belongings before visiting the wards. Parents were able to visit young people in their bedrooms. Visits from friends and siblings took place in a room away from the ward and needed to be booked in advance.

Staff reviewed risk checklists at least once a week, and integrated risk management plans into young people's care plans. The multi-disciplinary team updated young people's risk assessments during weekly ward rounds. The ward managers completed weekly audits of risk assessments to ensure they were in place and appropriate.

Observations of patients by the nursing team were used to manage the risks that patients presented. The level of observation was determined by the risk assessment and reviewed on an ongoing basis. Observation levels could only be reduced with the agreement of the ward doctor or the consultant psychiatrist.

Staff completed paediatric early warning scores (PEWS) for each young person to monitor their physical health. We reviewed 12 of these and found that they were completed correctly. The multi-disciplinary team reviewed patients' PEWS charts in weekly ward rounds. All staff had refresher training in PEWS, and staff said they felt confident in using the PEWS tool.

Use of restrictive interventions

There were a number of restrictive practices used on the wards, many of which had a clear rationale. Some restrictive practices had been reviewed and relaxed.

However, there was no formal restrictive interventions reduction programme, to review and reduce restraint and rapid tranquilisation and address the blanket practice of searching all patients' bedrooms.

Senior managers checked every month that all incidents of restraint and rapid tranquilisation had been recorded. The service did not have a restrictive interventions reduction programme. This was not in accordance with best practice guidance (Positive and proactive care: reducing the need for restrictive interventions, 2014). However, the senior management team did undertake an annual review of restrictive interventions.

Staff were able to explain the rationale for restrictions on the wards. For example, television remote controls were not permitted due to the risks posed by young people accessing batteries.

Young people were allowed their mobile phones during certain times of the day, but all phones were charged in the nursing office overnight. There were lockers where patients could store contraband items such as phone chargers. Staff told us about ways in which they had reviewed restrictive practices on the ward, including leaving the young people's kitchen open unless the level of risk on the ward was raised. They noted that some young people preferred to give permission for the monitored CCTV cameras in their bedrooms to be operational, to replace enhanced observations from a staff member in their bedroom.

Staff knew what constituted a physical restraint of a young person and told us that an incident form was completed on each occasion. All staff talked about using verbal de-escalation first to support young people during times of distress, and we observed staff using these techniques during the inspection including use of ice packs, music, and breathing techniques.

Staff said they and the young person involved in a restraint were offered a debrief, including time to reflect after each episode of restraint. They discussed with their manager what went as planned and what could have been improved. We reviewed records of four episodes of restraint by staff. All were filled out to a good standard and had the necessary information recorded including evidence of repeated attempts at de-escalation, rationale for restraint, position of restraint, and if the young person was seen by a doctor.

Staff told us that most restraints were to prevent absconding. In the last six months there had been 72 incidents of restraint. There had been 39 restraints of 12 young people on Oak Ward. Two of these restraints involved restraining young people in the prone position, where they were face down, and involved the administration of rapid tranquilisation medicine. There had been 33 restraints of 15 young people on Birch Ward. Four of these restraints involved prone restraint and rapid tranquilisation.

We checked records for a patient on each ward who had received rapid tranquilisation and found that appropriate physical health checks including monitoring vital signs, were recorded as appropriate.

Some rules on the wards formed part of the therapeutic routines. For example, young people were required to be in bed by 10.30pm on weekdays and 11.00pm at weekends, and to get up at 7.45am each morning. There was some flexibility in this rule for older patients. Patients had full access to their bedrooms during the day.

Decisions about leave for detained patients were made following the Mental Health Act 1983 as appropriate. Decisions to grant leave to informal patients were based on risk and competency. Patients were usually escorted when they left the hospital grounds, unless they were 17 or older. Searches were carried out by two members of staff when patients returned from leave based on current risks on the wards. Patients were given a list of items that were banned from the ward. Following an incident involving banned items, all young people had their bedrooms searched twice per month. This was a blanket practice for all patients and was not related to individual patients' risks. Searches involved looking through the young person's bags, checks with a metal detector and removal of shoes in line with the hospital policy. Room searches were conducted with patient consent. However, if a patient did not consent to a room search, the matter would be discussed with the multi-disciplinary team and the patient might be placed on one-to-one observations to reduce any risk to their safety.

There were no facilities for the seclusion of patients at the hospital. Staff explained that where there had been instances that young people required this level of intervention, they would be transferred to a psychiatric intensive care bed at another hospital. If it was necessary for a patient to remain in their bedroom during this period, this would be treated as seclusion, with the necessary checks and recording in place in line with the Mental Health Act Code of Practice.

Safeguarding

There was an established system to ensure safeguarding concerns were raised and discussed in the hospital. An annual survey of staff and patients was undertaken to check their knowledge of safeguarding. Prior to the inspection, the survey of patients had been undertaken and recorded that the majority of staff and patients knew about safeguarding.

The designated safeguarding officer was the CAMHS social worker. In addition, there were safeguarding leads on each ward. These leads received specific safeguarding supervision, had a higher level of safeguarding training and had dedicated time to spend on this role. They supported and assisted other staff to consider safeguarding where appropriate.

There was a clear system for recording safeguarding referrals and for keeping track of progress of those referrals. Monthly audits were undertaken to identify any themes and trends, and these were reviewed in the clinical governance meeting. A yearly audit of safeguarding referrals was reviewed by the quality committee.

The ward managers understood the risks associated with mixed gender accommodation and said they reviewed this on an individual basis. All bedrooms had en-suite facilities. Young people did not mix with adult patients during any part of their stay. Staff understood the potential risks of interactions with patients in other services at the hospital.

Staff access to essential information

Staff had access to all of the information they required to provide safe care and treatment to young people.

Young people's clinical records were stored on an electronic patient record system. All information needed to deliver patient care was available to the relevant staff, including agency staff, when they needed it and was in an accessible form.

Electronic records contained risk assessments, care records, progress notes and evidence of physical health observations. Staff also used paper records for some tasks, including monitoring physical observations following rapid tranquilisation and recording ward observations.

Agency staff had accounts for the care record system. This allowed them to update and view care plans and risk assessments in a timely manner.

Medicines management

Overall, there was good medicines management practice on both wards.

We checked six young people's medicines administration record (MAR) charts on each ward. All were fully completed with their allergy status, Mental Health Act status, height and weight. They indicated that staff were ensuring that young people were supported to take their medicines as prescribed. When young people had declined to take their prescribed medicines, this was clear from the charts. However, none of the MAR charts included a photograph of the young person, to aid staff administering medicines (particularly agency staff covering the wards), to ensure the correct identity of each young person.

The wards received support from an external pharmacist, who conducted weekly audits. Records of the storage and administration of controlled drugs were kept on each ward. The records showed that the service met legal requirements in relation to the monitoring and storage of controlled drugs.

On each ward staff dispensed patient medicines from a stable-door to the clinic room. Medicines charts clearly described the route for administration and a recorded rationale for the administration of 'as required' medicines.

The system for providing patients with medicines when they were discharged did not always meet best practice requirements. This was the case when patients decided to self-discharge and were not willing to wait. Medicines for the patient to take away were then dispensed by the ward doctor and a registered nurse. However, the medicine boxes did not have the required warning labels, such as for not operating machinery, or to be taken after food. This meant that the risks associated with medicines were not minimised. When we raised this with the management team, they immediately developed medicine information sheets for patients to be given out when this occurred. These included easy-read versions. They also planned to obtain the appropriate warning labels.

