The Priory Hospital Dewsbury

Quality Report

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Date of inspection visit: 3 and 4 March 2020
Date of publication: 18/05/2020

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

Our rating of this service went down. We rated it as requires improvement because:

- The wards were in need of redecoration and refurbishment and the environment on Hartley Ward was not clean in all areas. Health support workers had to carry out cleaning tasks during the evening and at weekends but they did not always have time to complete these tasks.
- We could not see whether staff undertook routine physical health monitoring on all occasions following the administration of rapid tranquillisation and ligature risks were not always updated following the admission of new patients on Hartley ward.
- The design, layout, and furnishings of the ward did not support the needs of patients with dementia and patients did not have access to a bath on Jubilee ward. Patient bedrooms did not have viewing panels which meant staff having to enter patients' rooms at night which could have disturbed people. On Hartley ward, the design of the showers did not support patients' privacy and dignity.
- On Jubilee ward, staff did not use protective equipment with patients at meal times which meant some patients had food spilled on their clothing. At inspection, most patients wore the same type of clothing and many did not have socks on. On Hartley ward, care plans were not always holistic and did not show evidence of patient involvement or discharge planning.
- Some of the systems in place were not effective to assess, monitor and improve the quality and safety of services provided. For example mechanisms were not in place to ensure that the risks on Hartley ward were managed well or that staff undertook appropriate physical health monitoring following all instances of rapid tranquillisation. Managers did not have oversight of blanket restrictions on the hospital and the restrictions log on Hartley ward did not reflect all the restrictions there were in place.
- The hospital used high numbers of agency staff but, at inspection, they did not have access to the electronic patient care record. Not all staff knew how they could be consulted or involved in the changes that were taking place in the hospital.

However:

- Staff on Jubilee ward managed patient risk well. Staff on both wards minimised the use of restrictive interventions and followed good practice with respect to safeguarding.
- Staff managed medicines well and patients had access to appropriate physical health monitoring and follow-up when they needed it.
- Staff on jubilee ward developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to a range of specialist staff. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness and dignity. They understood the individual needs of patients and actively involved them and their families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

Contents

Requires improvement

The Priory Hospital Dewsbury

Services we looked at:
Long stay or rehabilitation mental health wards for working-age adults; Wards for older people with mental health problems.

Summary of this inspection

Background to The Priory Hospital Dewsbury

The Priory Hospital Dewsbury is an independent mental health hospital that provides care and treatment for up to 32 male patients across two wards. The hospital is registered to carry out the following regulated activities :

• Treatment of disease, disorder and or injury

• Assessment and treatment for persons detained under the Mental Health Act 1983

At the time of the inspection, there was an overall manager in place who had applied to become the Registered Manager of the hospital. The previous registered manager left at the end of August 2019 and an acting hospital manager was in place until December 2019 when the current Hospital Director started in post.

The Priory Hospital Dewsbury delivers in-patient rehabilitation services for adults with mental health problems and in-patient services for adults with dementia. The hospital has two wards for the two different groups of patients. Hartley Ward is a 16 bed long-stay rehabilitation ward for adults of working age. It provides care and treatment for male patients suffering complex and enduring mental health needs including those with an undiagnosed or early onset memory related condition. At the time of the inspection, there were 16 patients detained on Hartley Ward. Patients on this ward included individuals who had their detention supervised by the Ministry of Justice. Jubilee Ward is a 16 bed older persons inpatient ward. It specialises in dementia care and offers care and treatment for male patients with neuro-cognitive conditions. The service can care for patients presenting with very agitated or aggressive behaviour and can provide assessment and treatment through to end of life care. At the time of the inspection, the ward had ten patients, all of whom were detained either under the Mental Health Act or on a Deprivation of Liberty Safeguard, (DoLS).

We last inspected The Priory Dewsbury in July 2017. At that time the service was rated overall good with an outstanding in the caring domain. At this inspection, we rated the hospital as requires improvement overall with good in the caring domain. We issued the provider with four requirement notices under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person centered care, premises and equipment, dignity and respect and good governance.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a variety of specialists: The specialist advisors comprised of two nurses, one of whom was specialist in older peoples' care, an occupational therapist and a speech and language therapist. We also had an expert by experience on the team.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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?

Summary of this inspection

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

Before the inspection visit, we reviewed information that we held about the location and sought feedback from a range of stakeholders including service commissioners.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients on Hartley ward
- spoke with four carers of patients on Jubilee ward and one of a patient on Hartley ward
- spoke with the two hospital managers and managers for each of the wards
- spoke with 17 other staff members; including doctors, nurses, occupational therapists, a psychologist, health support workers, a pharmacist, and domestic and catering staff
- received feedback about the service from one service commissioner and one independent advocate
- attended and observed two hand-over meetings
- carried out a short observational framework interview for inspection (SOFI)
- Looked at nine care and treatment records of patients from across both wards
- carried out a specific check of the medication management on both 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

Hartley ward

We spoke with six patients on Hartley ward and the family member of one patient.

Patients told us that staff were nice and treated them well. However, some felt that there was a lack of suitable activities on the ward and that they felt some activities were patronising. Patient also told us they weren't always able to go out when they wanted to because there weren't always enough staff.

Patients told us they had difficulty using the showers in their en-suite bathrooms and this meant staff had to help them and their privacy and dignity was therefore affected.

The carer we spoke with told us that staff were kind and helpful and that they had no concerns regarding the safety of their relative.

Jubilee Ward

We could not speak with any of the patients on Jubilee ward because none of them had the capacity to undertake an interview with us on the days we carried out our inspection. However, we spoke with four carers, all of whom spoke very highly of the care their relatives received.

They told us the ward was clean, there were enough staff to care for patients and there was always a nurse available on the ward. They said they felt their relatives were safe and well looked after. The staff were kind, compassionate and skilled in looking after patients with dementia. They felt staff involved them as much as possible in the care and treatment and were flexible about visiting arrangements. Staff were proactive in helping carers spend as much time as they wanted with their relative and even transported some carers where they had problems getting to the hospital. Carers could provide feedback and knew how to make a complaint. Negative feedback we received was in relation to patients' laundry going missing which two carers told us about, and the lack of stimulating activities which two carers mentioned. One carer commented that the food on offer did not always match the menu choices.

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 

Our rating of this service went down. We rated it as requires improvement because:

- Both wards were in need of redecoration and refurbishment and Hartley ward was not always clean. There were splash marks on walls and strong odours in parts of the ward. Health support workers on both wards had to carry out cleaning tasks during the evening and at weekends but they did not always have time to complete these tasks.
- Staffing levels on Hartley ward were based on those of a long stay/rehabilitation ward however, the patients on the ward were not always suitable for this type of ward.
- The ligature audit for the bedrooms on Hartley ward had not been updated following the admission of new patients and, on both wards, we could not see whether staff undertook routine physical health monitoring on all occasions following the administration of rapid tranquillisation.
- At the time of our inspection, agency staff did not have access to the electronic patient record on both Jubilee and Hartley wards.

However:

- Staff 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. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients 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 service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient'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 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.

Summary of this inspection

Are services effective?

Requires improvement 

Our rating of this service went down. We rated it as requires improvement because:

- Care plans of patients on Hartley ward were not always recovery oriented and did not include early warning scores.
- Patients did not have individual activity timetables and there was no guidance for staff on how to support patients who did not want to engage with them.
- Some specialists had a limited amount of time available to spend with patients. This meant they weren't able to ensure patients had the appropriate level of specialist care they required.

However:

- On Jubilee ward, staff developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Managers provided an induction programme for new staff which was bench-marked against care certificate standards for health support workers.
- 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 could explain 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.

Are services caring?

Good 

Our rating of this service went down. We rated it as good because:

- Staff treated patients with compassion and kindness. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff on Jubilee ward involved patients' families in care planning and actively sought their feedback on the quality of care provided. Staff on both wards ensured that patients had easy access to independent advocates.
- Staff on both wards informed and involved families and carers appropriately.

However:

Summary of this inspection

- Care plans of patients on Hartley ward were not always written in collaboration with patients.

Are services responsive?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- The design, layout, and furnishings of the ward did not support the needs of patients with dementia and patients on Jubilee ward did not have access to a bath because it had been broken for many months.
- Patient bedrooms did not have viewing panels which meant staff having to enter patients' rooms at night which may have disturbed people.
- Some patients had difficulty using the shower in their en-suite bathrooms. This meant staff had to be present while patients showered and impacted on their privacy and dignity.
- Meals provided on Hartley ward were not suitable for all patients. There was little choice and no options for patients who required specialist diets.
- Some patients were not able to access spiritual support as they wished. Staffing levels often prevented patients going to services and there were no religious leaders invited to the service to support patients.
- Staff on Jubilee ward did not use protective equipment with patients at mealtimes which meant some patients had food spilled on their clothing. At inspection, most patients wore the same type of clothing and many did not wear socks. We thought staff could have provided more support to help patients wear clothing that was more reflective of the individual personalities.

However:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- 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 helped patients with advocacy.
- 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.

Summary of this inspection

Are services well-led?

Requires improvement

Our rating of this service went down. We rated it as requires improvement because:

- Some of the systems in place were not effective to assess, monitor and improve the quality and safety of services provided. For example, mechanisms were not in place to ensure that ligature risks on Hartley ward were managed well or that staff undertook appropriate physical health monitoring following all instances of rapid tranquillisation. Quality audits did not always identify that improvements were needed in cleanliness.
- The provider did not have oversight of restrictions on Jubilee ward and the blanket restrictions log on Hartley ward did not accurately reflect all the restrictions in place. This was not in line with the Mental Health Act Code of Practice.
- The hospital used high numbers of agency staff but, at inspection, these staff did not have access to the electronic patient care record.
- Not all staff knew how they could be consulted or involved in the changes that were taking place in the hospital.

However:

- Ward managers 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 reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Detailed findings from this inspection

Mental Health Act responsibilities

At the time of our inspection, over 86% of staff had received training in the Mental Health Act. They demonstrated a good understanding of the Act, the Code of Practice and the guiding principles.

Staff had support from an on-site Mental Health Act administrator who provided staff with legal advice and support concerning the implementation of the Act. This person ensured the hospital's policies and procedures were up-to-date and that staff had access to the relevant procedures including the Code of Practice.

As part of our inspection, we looked at a sample of Mental Health Act files for current patients. We found that staff explained to patients their rights under the Mental Health Act and although, most patients lacked the capacity to understand and retain this information, staff repeated this at regular intervals and recorded they had done this.

Patients and their carers had access to independent advocacy through a service level agreement the hospital had with an external organisation. There were posters around the hospital with the name of the advocate, when they visited and how they could be contacted. Prior to our inspection, we spoke with the advocate who confirmed they visited the ward weekly, had access to multidisciplinary meetings and care programme approach reviews and attended hospital governance meetings with the patient representative from the other ward.

Staff requested an opinion from a second opinion appointed doctor when necessary and staff stored copies of patient's detention papers correctly.

The Mental Health Act administrator carried out Mental Health Act audits to ensure the Act was being applied correctly. The service was last inspected by our Mental Health Act officers on an unannounced visit in January 2019. Following this inspection, they did not raise any actions which meant the hospital was demonstrating good practice in applying the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, over 86% of staff were compliant with training in the Mental Capacity Act. Staff demonstrated a good understanding of the Act and the five statutory principles.

The hospital had a policy on the Mental Capacity Act, including deprivation of liberty safeguards and this was available on the hospital's intranet for any staff who required it. Staff could seek advice from the hospital's Mental Health Act administrator and medical consultant as needed.

Staff were skilled in carrying out mental capacity assessments and gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the capacity to make it.

We saw examples of best interest meetings taking place which involved the patient's nearest relative to take account of the patient's culture, history and possible wishes. Patients had fully documented best interests meetings concerning things like covert medication and physical health investigations.

