The Priory Ticehurst House

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated The Priory Ticehurst House good because:

- The hospital had appropriate staffing levels to meet the care and treatment needs of patients and young people. Staff used good levels of observation to mitigate against risks identified on all the wards. Staff demonstrated a good understanding of how to identify abuse or if patients were at risk of harm.
- Staff involved patients and young people in the assessment and planning of their care. The physical healthcare needs of patients and young people were assessed and monitored regularly. Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicines. A full range of qualified health care professionals including psychologists, consultants, occupational therapists and nurses were available to deliver care and treatment on the wards.
- Throughout our inspection across all wards we observed examples of staff interacting positively with patients and young people in a way that was both respectful and caring. Patients and young people were involved in planning their care and attended weekly community meeting which provided a forum to feedback about the hospital.
- On four of the wards patients and young people could meet their visitors in a quiet space and there were rooms off the ward to meet with families and carers. Patients and young people knew how to make a complaint.
- Ward managers had the necessary skills, experience and knowledge to perform their roles competently. Staff spoke highly of the support provided by their ward managers. Ward managers had dashboards to support them in their management role. They could access staff training, supervision and appraisal information.
- There was learning from incidents on the wards across the hospital.

However:

- The physical environment on Lowlands was not suitable for the needs of the patients accommodated there. The unit was small and cramped which made wheelchair accessibility very difficult. There was no clinic room so patients medicines and the ward's emergency medical equipment were held in a small office.
- There was no meaningful rehabilitation or recovery program in place on Lowlands ward.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	• Staff consistently carried out observation activities to mitigate risks identified in ward ligature risk assessments. • Wards were single sex which meant the provider complied with same sex accommodation guidance. • All ward areas were clean and tidy. The clinic rooms were well equipped and all emergency medicines were in date and checked weekly by the pharmacist. • Staff carried out comprehensive assessments, care plans, and physical health examinations with all patients following their admission to the wards. • Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicine. • We observed staff interacting with patients in caring and supportive ways. • When staff spoke with us about patients, during the handover and multidisciplinary meetings we observed, they discussed them in a respectful manner and demonstrated a high level of understanding of their individual needs. • Both wards had a full range of equipment and rooms including clinic rooms, quiet lounges, communal dining rooms, a gym, and communal television rooms to support the treatment and care of patients. • Patients had access to their own mobile phones which were charged in the nurses' station on patient request. Private ward phones were also available for patients to make calls. • Both ward managers we spoke with had administrative support. • Staff spoke with enthusiasm and pride about the work they did. They told us of the good morale they experienced within their ward teams. • Staff told us they felt able to raise concerns without fear of victimisation. • We found the wards to be well-led and that there was clear leadership at a local level. However

Summary of findings

- Staff we spoke with were unaware of clinical audits being undertaken or key performance indicators being reviewed across the wards. This meant there was little evidence that they were aware of how performance and outcomes were monitored by management and how their wards were performing against these measures.

Long stay/ rehabilitation mental health wards for working-age adults

Good

- Measures were in place to mitigate ligature risks.
- The provider complied with the Department of Health guidance on mixed sex accommodation.
- Emergency drugs and equipment were checked regularly.
- The provider had procedures to guide staff on the control of infection.
- There was an established staff team with a low staff vacancy rate.
- Patients were registered with the local GP practice and accessed community based treatments.
- The provider was working with external agencies and providers to identify appropriate in patient placements for patients to be discharged to.
- Staff understood the MHA and the code of practice.
- Patients had access to an Independent Mental Health Advocacy service.
- Staff were polite, respectful and addressed patients in their preferred way.
- Patients were fully involved in the arrangements for their care and treatment.
- Patients knew how to make a complaint or raise a concern, and staff knew the action to take in the event of a complaint.
- Staff knew the values of the provider.
- All staff on Lowlands had their annual appraisal for the year 2017/2018 and received monthly supervision.

However

- There was no clinic room and a small staff office was used to store patient medication, records and medical equipment.
- There was no assessment to demonstrate how the provider had considered the risks of the unit being left without qualified staff for periods of time.

Summary of findings

- The living space was too small and cramped for the aids some patients required.