Track record on safety

There had been 22 serious incidents in the year before the inspection. The threshold for the provider to classify an incident as a serious incident was lower than that in NHS services. The majority of these involved self-harm. Eight serious incidents concerned a young person absconding, which means leaving the ward without permission.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to use the hospital incident reporting system. The duty of candour was followed and staff received feedback following incidents and changes resulting from the learning from incidents.

Staff knew what incidents to report and used the provider's incident reporting system. A range of incidents were reported. The duty of candour was part of the incident reporting system. The duty of candour is a duty to be open and honest with patients and their families when something goes wrong that caused or could lead to significant harm. This was checked by the management team to ensure that the duty of candour was followed following incidents where it was required. Debriefing sessions for staff and patients were recorded after incidents took place.

The management team reviewed incidents for themes and trends and made changes following incidents. Changes in the service had included relational security training for staff and an additional door to try to prevent patients going absent without leave. Additional radios for staff and torches were also obtained following incidents. Following multiple incidents of young people absconding on their way to the hospital canteen for mealtimes, staff had altered the route, resulting in a reduction in absconsions in recent months. Staff had also made changes to arrangements for young people's unescorted leave following a recent incident.

Staff received feedback about incident investigations. Incidents were discussed in the monthly clinical governance meetings and lessons learnt group. Staff also

Good

Child and adolescent mental health wards

discussed incidents and subsequent actions in ward business meetings and group supervision sessions on the wards. Staff learnt about incidents in other services. We saw an example of photographs highlighting risks in the environment, which had led to incidents in other hospitals.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed the care records of nine patients. These records demonstrated good practice, including holistic care planning assessments. Comprehensive assessments of patients' physical and mental health were completed shortly after admission and were updated regularly following admission. All young people had a completed physical health assessment by a doctor upon admission. The ward's consultant psychiatrist completed weekly audits of young people's physical health assessments on admission to ensure they were complete. Blood pressure, height and weight were monitored each week and physical heath checks were being conducted regularly.

The care plans were updated by the multi-disciplinary team each week. Each young person had a care plan for keeping safe, well, healthy, and connected. They were personalised and recovery-orientated, including statements of the young person's strengths and their personal goals. There was evidence in each file that the patient had been involved in developing the plan.

Progress notes, care plans, and assessments were stored on an electronic patient record, secured by passwords. All staff had access to these records. Observation records were paper based, as staff needed access to them all throughout the day, and stored in the nursing office.

Staff had worked with young people in developing their care plans, and young people we spoke with told us they were involved in producing their care plans. Staff used the young people's own words in the plans, and the plans stated whether the young person had agreed with each care plan. Staff recorded when they offered young people a copy of their care plan.

Best practice in treatment and care

Young people were admitted to the ward for a variety of conditions including the treatment of depression, trauma and attention deficit hyperactivity disorder (ADHD). Patients were sometimes admitted for the treatment of psychosis. The first choice of treatment was psychological therapy. The ward managers advised that the multi-disciplinary team would look at other options before prescribing medicines, and this reflected national guidance for working with children and adolescents.

On admission each patient was allocated a therapist. Therapies included cognitive behavioural therapy, dialectical behavioural therapy, crisis management, trauma recovery, mindfulness and family therapy. Therapies took place in one-to-one sessions and within groups.

All young people had weekly physical health checks including blood pressure, height and weight.

Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) were used to measure improvements in the health and social functioning of patients during their admission. A summary of HoNOSCA scores showed that all patients were assessed against the HoNOSCA scale on admission and on discharge. The children's global assessment scale (CGAS) was also used as a clinical outcome measure.

The service carried out a number of audits. These included physical health assessment audits and audits to ensure patients' mental capacity was assessed and recorded. There were also a number of audits completed through the electronic records system, indicating areas that required attention. Ward managers were able to access the results of audits relating to their ward and shared the findings with the teams.

Most of the young people on the wards had a positive behaviour plan, which they kept in their bedrooms, to support them to address challenging or self-harming behaviours. Young people told us that they had been involved in compiling very specific plans for de-escalation when they were experiencing distress, including use of particular soothing objects and techniques that they found helpful.

Members of the multi-disciplinary team told us about a quality improvement project they were undertaking. This involved auditing the paediatric early warning scores

(PEWS) charts, setting up ad hoc sessions to discuss the findings, and planning teaching for the whole team. This included looking at the physical health monitoring of young people on antipsychotic medication, to better understand what needed to be discussed in ward rounds and included in discharge information.

Skilled staff to deliver care

The multi-disciplinary team included CAMHS consultant psychiatrists, ward doctors, a head of CAMHS therapy (a clinical psychologist) and assistant psychologist, occupational therapist assistant, a social worker, psychotherapists and a family therapist. They worked closely with the nursing team, staff from the education department and activities co-ordinators.

All new staff, including bank and agency staff, took part in an induction programme covering orientation to the ward environment, safety, risk and observation policy and professional conduct. Permanent staff had an initial induction period of six months. Some of the multi-disciplinary staff told us that they would have appreciated a longer period of induction before commencing on a full caseload on the wards.

Staff said they were due to receive supervision every month, however several staff told us that they were not receiving supervision this frequently due to the acuity of patients and recent incidents, particularly on Birch Ward. Supervision figures provided for both wards on 1 August 2019 indicated 95% completion of staff supervision. However, we looked at a sample of 21 staff supervision records and found that there were significant gaps in supervision in recent months. On Birch Ward, eight of 14 staff had not had supervision since July 2019, and two had not had a supervision session since August 2019. Supervision records were detailed, with a focus on practice and further development. Poor performance was escalated to the ward manager and addressed through the disciplinary procedure.

The ward manager on Birch Ward told us that he was in the process of restructuring arrangements for supervision. He noted that high acuity on the ward had an impact on staff levels of stress and morale.

Staff had annual appraisals. As of 9 September 2019, 88% of staff had had an appraisal and 92% of doctors had been revalidated. They were on track to complete all appraisals and revalidation by the end of the year.

Staff told us that they had opportunities to undertake training relevant to their role. At the most recent CAMHS training day staff had covered topics including dialectical behavioural therapy, obsessive compulsive disorder, and care planning. Several staff told us that members of the team would benefit from training in supporting people with eating disorders due to a recent increase in presentation on the wards. This had been identified by ward managers as an area for development.

Multidisciplinary and interagency team work

Nursing staff handover meetings took place twice a day, at the start and end of each shift. We attended one handover meeting during which staff discussed each patient on the ward. They covered the level of observation, mental state, attendance at therapy sessions, involvement in education, activities, contact with family, interaction with other patients and any specific incidents.

There was also a handover between therapists and a nurse each morning, and we also attended this meeting. There was a senior management team handover on Mondays and Fridays when the ward managers would meet with the hospital director.

Ward rounds were held each week led by a consultant psychiatrist. Young people were always invited to attend the ward round, with the option of having a family member/carer attend with them. Members of the multi-disciplinary team attended, including the social worker if they were available. Teaching staff contributed to information discussed at the ward rounds. A dietitian was also available on the ward to review young people each week.

The service maintained relationships with the young people's local authorities ensuring follow up care was planned for after patients were discharged. Care programme approach meetings took place every four to six weeks.

Staff spoke positively about the mix of skills and disciplines within the multi-disciplinary team (MDT). However, several staff observed that there were some divisions between the nursing team and the rest of the MDT. Some nursing staff said that sometimes the therapy staff did not communicate in full what progress or interventions had been discussed with patients, leaving them with a lack of up-to-date information after a patient had a session with a therapist. In turn, some therapy staff said that the nursing team did

not always follow through with the positive behavioural plans they produced with young people. Overall morale was lowest in the nursing staff team, particularly on Birch Ward.