The hospital's consultant monitored staff's adherence to the Mental Capacity Act and disseminated learning through clinical governance meetings.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Wards for older people with mental health problems	Good	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

Staff did not complete environmental risk assessments of all ward areas and remove or reduce any risks identified. Senior managers on site completed a monthly environmental walk round which was used to identify risks and areas for improvement however, we found this did not include all risks. For example, there was a large skip in the garden area, which was full of debris, this had not been included in the environmental walk round. Although an action plan was in place in relation to the environment, this was not adequate due these omissions.

Staff could not observe patients in all parts of the wards. The ward was set out in an L shape with doors for access to the small lounge areas, there was no mechanism for staff to observe all parts of the ward area. There were doors separating the main ward area from the patient's bedroom areas and the two lounge areas. This was usually mitigated through staff observations however; this was not always possible due to the need for staff to assist patients with activities. Although there had been no incidents as a direct result of this, we were concerned that this was a possibility.

Staff knew about any potential ligature anchor points however; audits were not always completed appropriately to enable staff to mitigate risks and keep patients safe. Ligature audits were carried out on the ward on a six-month basis, each area of the ward had its own ligature audit, and these were carried out at different times. We found, the majority of ligature risk audits had been completed in October 2019, with the audit of bedroom one completed in January 2019. The ligature risk audits gave each area of concern a rating which was formed using room risk, patient risk and ligature point rating. However, there had been two new admissions since the last audit was carried out and there had been no review of the audits in either patient's bedroom since their admission. In addition, there had been no update to the risk assessment for the outside area even though there was a skip outside the ward with potential ligature points.

Staff had access to alarms which could be used if they needed assistance. Staff were seen responding to alarms during our inspection. Patients had access to alarms which allowed them to get staff assistance if it was needed.

Cleaning arrangements did not allow for a clean and tidy environment to be maintained. The service had domestic staff who carried out cleaning duties on the ward during the day. At night and weekends care staff were required to carry out domestic duties. Some areas of the ward did not appear clean and we also saw areas where walls appeared to have been splashed with liquids. Care staff assisted some patients with cleaning of their bedrooms however, we found that some rooms were dirty and had lingering odours.

There were two sets of cleaning records in place, one which referred to the cleaning duties care staff carried out and another which was for the domestic staff. Cleaning records for care staff were available for the six months prior to the inspection and had been completed daily. Cleaning records for domestic staff had not been completed prior to January 2020, although those available had been completed fully.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Cleaning records had been prepared for future dates with details of work to be completed however, we found that some days were crossed through and had been annotated to show annual leave. This appeared to show that no cleaning would be carried out on those days and did not state how cleanliness would be maintained during this time. Staff we spoke with told us they did not always have time to carry out cleaning and the Hospital Director told us they were not confident that care staff completed all the required cleaning tasks. Systems within the service were not a reliable method for assessing whether cleaning was being completed.

Staff on the ward were observed to practice infection control principles throughout the inspection. The service had hand sanitisers attached to walls and staff were witnessed using these, washing hands and wearing gloves as appropriate.

The ward had its own clinic room which was fully equipped with accessible resuscitation equipment and emergency drugs which were checked daily. Equipment in the clinic room was clean and properly maintained. There were good processes in place to ensure there was no out of date equipment and weekly audits were carried out on medication stock.

Safe staffing.

The service did not always have enough nursing and support staff to keep patients safe. The service used a staffing ladder to establish the number of staff required on each ward.

The number of staff on the ward did not always meet the needs of the patients on the ward. The staffing ladder set an establishment for the ward which was based on a rehabilitation ward for adults of working age but at the time of the inspection some patients required additional staff to care for them.

We looked at the staff rotas for 12 weeks and found, the number of staff on duty for all shifts met the levels dictated by the staffing ladder used. The ward manager told us they were able to adjust the staffing levels on the ward if observation levels increased. Rotas we looked at showed the ward manager had extra staff on shift at times however, this was only when there had been an increase in observation levels.

When necessary, the ward manager used agency and bank care staff to ensure staffing levels met those dictated on the staffing ladder. When agency and bank staff were booked, the ward manager tried to ensure the same staff were used, and they were familiar with the ward and the patients. Agency and bank staff received an induction when they began working on the ward for the first time.

Staffing levels did not allow patients to have regular one-to-one time with a named nurse. Care records showed patients did not have regular one-to-one time and staff we spoke with told us they sometimes found it difficult because they were busy assisting others. Patients we spoke with did not mention one-to-one time specifically but did tell us that staffing levels affected activities on the ward.

Staffing levels meant patients were not always able to utilise Section 17 leave when they wanted it. The ward manager told us that staff tried to ensure patients were able to leave the hospital at the time they wanted however; this was not always possible. During our inspection we saw patients being told they could not utilise their leave as there were not enough staff available to allow an escort. Patients were offered an alternative time for leave, and ward staff made efforts to ensure at least two patients were able to leave the ward each day.

There were enough staff to carry out physical interventions safely. Staff told us they had received training in physical intervention and felt able to carry out these out safely. When needed, staff were able to summon assistance from the other ward on the site. Throughout the inspection we heard alarms being sounded and calls for assistance being made. However, when staff from the ward responded to the other ward, staffing levels on Hartley Ward were lower than establishment levels. Senior managers told us that other staff working in the hospital were also able to respond if needed and we heard requests for staff to attend incidents during our inspection.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. The service had a doctor who was on site throughout the day and an on-call system was in operation at all other times.

The service had a package of mandatory training for staff. Information from the provider showed all mandatory training for the service had a compliance rate above 75%. This included, immediate life support (88%), basic life support (100%), prevention and management of violence

and aggression (91%) and safeguarding adults (84%). This figure was for the entire hospital and not just ward staff. The figure provided for data protection and confidentiality (68%) was below the provider's compliance rate. This figure was for the entire hospital site and not just ward staff.

Assessing and managing risk to patients and staff

We reviewed the care records of four patients.

Staff completed a risk assessment of every patient on admission to the ward with reviews carried out monthly or when an incident had occurred. The service used a screening tool specific to the provider. Staff were aware of and dealt with specific risk issues. Of the care records we reviewed, three contained information about risk issues including choking risks, fire risks and personal safety while out of the hospital.

Staff on the ward identified changing risks to, or posed by, patients and responded appropriately to these. For example, by increasing observation levels or reducing levels of Section 17 leave.

Staff applied some blanket restrictions on patients' freedom. Due to the nature of the patient group on the ward staff found it necessary to lock areas which required patients to ask staff for support. These were classed as blanket restrictions and did not appear to fit with the rehabilitation model of the hospital. Rooms which required staff to support patients included, the bathroom, activities of daily living kitchen, laundry and outdoor space. There was a water cooler in the main ward area however, patients were unable to use it without staff support as the plastic cups were kept in the nurse's office. We asked staff the reason cups were not left by the water cooler and were advised it was because patients often took more than one cup at a time.

Some patients did have their own drinks which they kept in their rooms however, although hot drinks were available, this was only with staff assistance for most patients. We were told this was due to the risk from one of the wards patients. The service 'restrictive practice self-assessment audit tool' showed that there was no restriction with regards to the kitchen area, or outdoor space, however; it was dated April 2018 and had not been updated.

The ward manager told us that informal patients would be able to leave the ward if they wished. At the time of our inspection there were no informal patients on the ward which meant we were unable to check this.

The service had no seclusion room on site and there were no incidents of seclusion or long-term segregation in the 12 months prior to our inspection.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. From 1 May 2019 to 31 October 2019 there were nine restraints recorded on the ward, none of which were prone. Staff we spoke with told us prone restraint was not used on the ward. Hartley Ward participated in the provider's restrictive interventions reduction programme. We reviewed incident records for the ward and saw that physical restraint was only used after de-escalation had failed. Where appropriate, staff worked within the Mental Capacity Act definition of restraint.

Staff did not always follow guidance from the National Institute of Health and Care Excellence when using rapid tranquilisation. We reviewed 16 incidents of rapid tranquilisation and found that in ten of these there was no physical observation chart to show whether routine monitoring had been carried out in line with guidance and the policy of the provider. Staff told us this was a documentation issue as agency staff did not have access to the electronic record and some handwritten records had not been scanned to the electronic record properly. This meant patients were not always protected from harm when rapid tranquilisation was needed.

Safeguarding

Staff we spoke with were aware of their responsibilities in relation to the safeguarding of patients. Staff completed training in safeguarding of adults. The compliance rate for this training was 84%. Staff knew how to identify adults and children at risk of or suffering significant harm and were able to give examples of how they protected patients from harassment and discrimination. Staff followed safe procedures for child visitors. The service had a visitor's room which was situated in the reception area and was used when children wished to visit patients.

Staff access to essential information

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

The ward care records were electronic and there were hard copies of physical health documents. All the information needed to deliver patient care was available to staff when they needed it. However, at the time of our inspection agency staff were unable to use the computer systems to access information. This meant staff were required to print care records to ensure agency staff had up to date information and these staff were then required to record all information on paper which was input onto care records by nurses at the start of each shift. We were told this could take up to two hours and that care staff were unhappy as they felt patients were not kept safe. We spoke to the Hospital Director about this and arrangements were made to ensure long-term agency staff were able to access electronic records.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. We looked at the prescription charts for all the patients on the ward and found they were all accurate and clearly documented.

None of the patients on the ward were on high dose anti-psychotic treatments.

Staff regularly reviewed the effects of medications on each patient's physical health. There were good systems in place to ensure patients were monitored for potentially harmful effects of medications. All the records we looked at were completed accurately with no gaps.

Track record on safety

The ward had a good track record on safety. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team. In the 12 months prior to our inspection the ward reported only one serious incident.

When things went wrong staff apologised and gave patients honest information and suitable support.

Reporting incidents and learning from when things go wrong

Staff on the ward knew what incidents to report and how to report them. Staff reported all incidents they should report. We reviewed all the incidents reported on the ward for 1 December 2019 to 29 February 2020 and found they were recorded accurately with an appropriate level of detail.

Staff we spoke with were aware of the duty of candour and understood what it meant. Staff were open and transparent and gave patients and their families a full explanation if and when things went wrong. Staff received feedback from investigation of incidents and of any changes that resulted from these. Staff received feedback from incidents that occurred at other services in the provider group through emails and weekly bulletins.

Staff we spoke with told us they received debriefs and support from the ward manager after serious incidents.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at the care records of four patients on the ward. We found care records were detailed however, we found they were not written in collaboration with patients and did not represent the patient's wishes, thoughts and feelings. For example, one care record shows the patient has monthly visits from family, but this has not been discussed in the patient's care plan. Another care plan shows the patient has a low IQ but is written in a way that would be difficult for the patient to understand.

Staff assessed the physical and mental health of all patients on admission. Discussions about patient health were held during multi-disciplinary team meetings and any changes to care were recorded. However, we found that only two staff members on the ward were able to make changes to care plans and this meant that there could be short delays in updating computer records.

Best practice in treatment and care

Care and treatment interventions offered were not always appropriate to the patients on the ward. Some patients we spoke with told us activities were more appropriate to children and they felt patronised. During our inspection we saw patients colouring pictures, playing pool and going shopping. We reviewed the timetable of events for the ward which showed activities such as cooking and shopping took the majority of time although there were occasional

gym sessions, a creative mind group once a fortnight and a cycling group once a week. There were no planned activities at the weekend except for a pool tournament for one hour on Saturday afternoon.