Child and adolescent mental health wards

Good 

- Staff completed a thorough risk assessment of each young person at the point of admission. Staff reviewed and updated risk assessments regularly throughout a young person's admission.
- There were always two qualified nurses on each shift and five health care assistants during the day and three for the night shift. Regular agency staff were used as much as possible to ensure consistency and familiarity with the wards and hospitals policies and procedures.
- Staff demonstrated a good understanding of identifying abuse or if the patients were at risk of harm. The hospital had good links with the local authority and worked in partnership with other agencies whenever appropriate.
- Care plans were thorough, personalised and holistic and met the needs that had been identified during the admission assessment. Staff completed an assessment of young people's physical health needs when they were admitted and at regular intervals thereafter.
- We reviewed 15 care records which showed good use and consideration of Gillick competence and staff had clearly recorded and documented any capacity decisions they had made.
- We saw numerous examples of staff interacting with the young people on the ward with kindness, respect and empathy. Staff treated the young people with compassion demonstrating a caring attitude and approach.
- Both wards held a weekly community meeting for young people to attend and give feedback on the service. We saw minutes of these meetings which showed that actions had been taken and followed up by the ward staff. Families and carers were involved in discharge planning to ensure there was suitable provision for the young person on leaving the hospital, or transferring to another service.

Summary of findings

- Young people each had their own room which they could personalise as they wished. There was secure storage on the ward for young people to be able to store their possessions.
- All the young people on both wards had access to and were encouraged to attend school daily. We spoke with a teacher from the school who told us of the timetable and programme of teaching activities.

However

- Some of the young people we spoke with on Garden Court stated they did not know what was in their care plan.

Summary of findings

Contents

Good

Location name here

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults; Child and adolescent mental health wards; Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Background to The Priory Ticehurst House

The Priory Ticehurst House is situated in East Sussex. It provides inpatient mental health services for adults and young people.

The child and adolescent mental health service at the hospital has two female wards; a tier 4 ward with 13 beds and a high dependency unit again with 13 beds for young people.

The hospital also has two acute psychiatric wards. One ward is a 16 bedded ward for female patients and the other a 7 bedded male ward.

At the time of our inspection, the provider had closed two of its long stay rehabilitation wards leaving only Lowlands, a four bedded unit. The provider was in the process of arranging for the discharge of these patients to other in-patient services. Lowlands has a planned closure date of 31 August 2018.

The Priory Ticehurst House is registered for the following regulated activities: Assessment and medical treatment for persons detained under the Mental Health Act 1983; Diagnostic and screening procedures; Treatment of disease, disorder or injury; Accommodation for persons who require nursing or personal care; Accommodation for persons who require treatment for substance misuse.

The long stay and rehabilitation service was inspected in June 2017. Following this focussed inspection, we told the provider it must take action to ensure identified risks were properly addressed and managed, and that ligature risks were appropriately assessed and mitigated against. The inspection also found that care plans failed to focus on rehabilitation and discharge planning and there was a lack of therapeutic activity.

We issued the provider with two requirement notices for long stay/ rehabilitation mental health wards for working age adults. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person centred care
- Regulation 12 Safe care and treatment

A requirement notice is issued by CQC when an inspection finds that the provider is not meeting essential standards of quality and safety. At this inspection, we found these requirement notices had now been met.

Following our inspection concerns were raised with us about incidents affecting the welfare, health and safety of young people accommodated on Upper Court ward. In response to these concerns we undertook a focussed, unannounced inspection on 22 June 2018.

Our inspection team

The team that inspected the service comprised of three CQC inspectors, one bank inspector, an assistant inspector and three specialist advisors; one with experience working in rehabilitation and recovery services, one with experience working in child and adolescent mental health services and one with experience of forensic and secure in patient services. The team also had an expert by experience.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all five inpatient wards at the hospital site, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 22 patients who were using the service
- spoke with the managers for each of the wards
- spoke with 29 other staff members including two consultants, two doctors, nurses, health care assistants, activities co-coordinator, social worker, family therapist and a pharmacist
- attended and observed two hand-over meetings, two multi disciplinary meetings, and one clinical governance meeting
- observed a patient cognitive behavioural therapy group for anxiety
- collected feedback from 12 patients using comment cards
- looked at 34 care records of patients
- looked at 22 medicine records of patients
- carried out a specific check of the medicine management on both wards.
- reviewed staffing rotas
- reviewed mandatory training records of staff
- looked at a range of complaints, incidents, safeguarding referrals, policies, procedures and other documents relating to the running of the service.