Team meetings took place approximately monthly on each ward, and quarterly on both wards together. Topics discussed included long periods of time carrying out one-to-one observations without a break, recent incidents and learning, an emergency simulation, and patient activities.

At the most recent meeting, staff shared information from other sites about ways in which sharp objects used to self-harm might be concealed by patients. There were also weekly CAMHS leads meetings to share practice and lessons learned across other CAMHS services within the provider organisation.

The ward was introducing fortnightly reflective practice sessions for staff. However, staff told us that due to the high level of needs of patients on the wards, they were not always able to attend these.

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

Staff told us that they had completed training in the Mental Health Act 1983 (MHA) through an online course. Records showed that 78% of staff had completed this mandatory training. Staff were clear about the differences between informal and formal patients, and young people's rights in each case. We reviewed the statutory documents relating to the detention of two young people and found them to be filled out correctly, up-to-date and stored appropriately. Statutory forms were initially checked by the administrator and formally scrutinised by a consultant psychiatrist.

There was a record of each young person's capacity to consent to treatment. Patients were informed of their right to appeal under the MHA and this was recorded on patient files. These records confirmed that the patient had capacity to understand the information that was being explained to them.

At the focussed inspection published in December 2018, we found that staff did not always ensure that young people understood their status as an informal patient. At the current inspection, there was a poster explaining the rights of informal patients, which was on display in communal areas. Staff explained the rights of detained and informal patients at every community meeting on the wards. Young people told us that they understood what it meant to be an informal patient.

Administrative support was provided by the MHA administrator who was based at the hospital.

The hospital managers carried out regular audits of statutory forms relating to the MHA.

An Independent Mental Health Advocacy (IMHA) service was provided by a local advocacy organisation. All detained patients were given information about this service. We were told that this service regularly visited the hospital, and patients had the opportunity to meet with an advocate.

Good practice in applying the Mental Capacity Act

At the inspection published in July 2018 we found that staff on the CAMHS wards did not always have a good understanding of the Mental Capacity Act 2005 (MCA). At the current inspection we found that staff completed mandatory training on the MCA through an online course. Records showed that 82% of staff had completed this training.

Staff understood the issues/ complexities around competence, consent and capacity for under 18-year olds. They described how they had acted within the principles of the MCA when assessing and treating patients including making 'best interests' decisions. For young people under the age of 16, their Gillick competency was assessed. Staff had a good knowledge of the Gillick competency assessment.

Management were working to improve the quality of capacity and competency assessments by increasing the frequency of audits, and involving families, interpreters and speech and language therapists. They were clear about the need to ensure that capacity is reassessed whenever there is a change in the young person's presentation.

Good

Child and adolescent mental health wards

Are child and adolescent mental health wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

At the focussed inspection published in December 2018, we found that agency staff did not always treat young people on the wards with dignity and respect. At the current inspection, most young people we spoke with said that staff were kind, respectful and supportive. They said that the nurses and therapists were interested in working with them and they felt involved in care planning.

Throughout our interviews, staff consistently demonstrated positive attitudes towards the young people they worked with. Staff spoke in a positive manner about patient recovery and showed empathy for the challenges young people on the ward had faced. We observed good interactions between staff and young people on both wards, including prolonged attempts to support patients with de-escalation strategies when they were in distress. Staff told us that some young people used wrist bands as a way of demonstrating if they were feeling well or not.

We spoke with nine young people. Overall young people on Oak Ward described more positive experiences than those on Birch Ward. Several young people on Birch Ward said that there had been times when they thought there were not enough staff on duty and they had felt unsafe. They said that the nursing staff did not have a sufficiently visible presence on the ward and were often either in the office or clinic room or on one-to-one duty with another patient. Young people described mixed experiences with agency staff, and some communication issues between staff working on the wards.

Young people confirmed that they were involved in care planning, could have a copy of the plans, and knew who their named nurse was. All young people we spoke with said that they had access to advocacy.

Two young people said that they had experienced aggression from other patients. Whilst they felt able to speak with staff about their concerns, they said that staff did not always take action. Some young people raised concerns about cleanliness of the wards, furnishings, noise levels on Birch Ward, and the variety of meals provided. Most young people said that they had been given a welcome pack on arrival on the ward, but some said that they had not been given a tour of the ward when they arrived. Two young people said that they were not confident about treatment they were receiving for a physical health problem.

Involvement in care

Involvement of patients

The wards used a feedback questionnaire to gather the views and feedback of patients. An advocacy service visited the hospital once a week. We had the opportunity to meet with an advocate who visited the wards. They noted that one of the main issues young people raised with the service was anxiety about the uncertainty of what would happen once they were discharged from hospital. Staff we spoke with were aware of how this impacted on young people, and this was discussed at handover meetings. The advocate had plans to attend community meetings on the wards regularly.

Community meetings were held once a week and we saw staff acted upon patient feedback or concerns. Minutes of these meetings were written up and displayed on a notice board. We attended a community meeting during the inspection. The meeting was led by the young people. They went through items posted in the suggestions box for the ward and discussed what they would like to do for their next trip out. Minutes of meetings were displayed in a 'you said, we did' format. Examples included concerns from young people that their food items were being thrown out, addressed by labelling of all foods left in the fridge. A concern about tensions on one ward was addressed by offers of mediation groups.

Satisfaction surveys were completed by patients when they were discharged. Feedback from patients was a standing item on the minutes of clinical governance meetings.

The hospital did not have a range of initiatives to involve patients and young people in the operation of the service. Other areas of work had been prioritised. Previous work, such as young people being part of interview panels had not taken place for some time. The service had plans to further develop the involvement of patients and young people in the way the service ran in the months following the inspection.

Good

Child and adolescent mental health wards

Involvement of families and carers

When young people were admitted to the ward, their parents/carers were invited to a welcome meeting to meet with therapists and nursing staff. A meeting was also arranged to meet with the consultant psychiatrist in the first week of admission. Parents were encouraged to visit the ward frequently and nurses were able to update them on their child's progress by telephone. Some parents/carers visited the ward each week to attend the ward round.

The family therapist worked with the social worker on the wards to provide some monthly educational sessions for parents/carers on dialectical behavioural therapy, and a carers' support group. They were able to offer therapy up to twice weekly, with flexibility to provide times that the parents/carers could attend.

We spoke with four parents/carers during and following the inspection visit. Overall feedback was very positive about the level of care provided to young people on the wards. Parents/carers described good relationships with the ward consultant psychiatrists and doctors, noting that they would seek appropriate specialist support when needed.

They described staff as going beyond the call of duty and acting highly professionally after incidents on the ward. They were aware that Birch Ward had been very unsettled in recent months, and that this had led to some escorted leave being cancelled. They expressed some concerns about not always having sufficient staff on Birch Ward. They also raised issues about a need for more physical activities, and about the layout of the hospital making it difficult for young people to access outside space. One relative said that they were not always informed about important issues relating to their child.

The hospital did not have a wide range of initiatives to involve families and carers in the operation of the service. Although attempts had been made to get some family members of patients to join clinical governance meetings this had not happened. The service had plans to develop ways in which family members and carers could be involved with the operation of the service.

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

Good

Access and discharge

Bed management

Staff planned and managed admissions to the wards well. At the time of the inspection, there were six out of 12 beds occupied on Birch Ward, and six out of nine beds occupied on Oak Ward. The ward manager advised that there was a waiting list for the CAMHS beds, but they had made a decision not to admit any further patients at this time due to the high needs of young people currently on the wards.

