The Priory Hospital Roehampton

Quality Report

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Date of inspection visit: 15-29 September 2020
Date of publication: 30/12/2020

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Overall summary

This was a focused inspection on the Adult Eating Disorder Service that covered aspects of safe, caring, responsive and well-led. The rating of safe changed from good to requires improvement.

We undertook an unannounced focused inspection of this ward due to an incident that had occurred on the ward in which a patient had their hair cut by staff. At the time of writing this report, we were considering our regulatory response to this incident using our specific incident guidance. We will add full information about our regulatory response to a final version of this report, which we will publish in due course. As part of the inspection, we reviewed the management of patient risk, involvement of families and carers, how the staff maintained patients' privacy and dignity, and the culture and leadership of the ward.

Summary of findings

We found:

- Staff had acted inappropriately when they cut a patient's hair against their will under restraint. They had not exhausted all other options and had not involved the patient and their family fully in taking this decision. The patient felt this had a significant negative effect on their mental health and was not proportional to their level of risk. This meant the service had not safeguarded the patient from improper treatment which was degrading.
- On the night we visited the ward, there were no permanent members of the ward staff working on the night shift. The team working consisted of agency members of staff and members of staff that usually worked on other wards at the hospital. However, the staff that we spoke to on the ward were knowledgeable about the patients and had a detailed handover at the start of their shift. Patients fed back that it would be nicer to have more permanent staff.
- On the night we visited the ward, there was one nurse working on the night shift. An additional nurse was available to the ward to support with medication and if there were any incidents. However, the staff member was also covering the entire hospital site, so would not always be available to assist on the ward.

However:

- The ward environments were safe and clean. The wards had enough nurses and doctors; however, there were two shifts between 14 September 2020 and 4 October 2020 where there were no permanent staff working on the ward. Staff assessed and managed risk well.
- Overall, patients were positive about the staff on the ward. Patients enjoyed the therapies that were available on the ward and felt that permanent staff on the ward were kind and approachable. One patient said that there was always a member of staff to talk to. However, four of the six patients we spoke to felt they should have been more supported after the recent incident in which staff cut a patient's hair. The service was well led and the governance processes ensured that ward procedures ran smoothly.

Summary of findings

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Good

The Priory Hospital Roehampton

Services we looked at
Specialist eating disorders services

Summary of this inspection

Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides support and treatment for people with mental health problems and substance misuse problems.

This location is registered to carry on the following regulated activities:

Assessment or medical treatment for persons detained under the Mental Health Act 1983; Treatment of disease, disorder or injury

Following our last comprehensive inspection in March 2019, we rated this location as good overall.

This was a focused inspection we undertook to investigate specific concerns in respect of four key questions; is the service safe? are staff caring? is the service responsive? and is the service well-led?

As part of our inspection, we inspected East Wing, a mixed ward for 10 adults with eating disorders.

Our inspection team

The team that inspected the hospital comprised of a CQC inspector, a CQC inspection manager and a Mental Health Act Reviewer.

Why we carried out this inspection

We undertook an unannounced focussed inspection of this ward due to a serious incident that had occurred on the ward. There had also been a rise in self-harm incidents on the ward.

How we carried out this inspection

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to patients, staff and our inspection team. This meant that we limited the amount of time we spent on the wards to prevent cross infection. Two inspectors visited the ward on 15 September 2020 for three hours to complete essential checks. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures. The remainder of our inspection activity was conducted off-site. This included staff interviews over the telephone and analysis of evidence and documents. Our final telephone staff interview was completed on 29 September 2020.

This was an unannounced inspection and, in order to see how the service operated outside office hours, the site visit started at 8:30pm.

During the inspection visit, the inspection team:

- visited the ward and observed the quality of the ward environment
- spoke with 18 staff members including nurses, health care assistants, occupational therapists, the ward consultant and ward manager
- spoke with six patients
- spoke with three carers/relatives
- reviewed ten patient care and treatment records

Summary of this inspection

What people who use the service say

Patients who used the service were mainly positive about the staff and treatment provided. Patients enjoyed the therapies that were available on the ward and felt that permanent staff on the ward were kind and approachable. Patients said that they would prefer more permanent staff to work on the ward. Four out of six patients that we spoke with told us that they felt affected by a recent incident on the ward. They felt that staff should have provided more support immediately after this incident to them and the patient it involved.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires improvement	N/A	N/A	N/A	N/A	Good
Overall	Good	Good	Good	Good	Good	Good

Notes

We did not re-rate the overall rating for this service.