None of the patients on the ward had an individual activities timetable and there was no guidance for staff on how to support patients who did not want to engage with them. Activities offered were not in line with those of a rehabilitation ward and this was further complicated as staff were not award of the type of rehabilitation model they should be working to. We reviewed the monthly statistics in relation to patient activity and found four patients spent more than 50% of their time watching TV or listening to the radio. None of the patients on the ward spent more than 1% of their time with the occupational therapist or working towards goals set by the occupational therapist. Other activities recorded on the monthly statistics included, Section 17 leave, making drinks, group sessions, domestic tasks, sat/walking in the garden and ordering takeaway. Seven patients on the ward had access to a psychologist, however, we found that only two of these patients had actively engaged with the psychologist for a period of only 1% of their time.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. All the care records we looked at showed patients were seen by appropriate healthcare professionals when they had physical health concerns.

Staff requested assessments from specialists regarding patient's food and fluid needs. Speech and language therapists had assessed patients and had prescribed specialist nutrition for some including, softened diets and drinks supplements where necessary.

Staff supported patients to live heathier lives, for example through smoking cessation schemes, healthy eating advice and encouraging exercise, patients in the service had access to a gym and some were members of a cycling group.

Staff used recognised rating scales. Care records showed staff had recorded Health of the Nation Outcome Scores. However, care records we looked at did not contain early warning scores. We also found staff carried out clinical audits but there was no benchmarking and no improvement initiatives.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. This included doctors, occupational therapists, physiotherapists and speech and language therapists. Although the service had these specialists available, they were only available for a limited amount of time and they didn't have a sufficient amount of time to ensure patients had the level of specialist care required. Managers made sure they had staff with a range of skills needed. Managers provided an induction for new staff, including bank and agency staff.

Staff supervision on the ward was low and we found most staff had not received supervision in line with the service policy. However, from January 2020, we found all ward staff had received supervision. Information from the provider showed the percentage of staff that had received an appraisal in the last 12 months was 100% and the number who had received regular supervision was 70% but this was the figure for the hospital and not specific to the ward.

Poor staff performance was dealt with promptly and effectively. Managers used supervision to discuss concerns with staff performance and these were managed in line with the providers policy.

Multi-disciplinary and inter-agency team work

Staff from different disciplines worked together as a team to benefit patients. However, with specific care areas like occupational therapy or physiotherapy, care staff did not have the required skills or information to ensure patients were given the correct support. The ward team had effective working relationships with other staff from services that would provide aftercare following the patient's discharge and engaged with them early to plan discharge.

Adherence to the MHA and the MHA Code of Practice

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 could explain patients' rights to them. 87% of staff in the service had received training in the Mental Health Act.

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

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

The provider had relevant policies and procedures relating to the Mental Health Act which reflected the most recent guidance. All staff working in the service had easy access to Mental Health Act policies and procedures and to the Code of Practice.

Patients were provided with information on advocacy services. Patients we spoke with told us they used advocates and that they attended meetings with them and spoke on their behalf when needed.

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. We looked at the records of four patients and found all had their rights explained to them on a regular basis and this was clearly recorded.

We found that patients were not always able to take leave when they wanted it. This was usually due to staffing levels however, staff on the ward made efforts to get patients out as soon as they were able. During our inspection, we saw staff explaining to patients that they couldn't go out at that time but that they would take them out later in the day.

Detention papers and associated records were stored correctly and were available to staff when they needed to access them. Care plans did not always refer to Section 117 aftercare services. We reviewed four care records and found only one of these referred to Section 117 aftercare. However, the provider did arrange Section 117 meetings for patients as part of their discharge planning and we found that the records which did not refer to Section 117 aftercare were those of patients who were not ready for discharge.

Regular audits were carried out to ensure that the Mental Health Act was being applied correctly. Monthly audits were carried out by the Mental Health Act administrator and any concerns or areas for improvement were reported back to the ward manager and the required changes were made.

Good practice in applying the MCA

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. 86% of staff working in the service had completed training on the Mental Capacity Act.

Staff we spoke with had a good understanding of the Mental Capacity Act and the five statutory principles. The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff knew where they could access the provider's policy and where to get advice if they needed it.

Staff carried out capacity assessments and recorded them accurately. Capacity assessments had been carried out using the statutory principles and best interest decisions were clearly documented in care records.

The provider carried out monthly audits to ensure the quality of Mental Capacity assessments were carried out and recorded in line with the provider's policy. In addition, spot tests were carried out to monitor staff understanding of the Act.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Throughout our inspection we saw staff working with patients to support them in activities and found they spoke with them in a patient and caring manner. We saw staff making changes to plans in order to accommodate patient's wishes and to ensure they were able to take Section 17 leave when they wanted.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. We spoke with staff who told us about specific needs some patient's had in relation to their religious needs and regarding family contact.

Staff we spoke with told us they had not witnessed any disrespectful or abusive behaviour or attitudes towards patients. Staff told us they would report to managers if they witnessed any form of mistreatment.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Involvement in care

Staff did not always involve patients in care planning and risk assessment. We looked at four care records and found three showed no evidence of patient involvement and the fourth showed the patient had declined to discuss it. We found care plans were long and complex and would be difficult for some patients to understand. Staff communicated with patients so that they understood their care and treatment.

Staff involved patients when appropriate in decisions about the service. The ward had a patient representative who attended and participated in clinical governance meetings. Information from the provider was that patients had not participated in any surveys in the 12 months prior to our inspection, although we were told that patients gave daily feedback directly to staff.

Staff ensured that patients had easy access to independent advocates. The service used four different advocacy services and patients were supported to use other services if they wished. Patients we spoke with told us that advocates visited the service and attended meetings with them if they wished.

Staff informed and involved families and carers appropriately. Patients were asked about whether they wanted their family involved in their care. Most patients on the ward did not have any family involvement however, we found that those who were involved were provided with appropriate levels of communication and were asked for feedback on the service.

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

Requires improvement

Access and discharge

In the 12 months prior to our inspection there had been no delayed discharges from the ward.

Staff maintained good working relationships with external agencies and discharge was rarely delayed for anything other than a clinical reason. Staff planned and managed discharge well however, discharge plans were not carried out routinely when patients were first admitted and plans we saw were not always updated.

Information from the provider showed the average length of stay for the period 1 November 2018 to 31 October 2019 was 1866 days. At the time of our inspection the patient on the ward longest had been there for 1890 days.

We looked at the care plans of four patients and found one had a clear discharge plan with an identified exit pathway in place, one contained a discharge plan which was dated November 2017 and was noted as 'looking for suitable accommodation' and although a hearing had taken place on 28 February there had been no update to the discharge plan. One record showed a discussion regarding discharge had been held as part of another meeting in November 2019 but there was nothing to show how the patient's discharge was progressing. The final record had a discharge in place but was noted to say the patient, 'disengages from all activities related to rehabilitation'. Although the patient had been in the service for more than four years there had been no changes to the discharge plan.

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

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout and furnishings of the ward did not support patients' treatment, privacy and dignity. All patients on the ward had their own bedrooms with en-suite facilities. Showers had a push button timer which switched on the water for a short period of time and then had to be pressed again to restart the flow. Some patients told us they found it difficult to press the button and needed staff help. This meant staff had to be with patients when they showered, and this impacted on their privacy and dignity. We spoke with the ward manager about this and she confirmed what we had been told. We were told that this had been raised with the previous hospital manager but not actioned. We raised this with the service manager and were told they would look at the issue.

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

Patients were encouraged to personalise their bedrooms and all patients had a secure place in which to store their possessions. However, we found one patient was unable to lock his room as the key had been lost and had not been replaced.

There were a range of rooms available, but patients could not access them easily. Some of these were locked and patients were only allowed into them with a staff member. For example, the activities of daily living kitchen, laundry and activity room. The ward had a quiet room which patients were able to use however, the sofa in the room had a large tear and had an unpleasant odour. The provider was aware of this and had ordered a new sofa for the room.

There was a visitor's room in the main reception area of the service which had a kitchen and bathroom area to allow patients to meet with visitors in private.

The hospital had an enclosed garden area which patients were able to access. At the time of our inspection there was a skip in the garden which was full of debris and a potential risk to patients. This had not been included as part of the monthly walk round however, patients were usually not able to access the garden area without a staff member present.

Most patients could not make hot drinks and snacks without staff supervision or assistance to do so. There was a drinks cooler in the main area of the ward for patients and staff to use however we found there were no plastic cups as they had been kept in the nursing office. This meant patients who wanted a drink had to ask staff for cups. The ward manager told us there was no reason for this and the cups should always be available to patients.

Patients' engagement with the wider community

When appropriate, staff ensured that patients had access to education and work opportunities. One of the ward patients was carrying out volunteer work at a bakery. Processes had been put in place to ensure the patient was safe while out and there was good communication between the service and the patient's place of work.

Meeting the needs of all people who use the service

The ward did not have facilities for people with physical disabilities however, the manager told us that they would not refuse to admit a patient on these grounds and that if needed, adjustments would be made to the environment in order to allow for an admission. Although none of the patients on the ward had specific communication needs, we found the service had access to a library of information which could be accessed if a patient required it.

Patients were provided with information regarding treatments, local services, patient rights and how to complain. Patients were given information when they were first admitted to the ward and were provided with updates as necessary. For example, patients were informed of their rights while detained regularly and we saw updated information relating to medication had been provided to patients and was recorded in medication charts.

The food was not of good quality. We looked at the menu of food served in the service. The menu was on a four-week rotation and there was a vegetarian option available each day. However, we found that the meals offered did not have any options for people who needed a special diet for either health or religious needs and the only option for each day was either meat or vegetarian. For example, hot dog or vegetarian hot dog. The service had hired a new chef just prior to our inspection and we were told that he was developing new menus in order to ensure patients received balanced meals and the service catered for specific patient needs. The new chef provided us with copies of the new menus, and we found these were of a better standard and allowed choices, including halal, vegetarian and healthy eating.

The service had a multi-faith room on site which patients were able to access, and some patients were also able to access local religious services. We did however notice that one patient who liked to attend services was not always able to go as this was subject to Section 17 leave. The patient told us they would like religious leaders to visit the site, but they had not been invited by managers. This meant patients were not always able to follow their faith.

Listening to and learning from concerns and complaints

The provider reported two complaints in the 12 months prior to our inspection, none of which was upheld. Patients we spoke with told us they knew how to raise complains and concerns.

We were aware of complaints made by one patient and found that although some complaints were of genuine concern to the patient, a note had been made on the care record to say the patient was, 'a constant complainer'

Long stay or rehabilitation mental health wards for working age adults

Requires improvement

which gave the impression of complaints not being taken seriously. We were told that the patient in question had a care plan in place which was to deal with the issue of complaints. The ward manager was the first point of contact for these complaints and would attempt to rectify the patient's concerns. Where appropriate, complaints would be escalated in line with the service complaints procedure.

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

Requires improvement

Leadership

Staff and patients we spoke with told us the ward manager was visible and approachable. However, staff and patients told us more senior staff in the service did not visit the wards often and they were not sure who they were. The service had recruited a new Hospital Director and Clinical Services Manager who, at the time of our inspection had been in post for only three months and were therefore still new to staff. The new managers were taking steps to rectify this.

The ward manager told us that she had received leadership training from the provider but at the time of our inspection there were no opportunities for staff of lower grades to receive this training. The results of the last survey showed that only 61% of staff in the service felt they had opportunities to learn and grow.

Vision and strategy

Staff were aware of the provider's visions and values and how they were applied in their day to day work. Throughout our inspection staff were able to demonstrate that they cared about patients and worked to ensure they were happy. At the time of our inspection staff had not had the opportunity to contribute to discussions about the strategy for the service.

Culture

Most of the staff we spoke with told us they felt respected and supported. The results from the last staff survey showed that 74% of staff in the service felt valued and recognised. Some staff told us they were concerned about the level of support they would receive from the new managers but also said they had noticed positive changes since they had been in post and were hopeful that this would mean they would be supported in all areas.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process and about the role of the speak up guardian. All the staff we spoke with told us they would be able to report concerns and felt they would be supported by the ward manager.