Over the last six months bed occupancy on Birch Ward had been 85% and on Oak Ward had been 89%. Over the last year from 1 August 2018 to 11 September 2019 the average length of stay had been 74 days on Birch Ward and 80 days on Oak Ward.

Prior to admission, members of the multi-disciplinary team spoke to the referring team to discuss the young person's needs and the purpose of admission. The majority of young people were funded by NHS England.

The ward did not admit young people to beds that were allocated to a young person who was on leave. Young people were occasionally moved between wards in response to bullying or serious disagreements between patients. These moves always took place with the consent of the patient.

Where clinically appropriate, young people could have overnight leave to help them adjust to being out of hospital.

Staff discharged young people at an appropriate time of day. They agreed the time of discharge with young people and their families/carers.

Discharge and transfers of care

Staff planned and managed discharges effectively, they liaised well with services that would provide aftercare. Staff told us that when patients were discharged following recovery, they planned a party to mark the occasion and to wish them well in the future.

If patients became increasingly unwell, the level of observation was increased. Staff tried to avoid transfers to

psychiatric intensive care units (PICUs) as this can be very disruptive for the patient. However, in the month prior to the current inspection, two young people had been transferred to PICU beds.

Delays to discharge were usually caused by a lack of accommodation for young people to move into. All delayed discharges were reviewed by NHS England, the commissioning authority. In the last six months, there were seven delayed discharges on Birch Ward and four on Oak Ward.

Staff told us about how they worked collaboratively to plan a transition period for young people who reached adulthood whilst on a CAMHS ward.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards supported young people's treatment, privacy and dignity. Young people had their own bedrooms and could personalise them. We observed bedrooms that had personal belongings and decorations. Young people could store their possessions securely in their rooms, and contraband items such as phone chargers in lockers on the ward. They were able to adjust vision panels on their bedroom doors for their privacy.

Staff and young people had access to a full range of rooms and equipment to support treatment and care. This included a lounge, activities room, communal kitchen, and school classroom. The ward did not have a specific room for visitors, but a group room could be booked. External rooms could be booked for visitors under 18 years of age. Staff and young people were in the process of decorating the ward corridors with a number of murals, with a tree and branches design to leave messages of support to other patients on the ward. Young people had said that they found this helpful and inspiring.

Young people had a separate dedicated part of the hospital garden with picnic tables. This could be used for playing games such as football. There was also a separate annexe downstairs from the wards with rooms that could be used by visitors and patients. This included a well-equipped art room. To access the hospital dining room, young people had to walk outside the building to avoid passing through the adult wards. The ward managers advised that there were plans to create a covered pathway to make this journey more comfortable for young people.

There was an education room on Birch Ward which was used by patients from both CAMHS wards. Young people attended the hospital school and were positive about the support they received there. In addition to academic subjects, they had recently been involved in developing their ceramics skills, making and glazing clay poppies for charity, gardening and horticulture. The school received visits from a therapy dog in training, which was popular with the young people. The school provision was regulated by Ofsted and was rated as Outstanding at the last inspection in December 2018.

Young people could make a phone call in private. Staff assessed whether young people could use their own mobile phones on an individual basis.

Young people told us they found the food to be of mixed quality. They had access to a kitchen to make themselves a drink or a snack at any time.

The ward had an activities timetable including team building, an occupational therapy group, a dance class, life skills, sports activities, film nights, and karaoke. Activities were organised by an occupational therapy assistant and facilitated by two activity coordinators in the evenings and on some weekend days. At other times, the nursing team carried out some activities with young people on the wards. Recent activities (outside of school hours) included crafts groups, pizza making, slime making, walks. The staff aimed to facilitate a group outing once a week. Recent outings included trips to restaurants, supermarkets, bowling, to the cinema, and local parks. There were also bicycles available for young people to use. During the inspection we observed staff playing cards with young people, and young people involved in art work and jigsaw puzzles. Most young people were satisfied with the activities available to them on the wards. Some young people and parents/carers told us that they would like to have more activities available on the wards at weekends, and more opportunities for exercise.

Patients' engagement with the wider community

Young people had access to education on site, and staff also assisted them to explore other educational opportunities. For example, staff were supporting one young person to attend their school in the local

community. Young people were also supported to access volunteering or work placements when possible. At the time of the inspection one young person was attending a placement at local stables.

Staff supported young people to maintain contact with their families and carers. Staff contacted them on a regular basis and encouraged their attendance at care programme approach meetings (CPAs). In cases where family members/carers were unable to visit, the wards had teleconference facilities they could use to include them in ward rounds or CPAs.

Meeting the needs of all people who use the service

The wards met the needs of all people who use the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support. Both wards were situated on the first floor. There was no lift available, so it was not possible to access the ward in a wheelchair. The ward could not admit young people who used a wheelchair due to the environmental layout. Staff would assess young people on referral and, if required, make adjustments when possible, or refer them to other services that offered full disability access.

All leaflets and other information were written in English. Staff said that this information could be translated into other languages if required. Information was displayed about treatment, patients' rights, how to make a complaint to the hospital and how to contact the Care Quality Commission.

The hospital was able to arrange interpreters and signers if they were required.

The food was of a good quality and patients could make hot drinks and snacks at any time.

The ward menus included dishes that were clearly labelled as being dairy free, gluten free, vegan and free from genetically modified ingredients. Kosher and Halal food was available on request. Some patients were unhappy with the choice of meals available to them, for example wanting a greater variety of vegan options.

The hospital helped patients to access spiritual support according to the specific requirements of the patient. Staff explained that this was usually done with the assistance of the young people's family.

Staff worked with lesbian, gay, bisexual or transgender (LGBT) young people to develop plans to support them, including their accommodation needs. Staff asked transgender young people if they would prefer male or female staff to search them. We observed that staff respected young people's wishes in terms of their preferred gender pronouns, when speaking with them, and in their care records

Staff told us that easy-read formats for care plans could be made available for young people, but this was not applicable to any young people at the time of this inspection.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. Young people knew how to raise concerns. They could make complaints in writing, on the telephone and in person. They could also make complaints via their advocate. We also saw an example where nursing staff had raised a complaint on behalf of a patient.

There were nine complaints in the previous 12 months, of which six were upheld, and one was partially upheld. Staff knew how to deal with complaints and there was an established system for ensuring complaints were responded to. This included informing the person who had complained of the timescale when they would receive a response.

The hospital director wrote a response to patient complaints. These responses identified each area of complaint and whether this was upheld, partially upheld or not upheld. There was also a description of how the complaint had been investigated. When parts of a complaint were upheld, there was an apology and details of how the service would take action to reduce the chance of similar complaints in future.

The wards had received 54 compliments within the last year.

Are child and adolescent mental health wards well-led?

Good

Child and adolescent mental health wards

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. The senior management team had a good grasp and oversight of the services they managed. The new director of clinical services had been in post for three weeks at the time of the inspection. They had already made an impact and gained the trust and respect of staff. Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Leaders in the service were visible and accessible to staff and patients. Staff spoke highly of the senior leaders in the service, and told us that they frequently visited the CAMHS wards. Leaders in the service could describe how staff were working to provide safe, high quality care.

Development opportunities were available for staff in the service. A non-registered nurse had been sponsored to undertake education to become a registered nurse. The charge nurse on Oak Ward was being supported in their new role of acting ward manager.

Vision and strategy

The provider had a clear vision to make a real and lasting difference to patients' lives by putting people first, being a family, acting with integrity, being positive and striving for excellence.