Good

Specialist eating disorder services

Safe	Requires improvement
Effective	
Caring	
Responsive	
Well-led	

Summary of findings

Are services safe?

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

- Staff had cut a patient's hair against their will under restraint. The patient felt this had a significant negative effect on their mental health and was not proportional to her level of risk. At the time of writing this report, we were considering our regulatory response to this incident.
- There were two shifts between 14 September 2020 and 4 October 2020 where there were no permanent staff working on the ward. However, the agency and bank staff that we spoke to on the ward were knowledgeable about the patients and had a detailed handover at the start of their shift.

However:

- The ward was safe, clean, and fit for purpose.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Are services effective?

We did not include this key question in this inspection. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Are services caring?

Our rating of caring stayed the same. We did not inspect the whole of the key question during this inspection and therefore did not rate the core service. We found no evidence to suggest the existing rating of Good should be reviewed or changed. We found:

- Staff respected patients' privacy and dignity most of the time; however, due to one incident, a patient on the ward felt that they were not treated with dignity and respect. Three other patients on the ward raised concerns about this incident.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided in most of the care they delivered. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive to people's needs?

Our rating of effective stayed the same. We did not inspect the whole of the key question during this inspection and therefore did not rate the core service. We found no evidence to suggest the existing rating of Good should be reviewed or changed.

Are services well-led?

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.

Good

Specialist eating disorder services

Are specialist eating disorder services safe?

Requires improvement

Maintenance, cleanliness and infection control

Ward areas were clean, had good furnishings and were well maintained.

Staff followed the current infection control policies and procedures. Staff were using social distancing, good hand hygiene, and other measures to prevent the spread of infectious diseases where possible.

Staff had access to personal protective equipment (PPE). During our onsite inspection, all staff we observed were wearing the correct PPE. The nursing office on the ward had a sign on the door indicating that no more than three people could be in the room at the same time. Alcohol hand gel dispensers were readily available at the reception and on the ward.

Safe Staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. Between 14 September 2020 and 4 October 2020 all shifts had sufficient staff, however there were two occasions where there were no permanent staff working on the ward. On the night of our onsite visit, there were no permanent staff working on the ward. There was one agency nurse, one agency health care assistant, one bank health care assistant and one health care assistant who normally worked on another ward within the hospital. The staff that we spoke to on the ward were knowledgeable about the patients and had received a detailed handover.

On the night we visited the ward, there was one nurse working on the night shift. An additional nurse was available to the ward to support with medication and if there were any incidents. However, the staff member was also covering the entire hospital site, so would not always be available to assist on the ward.

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

At the time of our inspection there were four health care assistant vacancies from an establishment of 11.5. These vacancies were being covered by bank or agency staff. Following our inspection, the provider had successfully recruited to all of the health care assistant positions.

When agency and bank staff were used, those staff received an induction and were familiar with the ward. We spoke to several bank and agency staff members during our inspection. Staff were knowledgeable about the patient group and said that they had received a full induction. Long-term agency staff within the hospital received monthly supervision from a permanent member of staff.

There had been several incidents on the unit while patients were on close observations. All of these incidents involved agency staff members. The local safeguarding authority were suitably informed on each occasion. Following these incidents the nurse in charge would try and use permanent staff on close observations with the patient involved, however there were occasions when this was not possible.

Staffing levels allowed patients to have regular one-to-one time with their named nurse. Staff felt that having an additional staff member on the ward could increase the amount of one-to-one time with patients. Staff also thought that extra support could be provided to the team during meal times as those times of day were particularly busy; however, they felt that the ward was safe at all times.

There were enough staff to carry out physical interventions. Due to Covid-19, face to face training was postponed. This meant there were less opportunities for staff to be Prevention and Management of Violence and Aggression (PMVA) trained. The ward manager made sure that there were enough PMVA trained staff on each shift. Face-to-face training resumed in September and all new staff members were trained in PMVA that month. Staff we spoke to said that restraint was rarely used on the ward and restraint would only be used as a last resort.