Managers in the service dealt with poor staff performance when needed. Concerns regarding performance were initially dealt with through supervision however, if concerns were more serious or if improvements in performance had not been made, managers dealt with performance through the providers policy.

Teams worked well together and where there were difficulties managers dealt with them well.

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at ward level and performance and risk were not always managed well. The ward was not operating as a long stay rehabilitation ward and some patients were not suitable for that type of service because their needs were too complex. Staffing levels on the ward had been worked out according to the requirements of a long stay/ rehabilitation ward and had not taken in to account the change in acuity of patients.

The previous Hospital Director had left the service in August 2019 and the new Hospital Director had not been recruited until December 2019. This had resulted in the service declining prior to the appointment of the Hospital Director and clinical services manager. Staff had not received an appropriate level of support and minutes of meetings were not always available. However, the appointment of two new managers had meant that systems and processes were being put in place and staff and patients had noticed improvements.

Although there was a cleaning schedule in place there were no systems to ensure wards had been properly cleaned, particularly at weekends and when domestic staff had time off. The Hospital Director had not included this on their monthly walk round and had told us he wasn't certain tasks

were being completed. However, the Hospital Director told us they were looking at the domestic staffing arrangements and hoped to recruit additional staff. There were no systems to ensure physical health monitoring had been completed following the use of rapid tranquilisation. Issues raised in clinical governance meetings were not always dealt with.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

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

Management of risk, issues and performance

The ward manager had access to the risk register and was able to escalate concerns when required.

The provider sent a copy of the risk register for September 2019. At that time risks included, staffing and the high use of agency, safeguarding, and estates management including required improvements. Items on the risk register matched concerns expressed by staff.

The service had plans in place for emergencies, for example, adverse weather or a flu outbreak. The provider had good links to other Priory services and agencies as well as a supply of bank staff they could call on if they needed additional support in case of emergency. Senior managers were reviewing contingency plans daily in response to the Covid-19 outbreak.

Information management

Staff had access to the equipment and information technology needed to do their work. At the time of our inspection agency care staff were not able to access electronic care records however, this was rectified following our inspection.

The information technology infrastructure did not always work well. During our inspection we witnessed staff trying to access care records and found the system was slow and crashed several times. This meant staff were not always able to access information when it was needed and caused delays in updating care records.

Information governance systems included confidentiality of patient records. All patient records were stored securely and staff who accessed records were aware of the need to protect patient confidentiality. All staff were required to complete training in IT security, and this was monitored to ensure it was completed.

Staff made notifications to external bodies as needed. Staff were aware of notifications that needed to be submitted to external bodies and completed these appropriately.

Engagement

Staff patients and carers had access to up-to-date information about the work of the provider and the service they used through the internet.

Staff were informed through meetings, email and intranet. Patients and carers had opportunities to give feedback on the service. Questionnaires were sent to carers and patients participated in community meetings when they could discuss matters of concern or interest.

Staff in the service engaged with external stakeholders. Managers engaged with people who were involved with care of patients and other relevant bodies like commissioners, Healthwatch and local safeguarding authorities.

Learning, continuous improvement and innovation

At the time of our inspection there were no staff involved in research or improvement initiatives however staff we spoke with believed they would be allowed to participate if opportunities arose.

The ward was not participating in any accreditation schemes. At the time of our inspection the service had decided to suspend their application for Accreditation for Inpatient Mental Health Services. There was no agreed date to review this decision.

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

The hospital employed a dedicated health and safety trained member of staff to undertake regular environmental risk assessments, including fire risk assessments. These were up-to-date. Patients had personal emergency evacuation plans in place and these were regularly updated. The hospital manager carried out a monthly tour of the ward to assess the safety and suitability of the care environment.

The ward layout did not allow staff to observe all parts of the ward but staff mitigated risks to patients through regular observation in line with each patient's risk assessment. We checked the records to ensure staff were observing patients in the right way at the correct time which they were. Staff had access to an up-to-date ligature risk audit which identified all the potential ligature points on the ward. A ligature point is anything that can be used to attach a rope of other material for the purpose of hanging or strangulation. The ward had many ligature points which could not be mitigated through the use of anti-ligature fittings but the nature of the patient group meant that the risk of deliberate self-harm was significantly less than on other mental health wards. In addition, many anti-ligature fittings would be inappropriate for the patients on Jubilee ward, all of whom had a diagnosis of dementia.

The ward only admitted male patients and therefore complied with national guidance on eliminating mixed sex accommodation.

Staff had easy access to alarms and patients had access to staff alarm call points in their bedrooms. Following assessment, some patients had special equipment installed in their bedroom such as falls mats, which alerted staff to their urgent need for support. This was because not all patients had the capacity to use the alarm call points.

The ward areas were clean but many of the furnishings, including the upholstery were stained and worn. On the first day of our inspection, we noticed a malodour which appeared to be coming from a patient bedroom. Cleaning staff only operated Monday to Friday during the day. At night and at weekends, healthcare staff took part in the cleaning rota but told us they did not always have time to complete the required tasks depending how busy the shift was. On the second day of our inspection, we did not notice any malodours on Jubilee ward. Although the hospital manager carried out a monthly tour and check of the ward areas, they did not check cleaning records. The hospital manager confirmed they were recruiting for ten hours of additional cleaning for over weekends and would ensure they checked ward cleanliness on the monthly walk-round going forward.

The general appearance of the ward was in need of refurbishment. The paint-work on walls and door frames was badly scuffed in places. Walls had visible stains which staff told us could not be removed despite being cleaned. There was what looked like a deflated bean bag under a table in one of the patient lounges and one of the kitchens was being used as a store for a hoist and old mattresses. The kitchen was locked and not in use for patients but

some of the mattresses stored in there were damaged or very dirty. The manager confirmed maintenance staff had appropriate disposal arrangements in place and they would be removed as soon as possible.

The hospital manager, who had only been in post just over two months had ordered some new furniture and had drafted a schedule of refurbishment that was being considered by higher managers in the parent organisation. Following inspection, the provider sent us their refurbishment schedule where work was due to start in April 2020. It specified the redecoration of the communal areas and new seating in the lounge and dining room. However, the schedule did not specify any improvements to the hard flooring which was heavily scratched and worn in places.

Staff received mandatory infection control training and adhered to infection control principles including hand-washing.

The hospital did not have a seclusion room and they had not secluded any patients in the 12 months prior to our inspection.

The ward had a clinic room which was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. We asked staff to ensure the external automated defibrillator was moved to a more accessible place in the nurses office which they did immediately.

Staff maintained equipment well and kept it clean but we could not see a cleaning schedule for the electrocardiogram, (ECG) machine or for the suction machine, however, they looked visibly clean. The clinic room itself was clean and tidy.

Safe staffing.

The service had enough nursing and support staff to keep patients safe. Managers used a staffing tool to calculate the number and grades of healthcare assistants required and this was based on the number of patients on the ward. At the time of our inspection, there were ten patients on the ward but two of them were on leave. This meant that on the day shift there were two qualified nurses and two healthcare assistants on duty and at night there was one qualified nurse and three healthcare assistants. This was in addition to a full-time ward manager who was also a qualified nurse.

Ward managers could adjust staffing levels daily according to patient need and we saw examples where staffing had been increased to take account of a patient that required two staff to be with them at all times. The number of nurses and healthcare assistants matched this number on all shifts and a qualified nurse was present on the ward at all times.

At the time of the inspection, there was a 0.75 whole time equivalent vacancy for a qualified nurse and a 1.25 vacancy for health support workers. Managers had an active recruitment campaign underway which meant three nurses and four health support workers were waiting to start in post. The hospital had been heavily reliant on agency staff but they had tried to use the same staff who were familiar with the ward and the patients. Permanent staff confirmed that most of the time, the same agency staff were used. Some of the agency staff we spoke with at inspection had worked on the ward a number of years.

There were enough staff to carry out physical interventions and where additional support was required staff could call for assistance from the rehabilitation ward located next door or from the wider multidisciplinary team. At the time of our inspection five out of twelve staff had been assigned but were waiting to complete their managing violence and aggression training. Staff, including agency staff who were not compliant with this training would be trained in breakaway techniques as a minimum before being allowed on shift. In this scenario, staff would summon assistance and would not get involved in a restraint unless they had received their full training in managing violence and aggression.

Staffing levels sometimes meant that staff did not have time to interact with patients other than to deliver personal care. Although the ward had support from an occupational therapist and an assistant, they were only available during the day Monday to Friday. None of the patients on the ward had unescorted leave because they were not able to go out on their own.

The hospital employed a consultant psychiatrist for three days per week and a full-time speciality doctor. This post was being covered by a locum doctor but recruitment for this post was underway. Out of hours, staff and patients had access to doctors through an on-call rota provided in partnership with a local mental health trust. Staff and carers, we spoke with confirmed that patients had good access to doctors in an emergency. The Priory group

employed a psychiatrist with a specialism in neuro-degenerative conditions and this person attended the ward once per month to see patients. They were also available by phone to provide staff with advice.

Staff had received and were up-to-date with mandatory training. At the time of our inspection, overall compliance was at 95%. There was one individual course where compliance rates were below 75% and this was for managing aggression and violence. Staff had been booked on to complete the training. There were 18 mandatory training modules including basic life support, intermediate life support, safeguarding, safe handling of medicines, Mental Capacity Act and Deprivation of Liberty Safeguards, moving and handling and managing aggression. Managers had higher levels of health and safety training. Courses were delivered via a mixture of on-line and face to face training. The staff we spoke with told us they were up-to-date with their mandatory training.

Assessing and managing risk to patients and staff

At inspection, we reviewed five care records for current patients. All five records evidenced that staff undertook a risk assessment on every patient on admission and updated it regularly following any incident. Staff did not use a recognised risk assessment tool but used a template developed by the provider which covered the appropriate risk domains.

Staff were aware of and dealt with any specific risk issues such as pressure ulcers. We saw that one patient had a re-positioning chart which staff followed to reduce the risks to the patients from pressure sores. They liaised appropriately with local healthcare providers to monitor physical healthcare risks. However, agency staff did not have direct access to the electronic patient record which meant that if patient risks changed between shift handovers, there was a possibility that they would not be aware of the most up-to-date risk information. Following the inspection, managers confirmed that all agency staff had been provided with log-on details to access the electronic care record. We checked with staff on the ward that this was the case and they confirmed it was.

Staff followed the provider's observation policy and monitored the whereabouts of all patients regularly and in accordance with the levels prescribed in risk assessments.

The hospital was not smoke-free and patients could smoke in the garden area if they wanted to. At the time of our inspection, none of the patients on Jubilee ward smoked.

There was no sign telling informal patients they could leave the ward but staff told us that only patients detained under the Mental Health Act or on a Deprivation of Liberty Safeguard would be admitted to the ward. Informal patients would be treated in other services.

In the 12 months prior to our inspection, there were zero episodes of seclusion and zero episode of long-term-segregation.

Between 01 May 2019 and 31 October 2019, on Jubilee ward, there were 36 restraint episodes with six different patients. There were a larger number of restraints associated with one patient who displayed challenging behaviour linked with his degenerative brain condition.

Staff used restraint only after de-escalation had failed and the restraint techniques approved by the hospital were outlined in the training. Staff did not use prone restraint as this was against hospital policy. The provider had introduced an alternative prevention and management of violence training course, which was accredited by the British Institute of Learning Disabilities, (BILD). All staff at the Priory hospital in Dewsbury were due to undertake this training later in 2020.

The provider had a restrictive interventions programme and this included additional training for clinical staff in positive behavioural support and verbal de-escalation. Hospital managers monitored the numbers of patient restraints through their clinical governance meetings.