Bi-monthly employee awards recognised staff who achieved and demonstrated the provider's values. In addition, information on expected standards and behaviours were given to staff in the form of a 'credit card'. The value of being a family was also promoted by staff groups throughout the hospital providing feedback to the clinical governance meeting.

Staff we spoke with all demonstrated a positive attitude that was caring and supportive to patients. Staff spoke positively about working with their team and the ongoing opportunities for learning and development.

Culture

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Staff were positive about working at the hospital and were very positive regarding the hospital director and new director of clinical services. Overall staff morale across the hospital was high. However, the morale of staff on Birch Ward was not high. This was due to a number of changes that had taken place and some particularly challenging clinical situations. The hospital leadership team were aware of this and taking steps to improve staff morale.

Efforts to improve staff morale had included providing gift vouchers for staff who had worked for the provider for five, 10 and 20 years. 'Surprise Fridays' included an ice cream van onsite for staff during hot weather or providing high quality donuts for all staff. There were also plans to fund a Christmas party for staff.

The staff survey the previous year had an overall response rate of 30%. At the time of the inspection, a staff survey had just started. In one week, 40% of staff had responded to the survey. This demonstrated there was already more engagement for staff before the staff survey had been completed.

When performance issues had been raised, the management team took action to address these. This included suspending staff when necessary for an investigation to take place. Supervised practice, support and coaching were also used to assist staff in meeting expected standards.

Staff were aware of the provider's whistleblowing policy and told us that they would speak up about any concerns they had.

Governance

Our findings from the other key questions demonstrated that governance processes generally operated effectively at ward level. At the focussed inspection published in December 2018, we found that the provider had made improvements but needed to continue to ensure that there was effective leadership of the CAMHS wards. This included ensuring that systems and processes were effective in identifying potential risk and monitoring the quality of care

on the wards. During this inspection, we saw that the wards had received intensive senior management support, and input from an experienced child and adolescent service manager.

The governance system for the service had been reviewed and changed considerably in the previous year. The monthly clinical governance meeting included written reports from all staff groups, such as registered and non-registered nurses, and housekeeping staff. The clinical governance meeting reviewed a wide range of quality and safety information, including ward community meeting minutes, infection control audits, incident reports and complaints. The minutes of the clinical governance meetings were stored on the staff intranet so that all staff could access and read them.

The hospital quality and safety committee met every three months. This committee reviewed themes and trends from health and safety incidents, audits and other quality-focused work. The lessons learnt group looked at incidents, safeguarding matters and complaints to identify learning and put in place actions to minimise repetition.

At hospital and ward level, there were standard agenda items for team meetings. This ensured incidents, complaints, safeguarding referrals and learning from investigations were shared with staff. There were also senior management team meetings and heads of department meetings. These focused on overall quality and safety matters with the aim of improving communication across the hospital and between staff groups.

Ward managers told us that they felt supported by the hospital director and had sufficient authority to manage the wards. They were supported by a ward clerk. Staff told us that there were some communication issues that could be improved between the hospital reception and ward staff. They also noted that human resources procedures could be improved, referring to long waits to hear back from human resources personnel.

Management of risk, issues and performance

The hospital had a risk register which outlined the current highest risks in the service. These risks reflected those we found during the inspection and reported by staff. Staff could submit items to the hospital's risk register through the ward manager or they could speak directly to senior managers.

'Flash' meetings were held every weekday morning. These involved ward managers and senior managers. The purpose of these meetings was to predict any potential difficulties in providing safe and high-quality care for patients that day. This could involve staffing difficulties or particular clinical situations. The 'flash' meeting ensured that senior managers were aware of the potential difficulties and could take action to minimise them. This could include senior managers spending time on the wards to support staff.

Ward managers were involved in implementing the site improvement plan, in place since the previous inspections in 2018. They noted that to address issues of recruiting registered nurses on the CAMHS wards, the provider had improved payments for new staff. They advised that they were able to increase staffing and suspend admissions when needed to keep the wards safe.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. Staff had access to the equipment and information technology needed to do their work. However, some staff said that the electronic patient recording system could be very slow. Otherwise the information technology infrastructure, including the telephone system, worked well.

Staff stored confidential records securely using the provider's electronic record systems. When they used paper records, they stored them securely in the nursing office.

Team managers had access to information to support them with their management role. They discussed information in clinical governance meetings, and they received support from Mental Health Act administrators and safeguarding leads.

Engagement

Staff had up-to-date information about the service. They could access clinical governance meeting minutes and learned about developments in staff business meetings. The senior management team were clearly focused on improving engagement with staff and were visible and accessible on the wards. Staff could also access news items

on the providers' intranet to learn of developments within the provider. Engagement with staff was further promoted by 'Surprise Fridays' and staff receiving various types of vouchers for their performance.

Patient were asked to complete a satisfaction questionnaire at the end of their treatment. This was in paper form or online. Feedback from patient satisfaction questionnaires was discussed in ward community meetings, which members of the senior management team attended. This feedback had included more sports activities being available, and the service was working towards operating a gym on site.

The senior management team recognised there was more they could do to develop the engagement of patients and their relatives or carers. Attempts to have a patient attend the clinical governance meetings had not been successful. However, other plans included young people sitting on staff interview panels and developing a carers group to obtain feedback.

Learning, continuous improvement and innovation

The hospital management team were clearly committed to continuous improvement of the service. There had been a focus on staff inductions, the required standards and behaviours of staff and on staff morale and engagement. The hospital also had a quality improvement facilitator to support staff with identifying and implementing ways of working to improve the quality of care to patients.

The two child and adolescent wards were accredited by the Royal College of Psychiatrists Quality Network for Inpatient CAMHS (QNIC). They had recently completed a QNIC service review and were awaiting the outcome.

Good

Hospital inpatient-based substance misuse services

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

Are hospital inpatient-based substance misuse services safe?

Good

Safe and clean environment

Safety of the ward layout

During this inspection a risk reduction action plan was in place, with recommendations around making some environmental changes to reduce potential risks. The ward was in the process of having five safer bedrooms installed on the ward. These bedrooms had anti-ligature fittings and observation panels in the bedroom doors.

Maintenance, cleanliness and infection control

All ward areas were clean, had good furnishings and were well maintained. Cleaning records were maintained for the general ward environment and showed that all areas were cleaned regularly.

Staff adhered to infection control principles, including handwashing and wearing personal protective equipment such as disposable gloves. There were appropriate arrangements for clinical waste disposal, including sharps bins in the clinic rooms which were dated on opening and not overfilled. Staff completed monthly infection control audits.

Safe staffing

Staffing levels and skills mix

The ward reported an overall vacancy rate of 43% for registered nurses as of 9 September 2019. This core service reported an overall vacancy rate of 15% for healthcare assistants as of 9 September 2018. The majority of vacancies were filled by long-term agency workers to ensure consistency of care for clients.

A staffing calculator was used on the ward which outlined minimum staffing levels. For example, when there were 24 clients on the ward the staffing calculator indicated that two registered nurses and four nursing assistants should be present during the day. Two registered nurses and three nursing assistants should be present during the night. Rotas showed that staffing met these establishment levels and often exceeded them.

The ward manager could adjust staffing levels daily to take account of the patient case mix. For example, when a patient required enhanced observations.

When necessary, managers deployed agency and bank staff to maintain safe staffing levels. Between the 10 June 2019 and 9 September 2019, the service used agency staff to fill 125 shifts.

When agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. The ward manager had recently started using an agency staff profile document. The staff profile document was created to ensure that all agency staff were competent, and that new staff had received a full induction to the ward. The profile covered an assessment of competencies for administering medication, a checklist to ensure staff were familiar with policies and procedures for the ward, and to ensure new staff were introduced to clients. Agency staff members' training compliance was also included in the agency staff profiles.