Quality of records

The care plans were holistic, comprehensive and included patient views in detail. We conducted a review of care and treatment records off the ward as part of our inspection, we reviewed 10 patient records. This part of the inspection was done off the ward to reduce the risk of cross infection. Staff on the unit used a combination of paper and electronic records which meant it was difficult to view all relevant patient information simultaneously. We were unable to

locate capacity assessments, consent to treatment and consent for the use of closed-circuit television cameras (CCTV) on the electronic system. We reviewed these documents at a later date as they were held as paper copies on the ward. Senior leaders at the hospital said that following our inspection they would ensure that key documents are scanned onto the electronic system. Staff did not report any issues with having a paper and electronic system.

Assessment of patient risk

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff gave examples of how they would de-escalate patients that were engaging in self-harm. For example, staff would verbally de-escalate patients that were headbanging while also using a pillow to reduce the risk of patients causing harm to themselves.

Staff did a risk assessment of every patient on admission and updated it when there were changes in the patient's behaviour or after incidents. We reviewed one patient record where the severity of self-harm was not evident in the care and treatment records in comparison to what staff on the ward had told us.

Staff had a good understanding of the potential risks associated with each patient and written records were up-to-date. Risk assessments highlighted specific risks for each patient such as the risks of suicide, self-harm and self-neglect.

Management of patient risk

Staff created management plans for all identified risks. For example, where a patient was at risk of self-harm, the patient was observed more regularly.

Staff discussed any changes in risk level each day at a handover meeting. Staff used a RAG (Red-Amber-Green) rating system for risk. Patients that were in the red zone were observed four times an hour, two times an hour for amber and once an hour for green. At the time of our inspection, there were four patients in red zone, three in amber zone, two in green zone and one patient on home leave. Staff said there were enough staff on the ward to complete the required level of observations. With permission from patients, staff were also using a monitored system of closed-circuit television cameras (CCTV) in some bedrooms to monitor patients at high risk of self-harm. The consent documentation for the use of CCTV was reviewed as part of the inspection and was complete and up to date.

'Flash meetings' took place daily where staffing and patient risks were reviewed for all patients in the hospital. Staff were redeployed as required to ensure patients were kept safe.

There was a recent intervention on the ward where it was not clear that the least restrictive option had been implemented. A patient had their hair cut under restraint. Staff said this was done to prevent the patient using their hair to self-harm. The patient involved did not feel that this intervention was the right approach to managing their risk and they did not feel that they had been suitably consulted. The patient did not consent to this intervention and they felt that the incident had a significant negative effect on their mental wellbeing. There was no documented evidence that the senior management team at the hospital were informed before this intervention took place. The service had implemented some alternative measures before the incident, including trying to arrange a planned haircut and using closed circuit television in the patient's bedroom. However, staff did not use enhanced observations and the patient's relative was also not informed.

We spoke to the ward manager, ward consultant, nurses and health care assistants about this incident. Staff explained that the decision for this intervention was made to keep the patient safe, as they thought there was an immediate risk to the patient's life. Leaders on the ward said that they had learned lessons from the incident. Staff told us that they would ensure that the decision-making process would be clearly documented and they would consult a wide range of individuals before carrying out a similar intervention. As part of the review process, the provider informed the local safeguarding authority about this intervention. They have since closed the incident but suggested that the team apologise to the patient involved.

Senior leaders were concerned about this incident and the medical director was conducting a serious incident review at the time of our inspection. Senior leaders at the hospital did not think there was a systemic issue within the multi-disciplinary team (MDT) that was responsible for the incident. Senior leaders reported that communication between the MDT and senior management team (SMT) had

improved following this incident. Patients on the ward were concerned about this incident and how it had been managed by staff, but they did not raise any wider concerns about the culture of the staff on the ward.

At the time of writing this report, we were considering our regulatory response to this incident using our specific incident guidance.