Staff on Jubilee ward rarely used rapid tranquilisation with patients and had only used it with one patient in the 12 months prior to our inspection. We examined the records for this patient who was administered intramuscular tranquillisation on nine occasions between February and December 2019. Records showed that whilst staff supported patients to identify triggers and early warning signs for aggressive behaviours, the records did not evidence that the appropriatephysical health monitoring had taken place on six out of the nine occasions following rapid tranquilisation but staff told us this was a documentation issue. Agency staff did not have access to the electronic record and some handwritten notes may not have been scanned onto the patient's record properly. Staff between wards shared a piece of suction equipment which

meant it might not be available for patients on Jubilee ward if the other ward had borrowed it. Both these incidents were contrary to guidance issued by the National Institute for Health and Care Excellence, (NICE).

Staff applied blanket restrictions to patients freedom of movement on the ward because they could be disorientated and could hurt themselves if they had unrestricted access to their bedrooms which were locked. The hospital did not have a blanket restrictions log for Jubilee ward which meant there were not suitable arrangements in place to monitor their use as required by the Mental Health Code of Practice.

Safeguarding

Staff received mandatory training in both adult and child safeguarding. At the time of our inspection, over 80% of staff were compliant with safeguarding adults training and over 85% of staff were compliant with safeguarding children training. Staff knew how to make a safeguarding alert and they could give examples of how to protect patients from abuse. In patient records we saw that staff had raised safeguarding adult alerts when appropriate.

Staff received training in equality and diversity and could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff worked in partnership with the local authority and other agencies, such as community nursing, to identify and protect adults and children at risk of significant harm. The ward manager had received additional training to support them to act as a safeguarding lead for staff and patients.

Staff followed safe procedures for children visiting the ward. Children were not allowed on the ward but could meet patients in a separate visitor's space away from the ward.

Staff access to essential information

Staff used a mixture of paper and electronic records to record information about patient care and treatment. However, at the time of our inspection, agency staff did not have access to the electronic patient record system and managers had to print copies of care plans so they were available for agency staff to refer to. We had concerns about the risks of this especially because the ward had high use of agency staff. Staff had to transcribe notes made by agency workers into the electronic record and they told us this consumed a lot of time and took them away from patient care. Each patient had a variety of different care plans but there was little guidance for staff about what they should record in each different care plan. We were concerned that it might be difficult for staff to know which care plan to use for which patient need. We saw examples of similar needs for different patients being met by different care plans.

Following our inspection, the hospital manager confirmed agency staff had been provided with access to the electronic patient record. We checked with staff on the ward that there were enough log-in credentials for all the agency staff who might need to use them and we were told there were.

Safe and clean environment

The hospital employed a dedicated health and safety trained member of staff to undertake regular environmental risk assessments, including fire risk assessments. These were up-to-date. Patients had personal emergency evacuation plans in place and these were regularly updated. The hospital manager carried out a monthly tour of the ward to assess the safety and suitability of the care environment.

The ward layout did not allow staff to observe all parts of the ward but staff mitigated risks to patients through regular observation in line with each patient's risk assessment. We checked the records to ensure staff were observing patients in the right way at the correct time which they were. Staff had access to an up-to-date ligature risk audit which identified all the potential ligature points on the ward. A ligature point is anything that can be used to attach a rope of other material for the purpose of hanging or strangulation. The ward had many ligature points which could not be mitigated through the use of anti-ligature fittings but the nature of the patient group meant that the risk of deliberate self-harm was significantly less than on other mental health wards. In addition, many anti-ligature fittings would be inappropriate for the patients on Jubilee ward, all of whom had a diagnosis of dementia.

The ward only admitted male patients and therefore complied with national guidance on eliminating mixed sex accommodation.

Staff had easy access to alarms and patients had access to staff alarm call points in their bedrooms. Following

assessment, some patients had special equipment installed in their bedroom such as falls mats, which alerted staff to their urgent need for support. This was because not all patients had the capacity to use the alarm call points.

The ward areas were clean but many of the furnishings, including the upholstery were stained and worn. On the first day of our inspection, we noticed a malodour which appeared to be coming from a patient bedroom. Cleaning staff only operated Monday to Friday during the day. At night and at weekends, healthcare staff took part in the cleaning rota but told us they did not always have time to complete the required tasks depending how busy the shift was. On the second day of our inspection, we did not notice any malodours on Jubilee ward. Although the hospital manager carried out a monthly tour and check of the ward areas, they did not check cleaning records. The hospital manager confirmed they were recruiting for ten hours of additional cleaning for over weekends and would ensure they checked ward cleanliness on the monthly walk-round going forward.

The general appearance of the ward was in need of refurbishment. The paint-work on walls and door frames was badly scuffed in places. Walls had visible stains which staff told us could not be removed despite being cleaned. There was what looked like a deflated bean bag under a table in one of the patient lounges and one of the kitchens was being used as a store for a hoist and old mattresses. The kitchen was locked and not in use for patients but some of the mattresses stored in there were damaged or very dirty. The manager confirmed maintenance staff had appropriate disposal arrangements in place and they would be removed as soon as possible.

The hospital manager, who had only been in post just over two months had ordered some new furniture and had drafted a schedule of refurbishment that was being considered by higher managers in the parent organisation. Following inspection, the provider sent us their refurbishment schedule where work was due to start in April 2020. It specified the redecoration of the communal areas and new seating in the lounge and dining room. However, the schedule did not specify any improvements to the hard flooring which was heavily scratched and worn in places.

Staff received mandatory infection control training and adhered to infection control principles including handwashing.

The hospital did not have a seclusion room and they had not secluded any patients in the 12 months prior to our inspection.

The ward had a clinic room which was fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. We asked staff to ensure the external automated defibrillator was moved to a more accessible place in the nurses office which they did immediately.

Staff maintained equipment well and kept it clean but we could not see a cleaning schedule for the electrocardiogram, (ECG) machine or for the suction machine, however, they looked visibly clean. The clinic room itself was clean and tidy.

Safe staffing

The service had enough nursing and support staff to keep patients safe. Managers used a staffing tool to calculate the number and grades of healthcare assistants required and this was based on the number of patients on the ward. At the time of our inspection, there were ten patients on the ward but two of them were on leave. This meant that on the day shift there were two qualified nurses and two healthcare assistants on duty and at night there was one qualified nurse and three healthcare assistants. This was in addition to a full-time ward manager who was also a qualified nurse.

Ward managers could adjust staffing levels daily according to patient need and we saw examples where staffing had been increased to take account of a patient that required two staff to be with them at all times. The number of nurses and healthcare assistants matched this number on all shifts and a qualified nurse was present on the ward at all times.

At the time of the inspection, there was a 0.75 whole time equivalent vacancy for a qualified nurse and a 1.25 vacancy for health support workers. Managers had an active recruitment campaign underway which meant three nurses and four health support workers were waiting to start in post. The hospital had been heavily reliant on agency staff but they had tried to use the same staff who were familiar with the ward and the patients. Permanent staff confirmed that most of the time, the same agency staff were used. Some of the agency staff we spoke with at inspection had worked on the ward a number of years.

Requires improvement

Wards for older people with mental health problems

There were enough staff to carry out physical interventions and where additional support was required staff could call for assistance from the rehabilitation ward located next door or from the wider multidisciplinary team. At the time of our inspection five out of twelve staff had been assigned but were waiting to complete their managing violence and aggression training. Staff, including agency staff who were not compliant with this training would be trained in breakaway techniques as a minimum before being allowed on shift. In this scenario, staff would summon assistance and would not get involved in a restraint unless they had received their full training in managing violence and aggression.

Staffing levels sometimes meant that staff did not have time to interact with patients other than to deliver personal care. Although the ward had support from an occupational therapist and an assistant, they were only available during the day Monday to Friday. None of the patients on the ward had unescorted leave because they were not able to go out on their own.

The hospital employed a consultant psychiatrist for three days per week and a full-time speciality doctor. This post was being covered by a locum but recruitment for this post was underway. Out of hours, staff and patients had access to doctors through an on-call rota provided in partnership with a local mental health trust. Staff and carers, we spoke with confirmed that patients had good access to doctors in an emergency. The Priory group employed a psychiatrist with a specialism in neurodegenerative conditions and this person attended the ward once per month to see patients. They were also available by phone to provide staff with advice.

Staff had received and were up-to-date with mandatory training. At the time of our inspection, overall compliance was at 95%. There was one individual course where compliance rates were below 75% and this was for managing aggression and violence. Staff had been booked on to complete the training. There were 18 mandatory training modules including basic life support, intermediate life support, safeguarding, safe handling of medicines, Mental Capacity Act and Deprivation of Liberty Safeguards, moving and handling and managing aggression. Managers had higher levels of health and safety training. Courses were delivered via a mixture of on-line and face to face training. The staff we spoke with told us they were up-to-date with their mandatory training.

Assessing and managing risk to patients and staff

At inspection, we reviewed five care records for current patients. All five records evidenced that staff undertook a risk assessment on every patient on admission and updated it regularly following any incident. Staff did not use a recognised risk assessment tool but used a template developed by the provider which covered the appropriate risk domains.

Staff were aware of and dealt with any specific risk issues such as pressure ulcers. We saw that one patient had a re-positioning chart which staff followed to reduce the risks to the patients from pressure sores. They liaised appropriately with local healthcare providers to monitor physical healthcare risks. However, agency staff did not have direct access to the electronic patient record which meant that if patient risks changed between shift handovers, there was a possibility that they would not be aware of the most up-to-date risk information. Following the inspection, managers confirmed that all agency staff had been provided with log-on details to access the electronic care record. We checked with staff on the ward that this was the case and they confirmed it was.

Staff followed the provider's observation policy and monitored the whereabouts of all patients regularly and in accordance with the levels prescribed in risk assessments.

The hospital was not smoke-free and patients could smoke in the garden area if they wanted to. At the time of our inspection, none of the patients on Jubilee ward smoked.

There was no sign telling informal patients they could leave the ward but staff told us that only patients detained under the Mental Health Act or on a Deprivation of Liberty Safeguard would be admitted to the ward. Informal patients would be treated in other services.

In the 12 months prior to our inspection, there were zero episodes of seclusion and zero episode of long-term-segregation.

Between 01 May 2019 and 31 October 2019, on Jubilee ward, there were 36 restraint episodes with six different patients. There were a larger number of restraints associated with one patient who displayed challenging behaviour linked with his degenerative brain condition.

Staff used restraint only after de-escalation had failed and the restraint techniques approved by the hospital were outlined in the training. Staff did not use prone restraint as

this was against hospital policy. The provider had introduced an alternative prevention and management of violence training course, which was accredited by the British Institute of Learning Disabilities, (BILD). All staff at the Priory hospital in Dewsbury were due to undertake this training later in 2020.

The provider had a restrictive interventions programme and this included additional training for clinical staff in positive behavioural support and verbal de-escalation. Hospital managers monitored the numbers of patient restraints through their clinical governance meetings.

Staff on Jubilee ward rarely used rapid tranquilisation with patients and had only used it with one patient in the 12 months prior to our inspection. We examined the records for this patient who was administered intramuscular tranquillisation on nine occasions between February and December 2019. Records showed that whilst staff supported patients to identify triggers and early warning signs for aggressive behaviours, the records did not evidence that the appropriate physical health monitoring had taken place on six out of the nine occasions following rapid tranquilisation but staff told us this was a documentation issue. Agency staff did not have access to the electronic record and some handwritten notes may not have been scanned onto the patient's record properly. Staff between wards shared a piece of suction equipment which meant it might not be available for patients on Jubilee ward if the other ward had borrowed it. Both these incidents were contrary to guidance issued by the National Institute for Health and Care Excellence, (NICE).