Medical staff

Each of the wards had a ward doctor Monday to Friday during normal work hours. Outside of these hours, there was a doctor for the hospital that staff could contact. A doctor could attend a ward quickly in an emergency at any time of the day or night

Mandatory training

Staff had received training and were up-to-date with appropriate mandatory training. The compliance for mandatory and statutory training courses at 9 September 2019 was 97%

Assessment of patient/service user risk

We reviewed five clients' care and treatment records. Staff carried out a risk assessment of all potential client risks when they were admitted for treatment. These included risks concerning physical health, alcohol withdrawal seizures, and potential risks concerning clients' mental health. Staff had a good knowledge of each clients' risks. However, clients' risks were not always recorded in enough detail on their electronic care records. For example, some clients' historical risk incidents were not recorded. Staff reported that the providers' IT system did not make the recording of all clients' historical risks easy.

Clients' risk assessments were reviewed regularly by the multi-disciplinary team. For example, on occasions clients made distressing disclosures in therapy sessions. At the end of the day the therapy team would meet with the nursing and medical team to discuss this and reassess clients' risks. Clients' potential risks were also reviewed during weekly multi-disciplinary meetings, and the records for these meetings were up-to-date and comprehensive.

Management of patient/service user risk

Following our inspection in May 2018, we told the provider that clients must have early exit plans to address the risks when clients left treatment early. During this inspection, we saw this in place. The risks to clients if they ended treatment early and recommenced using substances were clearly recorded in their recovery plan. There was evidence that such risks, which can be serious, were discussed with clients so that they were fully aware of them.

Staff actively planned for potential risks to clients associated with their treatment. For example, a clients' risk of seizures due to epilepsy formed part of their care plan. The care plan included how to minimise the risk of seizures. Clients' potential risks were reviewed in the weekday morning meetings and at the end of the day following therapy.

Staff observed clients' whereabouts and activities throughout the day. The frequency of visual observation by staff was determined by clients' assessed level of risk.

Clients having substance misuse treatment were informed of certain restrictions during their hospital admission. Clients agreed not to speak with family members of friends during initial detoxification treatment. This is common in detoxification treatment, as such contact can often cause clients additional stress and lead them to self-discharge. Clients were not allowed mobile phones on the ward and had regular urine and drug testing. Their rooms were also searched twice per month, or more, if indicated as needed. Clients were also expected to attend all therapy groups. These are all standard and agreed restrictions for clients having substance misuse treatment and clients were made fully aware of them on admission.

Staff implemented a smoke-free policy. All cigarettes and electronic cigarettes were banned in all hospital buildings. This meant that one method for clients to reduce or stop their use of cigarettes was banned. This may have amounted to a blanket restriction and have been counterproductive.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding referral, and did so when appropriate. Ninety-one per cent of staff on site had received training in safeguarding adults and safeguarding children at the time of our inspection. An annual survey of staff and clients was undertaken to check their knowledge of safeguarding. Before the inspection, the survey of clients had been undertaken and recorded that the majority of clients knew about safeguarding.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. This included working in partnership with other agencies.

The designated safeguarding officer was the hospital social worker. In addition, there were two safeguarding leads on Lower Court. These leads received specific safeguarding

supervision, had a higher level of safeguarding training and had dedicated time to spend on this role. They supported and assisted other staff to consider safeguarding where appropriate.

There was a clear system for recording safeguarding referrals and for keeping track of progress of those referrals. Monthly audits were undertaken to identify any themes and trends, and these were reviewed in the clinical governance meeting. A yearly audit of safeguarding referrals was reviewed by the quality committee.

Staff followed clear procedures to keep children visiting the ward safe. Rooms were booked outside the ward for clients to meet privately with young relatives.

Staff access to essential information

Patient care records were stored on an electronic system. Staff used this system to record and access each patient's progress notes, care plan, risk assessments and other information relating to care and treatment. All clinical staff had access to the electronic system. Existing records were assessible to staff if clients were re-admitted to the service at a future date.

Medicines administration records and physical health monitoring records were completed on paper. Staff were not expected to record information on more than one system.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines were stored securely and in well-organised cabinets and a medicines fridge and were disposed of safely.

Staff reviewed clients' medicines regularly and provided specific advice to clients and carers about their medicine.

The system for providing clients with medicines when they were discharged did not always meet best practice requirements. This was the case when clients decided to self-discharge and were not willing to wait. Medicines for the client to take away were then dispensed by the ward doctor and a registered nurse. However, the medicine boxes did not have the required warning labels, such as for not operating machinery, or to be taken after food. This meant that the risks associated with medicines were not minimised. When we raised this with the management team, they immediately developed medicine information sheets for clients to be given out when this occurred. These included easy-read versions. They also planned to obtain the appropriate warning labels.

Track record on safety

There had been no serious incidents on Lower Court in the year before the inspection. The threshold for the provider to classify an incident as a serious incident was lower than that in NHS services.

Reporting incidents and learning from when things go wrong

Staff reported all incidents that they should report. Staff across the hospital reported incidents such as medicines errors, clients going absent without leave and incidents of self-harm.

Staff understood the duty of candour. The duty of candour was part of the incident reporting system. This was checked by the management team to ensure that the duty of candour was followed following incidents where it was required. For example, a member of staff had fallen asleep during a night shift. The patient involved received an apology immediately after the incident. The duty of candour was part of the incident reporting system. This was checked by the management team to ensure that the duty of candour was followed following incidents where it was required.

Staff received feedback from investigation of incidents, both internal and external to the service. Incidents were discussed in the monthly clinical governance meetings and lessons learnt group. Staff also discussed incidents and subsequent actions in ward business meetings. Staff also learnt about incidents in other services. We saw an example of photographs highlighting risks in the environment which had led to incidents in other hospitals. Serious incidents would also be discussed in monthly supervisions.

Staff were able to give us examples of changes which had been made following incidents from across the service. For example, a second door had been added to the entrance to the ward as clients were previously absconding via the single door. Before the construction of the second door a staff member had been placed by the ward entrance to try and prevent clients absconding.

Good

Hospital inpatient-based substance misuse services

Managers debriefed and supported staff after any serious incident. Immediate debriefs took place following serious incidents. Sessions with counsellors and other necessary adjustments were made for staff who needed time to reflect following serious incidents.

Are hospital inpatient-based substance misuse services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Clients had a comprehensive assessment when they were admitted for alcohol or opiate detoxification. This included a full substance misuse history and assessment, mental state assessment and an assessment of their physical health. The physical health assessment included a physical examination, blood testing and an electrocardiogram (ECG). Blood testing was to identify any liver abnormalities and the ECG was to identify any heart abnormalities which could affect treatment. Pregnancy tests were offered to female clients.

Clients also had a nursing assessment on the day they were admitted to the ward. This assessment included clients' physical health, sexuality, relationships, religion and mood.

Clients' care plans were detailed, specific and comprehensive. Clients' care plans were developed under four areas; staying well, staying safe, staying healthy and staying connected.

Best practice in treatment and care

The inspection team reviewed five clients' care records. When clients were admitted for alcohol or opiate detoxification, they were prescribed medicines from standard prescribing protocols. Overall, the prescription of these medicines followed best practice guidance from the National Institute for Health and Care Excellence (Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011; Drug misuse in over 16s: opioid detoxification, 2007) and the Department of Health (Drug misuse and dependence: UK guidelines on clinical management, 2017). Clients having alcohol detoxification treatment were prescribed injectable vitamins to prevent memory loss.