The ward manager attended the fortnightly learning outcome group (LOG) meeting, chaired by the hospital managing director. Managers from across the hospital came together to discuss incidents and share learning from them. Following the incident on East Wing, the structure of the meeting was change so that higher risk patients for each ward were discussed at the start of the meeting. The director of nursing felt this allowed information to be shared more readily and ensured there was enough time to discuss each patient in detail. Learning from across the Priory Group was also shared at this meeting. The ward consultant attended a weekly meeting chaired by the medical director where all patients that were on close observations were reviewed.

Safeguarding

Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate. For example, where a staff member fell asleep while on one-to-one observations, staff reported this as a safeguarding incident and put plans in place to manage the patient's safety. Staff also apologised to the patient involved.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Are specialist eating disorder services caring?

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. Staff respected patients' privacy and dignity; however, a patient on the ward felt that they were not treated with dignity and respect following during a recent incident when they had their hair cut. Staff supported patients to understand and manage their care, treatment or condition. Nurses met patients individually and patients were invited to attend ward rounds with their consultant. However, one patient said there was one occasion when they were not invited to their ward round and felt like they had been forgotten.

Overall, patients were positive about the staff on the ward. Patients enjoyed the therapies that were available on the ward and felt that permanent staff on the ward were kind and approachable. One patient said that there was always a member of staff to talk to. However, four of the six patients we spoke to felt they should have been more supported after a recent incident on the ward. Following our on-site inspection, staff met the patient group to discuss the incident in more detail. Patients also felt that it would be better to have more permanent staff on the ward as it was difficult to build rapport with temporary staff.

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

Involvement of families and carers

We spoke to three relatives as part of our inspection. Overall, they were happy with the quality of care that their loved ones were receiving and felt suitably informed. One carer said that they commended all staff that worked on the ward and that they had a strong working relationship with their loved one. Family and carers were invited to ward rounds with the patients' permission, Staff members would help support patients to go on home leave. However, one relative felt they were not adequately informed before their daughter's hair was cut.

Patients were unable to have visitors to the hospital for several months due to the Covid-19 pandemic. Patients expressed that this was particularly difficult. At the time of our inspection, patients could see visitors outside, and a visit inside would be facilitated in some circumstances. Patients said that staff had supported them to stay in contact with their relatives through video chat applications during the pandemic.

Good

Specialist eating disorder services

Are specialist eating disorder services responsive to people's needs?
(for example, to feedback?)

Discharges and transfers of care

Staff planned for patients' discharge, including liaison with care managers/co-ordinators. Staff felt that several patients on the ward were not discharged in a timely way and felt that patients had deteriorated while waiting for another placement. Staff held regular professionals meetings with care co-ordinators however staff said that care co-ordinator involvement was mixed. The South London Partnership are due to begin overseeing the adult eating disorder pathway in early 2021. Senior leaders were optimistic this would help improve the eating disorder pathway and would allow more efficient discharges.

Are specialist eating disorder services well-led?

Leadership

Leaders on the ward had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible on the ward and were approachable for patients and staff. They understood the issues, priorities and challenges the service faced and managed them. Staff on the ward were still reflecting on the recent incident, however, they felt that they were being supported by their team and senior leaders at the hospital.

The senior management team had good oversight of the services they managed. All staff told us that senior managers within the hospital were approachable. Due to the Covid-19 pandemic, senior leaders were unable to visit the ward regularly and they felt that this could have impacted their visibility. The senior management team had daily contact with the staff on East Wing through virtual meetings, for example, the 'flash meeting'.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear. Staff felt supported by their colleague during a serious incident review which was ongoing at the time of the inspection.

Staff we spoke with were positive about the organisation, their team and their work. During the inspection, staff we interviewed spoke highly of the team they work in and were genuinely proud of being part of the team. Staff told us that even though it could be challenging on the ward due to the patient acuity, they still enjoyed their job and enjoyed caring for the patients on the ward.

Staff knew how to use the whistleblowing process and told us that they felt confident to speak to their managers if they had any concerns.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients are protected from abuse and improper treatment. This includes using restraint in a proportionate manner that is not degrading for the individual patient.

Action the provider SHOULD take to improve

- The provider should continue efforts to recruit more permanent staff on East Wing.
- The provider should review the number of nurses on East Wing at night to ensure safety on the ward.
- The provider should continue to work with placing commissioners and care-coordinators to ensure patients are discharged in a timely manner.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (4)