Staff applied blanket restrictions to patients freedom of movement on the ward because they could be disorientated and could hurt themselves if they had unrestricted access to their bedrooms which were locked. The hospital did not have a blanket restrictions log for Jubilee ward which meant there were not suitable arrangements in place to monitor their use as required by the Mental Health Code of Practice.

Safeguarding

Staff received mandatory training in both adult and child safeguarding. At the time of our inspection, over 80% of staff were compliant with safeguarding adults training and over 85% of staff were compliant with safeguarding children training. Staff knew how to make a safeguarding alert and they could give examples of how to protect patients from abuse. In patient records we saw that staff had raised safeguarding adult alerts when appropriate.

Staff received training in equality and diversity and could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff worked in partnership with the local authority and other agencies, such as community nursing, to identify and protect adults and children at risk of significant harm. The ward manager had received additional training to support them to act as a safeguarding lead for staff and patients.

Staff followed safe procedures for children visiting the ward. Children were not allowed on the ward but could meet patients in a separate visitor's space away from the ward.

Staff access to essential information

Staff used a mixture of paper and electronic records to record information about patient care and treatment. However, at the time of our inspection, agency staff did not have access to the electronic patient record system and managers had to print copies of care plans so they were available for agency staff to refer to. We had concerns about the risks of this especially because the ward had high use of agency staff. Staff had to transcribe notes made by agency workers into the electronic record and they told us this consumed a lot of time and took them away from patient care. Each patient had a variety of different care plans but there was little guidance for staff about what they should record in each different care plan. We were concerned that it might be difficult for staff to know which care plan to use for which patient need. We saw examples of similar needs for different patients being met by different care plans.

Following our inspection, the hospital manager confirmed agency staff had been provided with access to the electronic patient record. We checked with staff on the ward that there were enough log-in credentials for all the agency staff who might need to use them and we were told there were.

Medicines management

Staff followed good practice in medicines management. They worked in partnership with an external pharmacist

who visited the ward weekly. Staff transported, stored, dispensed and administered medicines in line with national guidance. Where appropriate, patients had detailed care plans for covert medication.

At inspection, we checked the prescription records for eight patients on Jubilee ward. We found records to be complete and staff followed current national practice to check patients had the correct medicines. Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about them.

Patient safety alerts were in evidence in clinic rooms to ensure patients received their medicines safely and decision-making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of medication on patient's physical health regularly and in line with national good practice guidance. At the time of our inspection, there were no patients on Jubilee ward that were prescribed high doses of anti-psychotic medication but medical staff confirmed that appropriate monitoring would be carried out with patients if they were prescribed higher doses of these drugs.

Track record on safety

The ward reported four serious incidents in the last 12 months. These included three unwitnessed falls where patients had to attend the emergency department for treatment.

Reporting incidents and learning from when things go wrong.

The hospital had an electronic incident reporting system but agency staff did not have access to it. Agency staff confirmed they did complete incident reports but these were submitted by permanent staff. Staff knew what incidents to report and we saw examples in patient care records of incidents that had been submitted.

Staff demonstrated a good understanding of the requirements of the duty of candour and were encouraged to be open and honest with patients and family members when things went wrong.

Staff received feedback from investigations of incidents through team meetings and information circulated by the hospital manager. We saw in team meeting minutes where staff had discussed feedback following incidents. The hospital manager had started a regular bulletin for staff which contained details of learning from incidents and we saw emails that had been circulated by the parent organisation disseminating lessons learned from other hospitals within the Priory group.

As a result of learning from incidents, staff had made improvements to safety including the installation of sensors and falls mats in patient bedrooms to alert staff where patients may require assistance. They had also introduced daily food and fluid charts for every patient during the first two weeks on the ward or longer where they needed it.

Managers held debrief meetings with staff following serious incidents and staff received additional support through supervision as required.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

At inspection we examined the care and treatment records of five current patients on Jubilee ward. Medical staff completed a comprehensive mental health assessment prior to the patient arriving on the ward. This included an assessment of the patient's physical health needs which they repeated on admission to the ward. All the records we looked at contained an up-to-date care plan that met the needs identified in the assessment. This included covert medication care plans where this was identified as appropriate. On the whole, care plans were holistic and identified strategies to help patients remain as independent as possible or move on to less intensive support.

Most patients on the ward did not have the capacity to be involved with their care plan but most care records contained statements which reflected the personal preferences of each patient, though some were more personalised than others. Staff updated care plans when necessary and printed the most up-to-date copy for agency staff to refer to. However, staff told us they could not always

have the most up-to-date copies of all care plans available because there were too many of them and they were updated too frequently. Following our inspection, the hospital manager confirmed that all agency staff had been provided with access to the electronic patient record.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for patients with dementia and neurodegenerative conditions. These included medication and care interventions aimed at helping patients reduce agitated behaviours. Medical staff aimed to reduce unnecessary medication for patients and they ensured all interventions delivered were in line with guidance set out by the National Institute for Health and Care Excellence, (NICE).

In general, patients did not have the capacity to respond to psychological therapies but a part-time psychologist was available and staff could consult them about individual patients.

Staff ensured patients had good access to physical healthcare including access to specialists when needed. All patients were registered with a local GP surgery and there was a service level agreement in place so that the GP visited the ward each week to see the patients that needed it. Staff had good links with local community nurses to help provide specialist input for patients who required, for example, wound care. Where patients did not have capacity to consent, staff sought the views of the patient's nearest relative in deciding whether they should undergo invasive physical healthcare procedures. The Priory group employed a consultant that specialised in neurodegenerative conditions and they attended the ward monthly to assess and monitor patients on Jubilee ward. The carers we spoke with told us that staff provided good physical healthcare for patients and referred to specialists in a timely way.

Staff assessed and met patients' need for food and drink. For two weeks following admission, each patient was monitored using a fluid and nutrition chart to assess their baseline food and fluid intake. This was monitored again where staff had concerns that a patient was not eating or drinking enough.

Staff used recognised rating scales to assess and record severity and outcomes. For example, they used tools to monitor patients at risk of malnutrition, pressure sores, and aggression and violence. Staff also used a recognised tool to assess patients' social functioning.

Staff participated in clinical audit and quality improvement initiatives. For example, all patients' physical healthcare was audited each month against national quality standards by the ward managers and speciality doctor. Staff had access to specialists to enable them to carry out medication audits and Mental Health Act audits.

Skilled staff to deliver care

The hospital employed a consultant, a speciality doctor, nurses, an occupational therapist, a psychologist, health support workers and occupational therapy assistants. Through links with external services, patients also had access to dieticians, speech and language therapists, social workers and care co-ordinators. An externally contracted pharmacist visited the ward every week to audit medicines management. They were available for consultation with staff, patients and families as needed.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of patients. The hospital only recruited nursing staff with experience in dementia care and healthcare support workers received training in dementia care. The provider employed a general nurse who could support mental health nurses to provide end of life care for appropriate patients.

Managers provided staff with an appropriate induction and for health support workers, this included induction that was aligned with care certificate standards.

Managers provided staff with supervision and access to regular team meetings. When we spoke with staff, they told us that one of the things that had improved since the hospital manager came into post just prior to Christmas 2019, was that staff were now regularly supervised. Compliance rates for supervision was at 70% but this only included data up to October 2019 before the current hospital director was in post. The staff we spoke with at inspection told us they had supervision every month and when we checked the records for the three months prior to our inspection, staff had been supervised each month.

The percentage of staff who had received an appraisal within the last 12 months was 100%.

Requires improvement

Wards for older people with mental health problems

Staff confirmed they had access to opportunities to develop their knowledge and skills. However, the ward had started to admit patients with acquired brain injury in combination with a diagnosis of dementia. However, staff said they had not received training in acquired brain injury and felt a lack of confidence in working with such patients. When we spoke to the hospital manager, they told us that the clinical manager was organising training for all staff in working with patients with an acquired brain injury. We confirmed these arrangements when we looked at governance meeting notes.

Managers dealt with poor staff performance promptly and effectively and had access on-site to human resource advice and support as well as from the parent organisation. The hospital did not work with volunteers.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Once each month, a specialist consultant psychiatrist from the Priory organisation met with doctors at the hospital to review each patient's care. Patients and their families were invited to attend these meetings, though in reality, most patients did not have the capacity to participate fully.

Handover meetings were held twice per day and involved all nursing staff and health support workers. Staff shared clear information about patients and any changes in their care. In care records we saw notes of multidisciplinary meetings which showed how staff from different disciplines worked together as a team to benefit patients. This included health support workers who could attend meetings if they had time.

The two wards had effective working relationships with each other and sometimes shared staff and training resources. There were effective relationships with other relevant organisations, for example, local community nursing teams. We saw examples in case files where staff had referred patients for speech and language therapy and for other specialist care.

Adherence to the MHA and the MHA Code of Practice

At the time of our inspection, over 86% of staff had received training in the Mental Health Act. They demonstrated a good understanding of the Act, the Code of Practice and the guiding principles.

Staff had support from an on-site Mental Health Act administrator who provided staff with legal advice and support concerning the implementation of the Act. This person ensured the hospital's policies and procedures were up-to-date and that staff had access to the relevant procedures including the Code of Practice.

As part of our inspection, we looked at a sample of Mental Health Act files for current patients. We found that staff explained to patients their rights under the Mental Health Act and although, most patients lacked the capacity to understand and retain this information, staff repeated this at regular intervals and recorded they had done this.

Patients and their carers had access to independent advocacy through a service level agreement the hospital had with an external organisation. There were posters around the hospital with the name of the advocate, when they visited and how they could be contacted. Prior to our inspection, we spoke with the advocate who confirmed they visited the ward weekly, had access to multidisciplinary meetings and care programme approach reviews and attended hospital governance meetings with the patient representative from the other ward.

Staff requested an opinion from a second opinion appointed doctor when necessary and staff stored copies of patient's detention papers correctly.

The Mental Health Act administrator carried out Mental Health Act audits to ensure the Act was being applied correctly. The service was last inspected by our Mental Health Act officers on an unannounced visit in January 2019. Following this inspection, they did not raise any actions which meant the hospital was demonstrating good practice in applying the Mental Health Act.

Good practice in applying the MCA

At the time of our inspection, over 86% of staff were compliant with training in the Mental Capacity Act. Staff demonstrated a good understanding of the Act and the five statutory principles.

Staff made three applications under the Deprivation of Liberty safeguards over the last 12 months but at inspection, all the patients on the ward were detained under the Mental Health Act.

The hospital had a policy on the Mental Capacity Act, including deprivation of liberty safeguards and this was

Requires improvement

Wards for older people with mental health problems

available on the hospital's intranet for any staff who required it. Staff could seek advice from the hospital's Mental Health Act administrator and medical consultant as needed.

Staff were skilled in carrying out mental capacity assessments and gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the capacity to make it. We observed how staff were skilled in interpreting patients' verbal and non-verbal cues to assist with decision-making.

On Jubilee ward, most patients had some degree of impaired mental capacity and relied on staff to make decisions in their best interests. We saw examples of best interest meetings taking place which involved the patient's nearest relative to take account of the patient's culture, history and possible wishes. Patients had fully documented best interests meetings concerning things like covert medication and physical health investigations.

For every patient admitted to Jubilee ward who lacked capacity, medical staff wrote to the Office of the Public Guardian to identify if there were any court appointed deputies in place. This is someone appointed by the Court of Protection to make decisions for a patient who is unable to do so on their own. Where staff could not identify a patient's nearest relative, they involved an independent mental capacity advocate, (IMCA). This is someone who can support and represent the patient in the decision-making process and ensure the Mental Capacity Act is being followed.

The hospital's consultant monitored staff's adherence to the Mental Capacity Act and disseminated learning through clinical governance meetings.