However, all clients having alcohol detoxification were prescribed a medicine to assist with sleep 'as required' for the first three nights. These medicines can be addictive. Other sleep hygiene measures or the prescribing of non-addictive medicines were not considered before prescribing this medicine. The blanket prescribing of sedative medicines was not in accordance with best practice guidance (Good practice in prescribing and managing medicines and devices, General Medical Council, 2013). We also heard mixed views from staff concerning whether medicines were prescribed to prevent patient relapse when they had completed alcohol detoxification. The prescription of these medicines is recommended by the National Institute for Health and Care Excellence. Some staff told us that patients did not wish to take these medicines. However, there was no record when or if patients had this discussion with staff and were informed of the benefits of these medicines.

Staff used the Clinical Institute Withdrawal Assessment for alcohol scale – revised (CIWA-Ar) to assess withdrawal symptoms for clients having alcohol detoxification treatment. The CIWA-Ar was used throughout clients' detoxification treatment. It was also used to assess the necessity and effects of additional 'as required' medicine. This was best practice and use of the CIWA-Ar is recommended by the National Institute for Health and Care Excellence.

For clients having opiate detoxification treatment, staff assessed their withdrawal signs using validated tools. Staff used both the Clinical Opiate Withdrawal Scale (COWS) and Short Opiate Withdrawal Scale (SOWS) which followed best practice guidance (Drug misuse and dependence: UK guidelines on clinical management, Department of Health, 2017).

Clients attended a 28-day treatment programme. The therapy programme was the 12 step programme, a widely used and recognised psychosocial treatment programme for people with addictions. The programme involved several therapy groups per day with individual activities for clients to complete outside of groups. The programme focused on the reasons why people took substances and the effects this had on them and others around them.

Clients' physical health was monitored during their treatment. A dietitian visited the ward to provide advice on healthy eating and clients were referred to physical health specialists when required.

Good

Hospital inpatient-based substance misuse services

Monitoring and comparing treatment outcomes

Staff and clients regularly reviewed clients' progress towards abstinence and adapted clients' care plans as necessary.

The nurse lead for substance misuse undertook ongoing audits to ensure that clients' treatment followed best practice guidance. This included auditing the use of validated withdrawal tools and that clients had breathalyser and urine tests.

The Health of the Nation Outcome Scales (HoNoS) and the Physical Activity Readiness Questionnaire (PAR-Q) were used as outcome measures for clients having substance misuse treatment.

Skilled staff to deliver care

All nursing staff had training regarding alcohol and opiate detoxification. This included long term agency staff who worked on Lower Court. This training included using validated withdrawal tools to assess clients' withdrawal symptoms and the risks associated with detoxification treatment. A senior nurse also acted as the nursing lead for substance misuse. They provided support and knowledge to other staff and monitored clients' detoxification treatment to ensure best practice guidance was followed.

Two consultant psychiatrists had specialist experience in treating clients with substance misuse. These consultants admitted most clients for detoxification treatment. When other consultants admitted clients for detoxification treatment, these clients were also discussed in the weekly multi-disciplinary meeting with the two lead consultants.

Managers provided staff with supervision. The provider's target rate for supervision compliance was 85%. The clinical supervision rate was 89% between 1 August 2018 and 11 September 2019. Supervision was recorded on a standard template. Supervision sessions included discussions about the employee's wellbeing, safeguarding, complaints, compliments, details of 1:1 sessions with allocated patients and career development. Staff we spoke to said they felt well supported by their managers.

Multi-disciplinary and inter-agency team work

A number of multi-disciplinary meetings took place concerning clients and their treatment. A meeting attended by nursing, medical and therapy staff took place each morning and after the end of therapy, during weekdays. This ensured good communication between the team concerning clients' care, treatment and potential risks. In addition, a weekly multi-disciplinary meeting was held with nursing, medical and therapy staff and the two lead consultants for substance misuse. This meeting was used to explore in depth clients' needs, including their physical and mental health and social circumstances.

Staff worked with other people and other agencies to ensure clients' were supported during and after their detoxification treatment. This included clients' relatives and family members, when clients had consented for staff to do so. Staff had strong links with the local safeguarding team, and mutual aid groups were held at the hospital for clients to attend and have peer support. Clients' GPs were informed of their treatment, and staff worked with clients to develop appropriate support packages when they were discharged.

Good practice in applying the MCA

As of September 2019, 82% of staff had received training in the Mental Capacity Act within the service. Staff that were due to undertake this training were booked on the next available training day.

All clients admitted for detoxification treatment had their capacity assessed by the ward doctor when they were admitted. If clients' capacity was in doubt, due to alcohol or drug use, their capacity was reassessed the next day. This was best practice. Decisions concerning clients' capacity were clearly recorded. Staff supported patients to make decisions on their care for themselves. They understood the Mental Capacity Act (MCA) and knew who to contact if they needed further advice.

The ward managers undertook peer audits of each other's wards with regards to the completion of documentation around capacity to consent to treatment. These audits were reviewed in clinical governance meetings. They were also supplemented by the provider's internal compliance inspector, who reviewed the audits during visits.

Polices on the use of the Mental Capacity Act and Deprivation of Liberty Safeguards were available for staff to access.

Are hospital inpatient-based substance misuse services caring?

Good

Hospital inpatient-based substance misuse services

Good

Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with clients showed that they were discreet, respectful and responsive, providing clients with help, emotional support and advice when they needed it. During the inspection we observed positive interactions between staff and clients. None of the clients receiving substance misuse treatment at the time of the inspection chose to speak with us.

Staff supported clients to understand and manage their care, treatment or condition. Nurses met clients individually and were invited to attend weekly ward rounds with their consultant.

Staff directed clients to other services when appropriate and, if required, supported them to access those services. A client had previously been supported to attend the local hospital for an ECG and MRI. Staff also supported clients to attend local dental practices.

Staff understood the cultural needs of clients. Staff would support clients to attend places of worship outside of the hospital when requested. A member of staff attended the equality and diversity group for the provider. The staff member was planning on setting up a specific LGBT+ group within the service for both clients and staff.

Staff told us there was an open culture within the staff teams and they were confident in raising any concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences.

Staff maintained the confidentiality of information about clients. For example, patient information was displayed on a whiteboard in the nursing office. When the whiteboard was not in use staff lowered a blind over the whiteboard to cover the patient information.

Involvement in care

Staff used the admission process to inform and orient clients to the ward and to the service. All clients were provided with a ward information pack. This pack contained information about the facilities on the ward, visitor information, complaints process and advocacy.

Staff involved clients and gave them access to their care planning and risk assessments.

Staff made sure clients understood their care and treatment and found ways to communicate with clients who had communication difficulties. The ward manager would arrange a translator to attend ward rounds if a client did not speak English.

The hospital did not have a range of initiatives to involve clients in the operation of the service. Other areas of work had been prioritised. Previous work, such as young people being part of interview panels had not taken place for some time. The service had plans to further develop the involvement of clients in the way the service ran in the months following the inspection.

The hospital did not have a wide range of initiatives to involve families and carers in the operation of the service. Although attempts had been made to get some family members of patients to join clinical governance meetings this had not happened. The service had plans to develop ways in which family members and carers could be involved with the operation of the service.

Staff ensured that clients could access advocacy. The service displayed contact details for the advocate on a notice board.

Are hospital inpatient-based substance misuse services responsive to people's needs?

(for example, to feedback?)

Good

Access, waiting times and discharge

Average bed occupancy on Lower Court between 1 March 2019 and 11 September 2019 was 79%, this included patients having treatment for mental health problems.