Are wards for older people with mental health problems caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Most of the patients on Jubilee ward did not have the capacity to participate in an interview with us at the inspection. However, we were able to observe staff interacting with patients and we carried out a short observational framework for inspection (SOFI). This is an observational tool used to help us collect evidence about the experience of people who use services, especially where they may not be able to describe these themselves because of cognitive or other difficulties. We also spoke with five carers of current patients who were able to describe how staff cared for their relative.

We observed staff interacting with patients which demonstrated they were skilled at interpreting their emotions, requirements and responses. Staff understood the individual needs of patients and they had taken time to get to know each patient's personal cultural and social needs by reading about their history and speaking with their families. Staff demonstrated a caring, compassionate approach and this was supported by all five carers we spoke with at inspection. Carers told us staff treated them and the patients well and behaved appropriately towards them.

While we did not observe any negative interactions, staff were often very busy and sometimes struggled to respond to every patient at the time they appeared to need it. We observed one patient who appeared to try to get up from his high-backed chair on several occasions but staff did not intervene to assist him. Another patient waited until after 2 p.m. in the afternoon for their morning shower because staff were busy with other patients. The patient was up and dressed during this time. We saw in patients' records where patients had been given hand massages by staff.

Involvement in care

Staff involved carers of patients and provided them with information about the ward and what would happen while the patient was there. This would be provided to patients where they had capacity.

Staff involved patients in care planning as much as they could given that most patients lacked capacity to interact meaningfully with their written care plan. Some patients had a paper file containing summary information about them, for example, who they were, what they liked and did not like but not all patients had this in place.

Where they had capacity, staff could involve patients in governance meetings through a patient representative but at the time of our inspection, there were no patients with the capacity to participate in decisions about the service.

Requires improvement

Wards for older people with mental health problems

Some patients had advanced decisions in place, for example to refuse treatment and staff knew who these patients were.

Staff ensured patients could access advocacy and this included their families. An advocate visited the ward every week and was involved in ward rounds and patient care reviews.

Carers told us they felt involved in the care of the patient and staff kept them informed appropriately. All the carers we spoke with were overwhelmingly positive about the care their relative received. Evidence in care records demonstrated that carers were involved in care review meetings and were encouraged to give feedback about care.

Staff told us that where appropriate, carers would be referred to the Local Authority for a carer's assessment.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

On Jubilee ward, the average bed occupancy over the six months prior to October 2019 was 76% but staff told us this could fluctuate rapidly due to the deterioration of patients with dementia and co-morbidities. At the time of our inspection, there were 10 patients on the ward but two of them were on home leave. Many of the patients were not from the local area because of the specialist nature of the hospital. Beds were available when needed for people living in the local area.

Staff supported patients and their families during referrals and transfers and there

were arrangements in place with a local hospital trust for patients to access the psychiatric intensive care unit should they become acutely unwell. Staff were experienced at managing patients on the ward who were mentally unwell. From 01 November 2018 to 31 October 2019, staff did not transfer any patients to the local psychiatric intensive care unit.

There was always a bed available when patients returned from leave as the hospital never admitted patients to a leave bed. Patients were not moved between wards because of the specialist nature of the treatment on that particular ward. Patients either moved back to a residential home or they reached end of life in the hospital. The hospital reported no delayed discharges in the period 1 November 2018 to 31 October 2019.

On Jubilee ward, the average length of stay for patients discharged in the 12-month period from 1 November 2018 to 31 October 2019, was 630 days. Staff planned for patients' discharge but we did not see evidence in care records of formal discharge plans. However, we did see that discharge planning was discussed regularly at monthly multidisciplinary care reviews and patients had an expected discharge date in their care records. Notes from multidisciplinary reviews were stored in patient care records.

The facilities promote recovery, comfort, dignity and confidentiality

All patients had their own rooms. They could personalise their bed rooms and the ward had a safe where patients could store any valuable personal items.

Staff and patients had access to a range of rooms and equipment to support treatment and care but these were not always appropriate for patients with dementia. For example, the ward had a dining area which was large enough to allow patients to eat in comfort but the area was sparsely furnished with no homely features. There were no directional signs or orientation aids anywhere on the ward. For example, patients bedrooms were not numbered and we only saw one bedroom with a personalised picture on the door to indicate the room belonged to a particular patient. Apart from that, all the doors looked the same with the same picture of a bed on them.

The ward had a sensory room but none of the equipment in the room was switched on during our inspection. It was quite cold and there was a large notice on the wall threatening disciplinary action for staff if they were found to be using the room themselves for relaxation. There was a projector in the room, which could project coloured images onto the wall but we did not think the images were age-appropriate and could have been disturbing to people

with dementia. Creating the right environment is very important in caring for people with dementia because patients are more likely to remain active, which will help them live well for as long as possible.

We noticed that all the patients we saw at inspection wore sweatpants or shorts and jersey tops. Many were not wearing socks. We thought staff could have provided more support to help patients wear clothing that was more reflective of the individual personalities and preferences.

One carer told us that clothes they had bought for a patient could not always be located and hospital managers told us that some clothes had apparently gone missing form Jubilee ward. This was being investigated by staff and arrangements were in place to replace the missing clothing.

The ward had equipment and resources available for patients assessed as frequent fallers. Some patient bedrooms had falls sensors and falls sensor mats. A hoist was available where patients needed it and there were disabled bathroom facilities including showers. However, the only accessible bath on the ward was broken and had been like that for many months.

Off the ward, patients had access to a fully equipped gym and a multi-faith room. There were quiet areas on and off the ward where visitors could spend time with patients.

Patients had access to their mobile phones where they had capacity to use them and there was an outside area with a garden and a patio which patients could use anytime.

Staff helped some patients to feed themselves and patients had access to hot drinks and snacks 24 hours a day, seven days per week but they needed staff assistance to do this. Patients could not use the patient kitchen on the ward because it was being used as a store room. There was a patient menu board but nothing was written on it. Staff used specialist feeding aids but we observed one occasion where a plate guard was used incorrectly by staff so the food was being spilled onto the patient's clothes. Later in the day, staff helped them to change their clothes. Patients did not have adequate protection when they were eating so food could spill onto their clothing.

The hospital had appointed a new chef who started work the week of our inspection. We spoke to this person who told us they intended to introduce new menus which would be seasonally adjusted to provide more variety for patients.

When we spoke with carers of patients on Jubilee ward, one person told us the food choices did not always match what was on the menu for the day but another carer we spoke with told us the food was of good quality. The chef and the staff used the International Dysphagia Diet Standardisation Initiative, (IDDSI) and referred to these in-patient diet plans. These standards contained recommendations for people with swallowing problems which many patients on Jubilee ward had.

The doors to patient bedrooms were solid and did not have vision panels. This meant that, at night, staff had to physically enter a patient's bedroom in order to observe them. Some patients required observing every hour and staff said they thought this disturbed patient's privacy and comfort. The doors were heavy and it was difficult for staff to open them without disturbing the occupant. Although patients could not verbalise this, staff thought that with one patient in particular, this disrupted their sleep pattern and could cause the patient to become stressed and irritable. Staff told us they had spoken with hospital managers about their concerns but they were not aware of any measures being taken to address this.

Patients' engagement with the wider community

Patients had access to activities and there was an occupational therapist and two occupational therapy assistants who worked across both wards in the hospital. These staff facilitated patient outings and some ward-based activities during the week but they did not work weekends. They supported staff to assist patients with breakfast and getting dressed in the morning but, they relied on the health support workers to engage patients in activities on the ward. Although staff told us they played games with patients and attempted to engage them in activities, in reality, they were often too busy delivering personal care to engage patients in activities. At inspection, while we saw staff interacting with patients in a caring way, we did not see evidence of much activity happening with patients. One of the five carers we spoke with told us they thought there should be more patient activities and, in one patient record we saw feedback from a carer saying they had not seen staff engaging patients much in activities when they visited. However, one carer we spoke with told us their relative had been involved in lots of activities

including a dementia singing group. None of the patients had an individualised activity timetable but there was a general activity timetable with activities including arts and craft sessions, supported exercises and a music group.

The feedback we received from all the carers we spoke with was that staff supported patients to maintain contact with their families and carers. We came across examples where staff had facilitated transport for carers to allow them to visit relatives in the hospital even where that was a significant distance away.

Meeting the needs of all people who use the service

Some of the patients on Jubilee ward had restricted mobility and staff made adjustments by providing the necessary equipment to assist them, for example, wheelchairs. The ward was originally a purpose-built unit and was therefore accessible for patients and visitors with disabilities. However, the only accessible bath on the ward was broken and had been for many months. We could see that this had been discussed in clinical governance meetings but progress was unclear. Staff told us that a previous patient whose relatives had said he enjoyed a bath was not able to have one when the bath became out-of-order. The new hospital manager was aware of this and said he had put this on the schedule for consideration in the refurbishment of the ward but we did not see this had been addressed in the refurbishment plan sent by the parent organisation.

Staff referred patients to external speech and language therapists where needed but we did not see any evidence of staff using any communication aids with patients. Some aspects of the ward environment did not meet the needs of patients with dementia. For example, there was a bookcase in one of the lounge areas but it was empty apart from two DVD's. We did not see evidence of any easy-read materials or pictures. There was no tactile stimulation on the wards. However, we did observe that staff interacted with patients in ways which suggested they knew patients well and could interpret their body language and other cues.

Despite most patients lacking capacity, we saw evidence that staff reminded patients of their rights including how to make a complaint. An advocate visited the ward weekly and would speak with patients as required. We did not see any information on the ward area for patients or their carers about treatments or local services. There was some information in the reception area of the hospital but it was unclear who the information was aimed at. The advocate told us they did not get many referrals to see families or carers and we wondered how well staff promoted the advocacy services to patients' families on Jubilee ward.

Staff said patients had a choice of food to meet their dietary requirements. In patient care records, we saw copies of diet plans including food supplements where this was required. Staff told us kitchen staff could prepare food to meet patient's spiritual and cultural requirements.

Patients and their visitors had access to a multi-faith room off the main ward and staff told us they would arrange specific spiritual support where patients required that. When we spoke with carers, we had no concerns that the hospital was not providing appropriate facilities and food to meet patients' spiritual and cultural needs.

Listening to and learning from concerns and complaints

The ward received very few complaints. In the period 1 November 2018 to 31 October 2019, there were no formal complaints relating to this ward. In the same period, staff on the ward had received three compliments from patients' carers.

When we spoke with carers, they confirmed they knew how to make a complaint and one carer had raised a concern about a patient's clothing going missing. Staff were looking into how this had happened and were in the process of replacing the clothes for the patient.

Staff received training in how to handle complaints and showed an awareness of how to protect patients who raised concerns from discrimination and harassment.

Staff received feedback on the outcome of complaints in one-to-one meetings where they had been directly involved and through a fortnightly bulletin circulated by the hospital manager.

Are wards for older people with mental health problems well-led?

Requires improvement

Leadership

Leaders had the skills, knowledge and experience to perform their roles and ward managers had a good

understanding of the services they managed. Ward managers and senior nurses were qualified in mental health nursing and had further training in working with patients with dementia. The hospital manager and the clinical services manager were new in post and still in the process of getting to know how the hospital worked but those those leaders were experienced managers with relevant mental health experience.

Although the hospital manager and clinical services manager had visited the wards, some agency staff said they had not met them. Other staff felt a little remote from higher managers but acknowledged this was early days. Ward managers and senior nurses were visible in the service and approachable for staff and patients.

Development opportunities were available for staff including trainee nurse apprenticeships and nursing degree courses. The hospital manager told us staff had opportunities to act up into management positions where appropriate with support and supervision.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied in the work of their team. Managers had successfully communicated the vision and values to front line staff in this service. Each employee had been sent a copy of the values and expected behaviours with their pay slips and this information was also available on the staff intranet. The manager told us he spoke with all new starters about the provider's vision and values as part of their induction. The values and expected behaviours had been incorporated into the care certificate workbooks for health support staff and were also embedded in recruitment processes.

The staff we spoke with did not feel they had the opportunity to contribute to strategy and did not feel listened to by the senior leadership team. Since the new managers came into post, weekly operations meetings had been cancelled and this reduced the opportunities for them to discuss some of the changes they felt needed to be made within the service. We spoke to the hospital manager who said some part-time members of the multidisciplinary team were spending too much time in meetings leaving them with too little time for patients. The operational meetings would still be going ahead but monthly rather than weekly. Staff felt they had little opportunity to contribute ideas about the refurbishment of the ward but the hospital manager told us that while outline plans had been drafted, staff on the ward would be consulted prior to any changes being implemented. Staff on the ward seemed unaware that operations meetings had not been cancelled completely or that they were to be consulted about environmental changes.

Culture

Staff felt respected, supported and valued at ward level but recently morale had dipped due to changes in higher management. Some staff welcomed the changes and felt there was more structure and better training while others did not. The current senior management team had only been in post since mid-December 2019 and prior to that, the two senior posts were being covered by one manager who had since left the organisation.

All the staff we spoke with felt positive and proud to work in their team. The provider carried out annual employee engagement surveys and we looked at the latest one available for the Priory hospital in Dewsbury which was carried out in 2018. It showed that 78% of staff felt proud about working at the hospital and 65% would recommend it as a good place to work. The overall engagement score was slightly higher compared to other hospitals in the Priory Group. The results from the 2019 staff survey were in the process of being analysed and disseminated.

Staff felt able to raise concerns without fear of retribution and knew how to use the whistleblowing process. There was information available in staff areas and all the staff we spoke with including non-clinical staff confirmed they had received information about speaking up and would feel able to do so where they had concerns.

Managers dealt with poor performance when needed and there was support on site to help staff deal with disciplinary and other performance issues. Staff had support from the parent organisation as needed.

Staff appraisals included conversations about career development and some staff told us they had support to be trained in nursing. Others were able to progress from health support worker roles to occupational therapy assistants and others were able to be recruited onto a nursing apprenticeship at the hospital.

Requires improvement

Wards for older people with mental health problems

The hospital manager calculated current sickness absence at the hospital to be at 2% which was an improvement since he started in the role and below the average for the Priory group as a whole.

Staff had support for their own physical and emotional health needs through a comprehensive employee assistance programme. Staff had access to confidential support from counsellors accredited by the British Association for Counselling and Psychotherapy,(BACP). They also had access to a staff welfare budget which was used to purchase staff raffle prizes and provide special event meals.

The provider recognised staff success within the service with employee of the month awards. Staff received information about these through a new fortnightly bulletin circulated by the hospital manager. The Provider also had other national employee recognition events including awards for highly performing individuals.

Governance

There were some systems and procedures in place to ensure that wards were safely staffed, that appropriate health and safety arrangements were in place, that staff were trained and supervised, that patients were assessed and treated well, that medicines were managed safely and staff adhered to the requirements of the Mental Health Act and Mental Capacity Act. However, there were no systems in place to check that wards had been cleaned properly especially when cleaning staff were on leave. The hospital manager did not check these on their monthly audit and staff said they did not always have time to carry out cleaning duties. Systems to check that staff had completed required patient health monitoring following the administration of rapid tranquilisation were not set up and no system was in place to identify and review blanket restrictions on Jubilee ward.

The environment was in need of refurbishment and it was not dementia friendly. When we last inspected the ward in July 2017, managers at that time had identified a number of improvements required to make the ward more suitable for people with dementia but not all of them had been carried out. As a result of changes in management at both the hospital level and in the parent organisation, the hospital had a new improvement plan with details of new dementia friendly signs to be incorporated. Managers spoke of developing a dementia friendly café but had not been in post long enough to effect these changes.

Patients could not have a bath because it was broken and had been like this for many months. The advocate and the service user representative told us they had raised maintenance issues in clinical governance meetings with the previous management but they had not responded in a timely way to the issues raised. However, we saw in recent governance meeting minutes how managers had replaced televisions and fixed other issues in response to patient feedback. The new manager was aware of the maintenance required to the bath.

Current managers had proposed changes to hospital meetings and to the environment on the ward but staff did not feel there were adequate mechanisms in place to consult with them about these changes. We saw minutes of hospital team meetings attended by senior managers where they asked for staff suggestions and ideas about improvements but these had only just started happening and not all staff were aware of the consultation methods.

There was no clear framework for what should be discussed at a ward, team or directorate level but senior managers were in the process of redesigning the structure and function of hospital meetings. There were, however, meetings to discuss essential issues such as incidents, complaints and health and safety matters and staff were aware of these. Some of these meetings had only just started again following the appointment of the new hospital director.

Staff had implemented recommendations from incidents and feedback including the use of sensory equipment to monitor patient falls and food and fluid charts for all patients. They undertook audits and acted on the results when needed. For example, we saw actions had been carried out in relation to medicines management and Mental Health Act administration.

Staff understood the arrangements for working with the other ward and they collaborated with each other, for example, in sharing resources including staff. Staff liaised well with other teams, like district nursing and safeguarding to meet the needs of the patients.

Management of risk, issues and performance

Requires improvement

Wards for older people with mental health problems

Staff had access to a local risk register and could escalate concerns up to the parent organisation. We saw that staff concerns matched those on the risk register, such as staffing and the ward environment. Staff discussed risks at monthly governance meetings.

The ward had business continuity plans for emergencies. Managers were updating these on a daily basis in response to advise concerning the COVID19 virus.

Information management

The service used systems to collect data from wards and these were not overburdensome for staff. However, staff said the electronic care record system was far too slow at times and they sometimes had to wait up to 10 minutes to log-on to the system. The hospital manager confirmed that an up-grade of the electronic patient record was due to take place later in the year and would provide greater ease of access for all staff. We confirmed this when we looked at senior management team minutes where the upgrade of the new system had been rolled out in other locations belonging to the parent organisation.

Information governance systems included confidentiality of patient records. Staff had mandatory training in information governance and each had their own secure passwords with individual authorisations to access confidential information.

Ward managers had access to information to support them with their management role. This included information on staffing, staff training, supervision and whether patient care plans and risk assessments were up-to-date.

Information was accessible, timely and identified areas for improvement. Managers had access to a dashboard with directional arrows to show which areas had increased or improved and decreased or stayed the same.

Staff made notifications to external bodies as needed including commissioners, the CQC and the local safeguarding authority.

Engagement

Patients and carers had access to up-to-date information about the work of the provider through their website and staff had access to an intranet site and a regular news bulletin circulated by the new hospital manager.

Patients and carers had opportunities to give feedback on the service through questionnaires given to them when they attended patient care reviews. We saw feedback from three carers who had completed these. On the whole, the feedback was very positive. One carer mentioned they would have liked more calls from staff about the patient's progress and another commented on the ward environment being in need of refurbishment. Staff acknowledged they needed to do more to engage families and respond to their needs and they had plans to work on this.

Patients were involved in decision-making to changes about the service through a patient representative who attended regular clinical governance meetings. Although, at the time of our inspection, there were no patients on Jubilee ward with the capacity to engage in clinical governance meetings, staff confirmed they could become involved in future. The hospital manager told us they were working on how to involve carers in decision-making in a meaningful way.

Staff were encouraged to have their say through a feedback forum held at corporate level. This was new and had therefore not happened yet. Adverts had gone out for a representative from the hospital to attend the forum and a volunteer had come forward. Staff also had access to a suggestion box in the staff break area.

Learning, continuous improvement and innovation

We were not aware of any continuous improvement initiatives taking place but the hospital had been running with reduced management capacity until the new hospital director and the clinical manager came into post.

Staff did not participate in any national audits and did not participate in any accreditation schemes relevant to older peoples' wards.

Outstanding practice and areas for improvement

Outstanding practice

Staff went out of their way to ensure carers for patients on Jubilee ward were able to maintain regular contact with the patients. Many of the carers lived out of the area, and some struggled to visit patients on the ward. As a result, on some occasions, the hospital facilitated transport arrangements to bring the carers to visit their family members on Jubilee ward.

Staff consistently demonstrated best practice in implementing the Mental Capacity Act and the associated code of practice. For example, for every patient admitted to Jubilee ward who lacked capacity, medical staff wrote to the Office of the Public Guardian to identify if there were any court appointed deputies in place. This is someone appointed by the Court of Protection to make decisions for a patient who is unable to do so on their own. Staff did this to make certain that if a patient lacked capacity on admission or lost capacity in the future, staff could be sure they were consulting with the people who had been nominated by the patient to represent their best interests. Staff continually evaluated their practice and hospital managers had good oversight of how the Mental Capacity Act was being applied. Staff training compliance rates were consistently high and staff demonstrated a good understanding of how to apply the principles of the Act.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the environment on Jubilee ward is dementia-friendly and suitable to meet the needs of the patients with dementia.
- The provider must ensure both wards are suitably refurbished and that patients have access to appropriate bathing facilities on Jubilee ward and that that en-suite facilities on Hartley ward protects patients' privacy and dignity.
- The provider must ensure patients on Hartley ward are involved in planning of their care including collaborative assessment of their needs and preferences. This should include goals for recovery and the use of early warning scores. Discharge plans must be included and updated appropriately.
- The provider must ensure suitable systems and processes to oversee and maintain cleanliness across the hospital.
- The provider must ensure there are systems in place across the hospital to monitor the use of observations following the administration of rapid tranquilisation and to ensure ligature risks are updated following the admission of new patients to Hartley ward.
- The provider must ensure that any blanket restrictions applied to patients are done so in line with the Mental Health Code of Practice.

Action the provider SHOULD take to improve

- The provider should consider how to ensure that patients on Jubilee ward wear clothing that is more reflective of their individual personalities and preferences.
- The provider should ensure that agency staff continue to have access to the electronic patient record.
- The provider should ensure that vision panels are fitted to the doors of patients' bedrooms to ensure their privacy and comfort is maintained when staff carry out observations at night.
- The provider should ensure that where needed, patients on Jubilee ward have access to equipment to protect their clothing at meal times.
- The provider should ensure staff are aware of the ways in which they can be involved in changes to hospital systems and the ward environment.
- The provider should ensure that staff continue to receive supervision in line with the provider's policy.
- The provider should ensure that work on new menus continues and that that food is nutritious and suitable for all patients on Hartley ward.
- The provider should consider reviewing the staffing levels on Hartley Ward.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The ward environment on Jubilee ward was not dementia friendly and did not meet the needs of patients with dementia. This was a breach of regulation 9 (1) (b) (c). Care plans on Hartley ward were not written collaboratively, did not include goals for recovery or early warning scores. This was a breach of regulation 9 (3)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The ward décor and furnishings on both wards were not properly maintained and the patient bath on Jubilee ward was not working. This was a breach of Regulation 15 (1) (a) (e) (2) Hartley ward was not clean and there were signs of spills on walls. There were lingering odours and care staff were required to carry out cleaning duties evenings and weekends.This was a breach of regulation 15(1)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems were not established to ensure the ward was always clean or that staff always followed national

This section is primarily information for the provider

Requirement notices

guidance when administering rapid tranquillisation. Systems to identify and review blanket restrictions across the hospital did not comply with the Mental Health Code of Practice. There was no system in place to ensure ligature risks were updated following the admission of new patients to Hartley ward. This was a breach of Regulation 17 (1) (2) (a) (b).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Showers in patients' rooms on Hartley ward were not suitable for all users and meant staff had to be present to assist patients when showering. This was a breach of regulation 10(2)(a).