Clients could be admitted to the service quickly, including outside of standard weekday hours. Clients who were admitted had already been assessed by one of the consultant psychiatrists at the hospital. This meant that important physical health, mental health and substance misuse information was immediately available for staff on the ward.

Good

Hospital inpatient-based substance misuse services

The service had clearly documented admission criteria. This was followed by staff and ensured that staff could meet clients care and treatment needs.

Discharge and transfers of care

Staff planned for clients' discharge by making plans with clients to use their support networks. This could include friends, family or mutual aid groups. Staff worked with other agencies to ensure clients were discharged safely with support to assist them to remain abstinent.

Clients requiring assessment from other healthcare specialists were referred with the appropriate information. This ensured continuity of care for clients.

The facilities promote recovery, comfort, dignity and confidentiality

Clients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Bedrooms were large, fitted with good quality furniture and had ensuite bathroom facilities.

Clients had somewhere secure to store their possessions. Clients could lock their bedroom doors to ensure their possessions were secure.

Patients'/service users' engagement with the wider community

Clients were supported to maintain contact with those that mattered to them, such as family members or friends. These included visits to clients and telephone contact after an initial period of treatment. Clients were involved with identifying mutual aid groups to assist their recovery when discharged.

Meeting the needs of all people who use the service

The service could support and make adjustments for people with disabilities. There was a wheelchair accessible bedroom and bathroom on the ward.

Staff ensured that clients could obtain information on treatments, local services, clients' rights and how to complain. Clients received this information in their welcome packs, this information was also displayed on notice boards in the communal area of the ward.

Staff could make information leaflets available in languages spoken by clients in response to clients' specific needs. These leaflets could be sent for full translation into any language by the hospital admission team.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All food was prepared and cooked onsite and could be made according to specific needs and preferences.

Clients had access to spiritual, religious and cultural support. Staff told us they escorted clients to the local places of worship. Prayer could also be facilitated in quiet places on the ward when necessary.

There was no specific information, or specific activities, for LGBT+ clients. However, a staff member was planning a specific LGBT+ group in the hospital for clients and staff.

Listening to and learning from concerns and complaints

In the 12 months before the inspection there had been 31 complaints [GA1]in relation to Lower Court. Following investigations, 17 were not upheld, five were partially upheld and nine were upheld. No complaints had been referred to the ombudsman.

Clients knew how to raise concerns. Clients could make complaints in writing, on the telephone and in person. They could also make complaints via their advocate. We also saw an example where nursing staff had raised a complaint on behalf of a client.

Staff knew how to deal with complaints and there was an established system for ensuring complaints were responded to. This included informing the person who had complained of the timescale when they would receive a response.

The hospital director wrote a response to client complaints. These responses identified each area of complaint and whether this was upheld, partially upheld or not upheld. There was also a description of how the complaint had been investigated. When parts of a complaint were upheld, there was an apology and details of how the service would take action to reduce the chance of similar complaints in future.

Good

Hospital inpatient-based substance misuse services

The service clearly displayed information about how to raise a concern in client areas. Staff provided clients with information about how to make a complaint when they were admitted to the ward.

When clients complained or raised concerns, they received feedback. Whenever possible, the ward manager dealt with informal complaints straight away and gave clients feedback.

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared in team meetings and during supervision.

The service used compliments to learn, celebrate success and improve the quality of care. The ward received 50 compliments during the 12 months before the inspection. Thank you cards were displayed on the wall in the ward managers office.

Are hospital inpatient-based substance misuse services well-led?

Good

Leadership

The senior management team had a good grasp and oversight of the services they managed. The new director of clinical services had been in post for three weeks at the time of the inspection. They had already made an impact and gained the trust and respect of staff. All of the senior leadership team were very experienced and had the knowledge and skills to undertake their roles.

Leaders in the service were visible and accessible to staff and clients. Staff spoke highly of the senior leaders in the service. Leaders in the service could describe how staff were working to provide safe, high quality care.

Development opportunities were available for staff in the service. A healthcare assistant had been sponsored to undertake education to become a registered nurse.

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Efforts to improve staff morale had included providing gift vouchers for staff who had worked for the provider for five, 10 and 20 years. 'Surprise Fridays' included an ice cream van onsite for staff during hot weather or providing high quality donuts for all staff. There were also plans to fund a Christmas party for staff.

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Management of risk, issues and performance

The hospital had a risk register which reflected the current highest risks in the service. These risks reflected those we found during the inspection and reported by staff.

'Flash' meetings were held every weekday morning. These involved ward managers and senior managers. The purpose of these meetings was to predict any potential difficulties in providing safe and high-quality care for clients that day. This could involve staffing difficulties or particular clinical situations. The 'flash' meeting ensured that senior managers were aware of the potential difficulties and could take action to minimise them. This could include senior managers spending time on the wards to support staff.

Information management

The service used systems to collect data from wards and directorates that were not over-burdensome for front line staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well. Staff said they had sufficient computers to carry out their roles.

Information governance systems included confidentiality of patient records. All computer systems were accessed by individual usernames and passwords.

Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Staff made notifications to the relevant external bodies as needed. Staff sent notifications in a timely manner to the Care Quality Commission in relation to clients sustaining injuries, allegations of abuse and incidents reported to the police.

Engagement

Staff had up-to-date information about the service. They could access clinical governance meeting minutes and learnt about developments in staff business meetings. The senior management team were clearly focused on improving engagement with staff and were visible and accessible on the wards. Staff could also access news items on the providers' intranet to learn of developments within the provider. Engagement with staff was further promoted by 'Surprise Fridays' and staff receiving various types of vouchers for their performance.

Clients were asked to complete a satisfaction questionnaire at the end of their treatment. This was in paper form or online. Feedback from patient satisfaction questionnaires was discussed in ward community meetings, which members of the senior management team attended. This feedback had included more sports activities being available, and the service was working towards operating a gym on site.

The senior management team recognised there was more they could do to develop the engagement of clients and their relatives or carers. Attempts to have a patient attend the clinical governance meetings had not been successful. However, other plans included young people sitting on staff interview panels and developing a carers group to obtain feedback.

Learning, continuous improvement and innovation

The hospital management team were clearly committed to continuous improvement of the service. There had been a focus on staff inductions, the required standards and behaviours of staff and on staff morale and engagement. The hospital also had a quality improvement facilitator to support staff with identifying and implementing ways of working to improve the quality of care to clients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient staff deployed on Birch Ward. Regulation 18(1)

Action the provider SHOULD take to improve

- The provider should ensure that a restrictive interventions reduction programme is operated with the aim of reducing the frequency of restraint, prone restraint and rapid tranquilisation.
- The provider should review the blanket practice of searching all patients' bedrooms twice per month.
- The provider should review the process for providing medicines to patients when they self-discharge from the hospital to ensure they receive safety information.
- The provider should review the standard prescription of sleeping medicines for clients having detoxification treatment. When clients are offered relapse prevention medicines this should be clearly recorded.
- The provider should ensure they continue with plans for recruiting registered nurses on all wards.
- The provider should ensure that all disposable medical equipment is within its' expiry date and that child size defibrillator pads are available on the CAMHs wards.
- The provider should reintroduce and develop ways for patients, young people, and carers to be more involved in the operation of the hospital.
- The provider should continue to improve patient care plans on Lower Court to ensure that they are personalised, holistic and recovery orientated.
- The provider should ensure that the clinical rationale for a change in patients' potential risks is clearly documented.
- The provider should ensure that nursing staff on Birch Ward have supervision at the frequency expected.

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
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1)**