What people who use the service say

The patients we spoke with on five wards were positive about all staff. Comments on comment cards we received informed us that patients were happy with the support and care they received during their admissions. They told us that they felt safe, listened to, that staff were encouraging, friendly, and available if patients wanted to talk to them. Patients told us that the wards were very clean and that the range and quality of food available was good.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

- Staff completed a thorough risk assessment of each patient and young person at the point of admission. Staff reviewed and updated risk assessments regularly.
- Clinic rooms on four wards were fully equipped with appropriate resuscitation equipment which staff checked regularly. Emergency drugs were appropriately labelled and stored.
- Staffing numbers could be adjusted depending on the acuity of patients and young people on the ward. Regular agency staff were used as much as possible to ensure consistency and familiarity with the wards and hospitals policies and procedures.
- Staff were 100% compliant with basic life support and prevention and management of violence and aggression training.
- Staff demonstrated a good understanding of identifying abuse or if the patients were at risk of harm. The hospital had good links with the local authority and worked in partnership with other agencies whenever appropriate.
- Staff consistently carried out observation activities to mitigate risks identified in ward ligature risk assessments.
- All wards were single sex which meant the provider complied with same sex accommodation guidance.
- There were enough staff to ensure that patients had one to one time. Staff and patients told us that activities were rarely cancelled due to staff shortages.
- The hospital had a number of rooms off the wards where patients could meet visitors including children if this was risk assessed as appropriate.
- The Director of Clinical Services chaired a monthly 'Learning From Experience' meeting where all incidents are reviewed to identify lessons learned and actions taken.

However:

- All permanent and bank staff were required to complete mandatory training in 11 subjects. The hospital's required compliance level was 100%, however only four out of 11 subjects had this training completion level. Overall mandatory training subject levels fell below the hospital's target rate of 100%. For example, Mental Capacity Act training compliance across five wards ranged from 57% to 75% and training on

Summary of this inspection

safeguarding children across the hospital ranged from 49% to 87%. The provider had an action plan in place and post inspection staff training compliance had improved. For example safeguarding children training had improved to 95.5% and Mental Capacity training had improved to 89.7%.
- There was no clinic room on Lowlands ward and a small cramped staff office was used to store patient medication, records and medical equipment.
- On Lowlands there was no assessment to demonstrate how the provider had assessed the risks of the unit being left without qualified staff for periods of time. Staff were unable to provide any written protocols around these arrangements.

Are services effective?

Good

- Care plans were thorough, personalised and holistic and met the needs that had been identified during the admission assessment. Staff completed an assessment of patients and young people's physical health needs when they were admitted and at regular intervals thereafter.
- We reviewed 15 care records on both young peoples wards' which showed good use and consideration of Gillick competence and staff had clearly recorded and documented any capacity decisions they had made.
- Managers provided staff with supervision and staff reported that supervision was relevant and useful. All staff received an annual appraisal and appraisal rates for the service were 100%.
- Staff carried out comprehensive assessments, care plans, and physical health examinations with all patients following their admission to the wards.
- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicine. For example, we saw evidence of appropriate monitoring and recording of patients' physical health following administration of rapid tranquilisation medicine in line with NICE guidance.
- Patients received a range of psychological therapies recommended by NICE including mindfulness in individual and group settings.
- All patients had access to physical health care while admitted to the wards including access to diabetes and cardiac care.
- A full range of experienced and qualified health professionals including a psychologist, consultants, a doctor, an occupational therapist, an activity co-ordinator, nurses, and health care assistants were available to deliver care on the wards.
- An external pharmacist visited each ward once weekly.

Summary of this inspection

- Mental Health Act documentation we reviewed was filled in correctly, up to date and stored appropriately.
- Patients had access to an Independent Mental Health Advocate.
- On Lowlands the provider was working with external agencies and providers to identify appropriate placements for patients to be discharged to.

Are services caring?

Good

- We saw numerous examples of staff interacting with patients and young people on all the wards with kindness, respect and empathy. Staff treated the patients and young people with compassion demonstrating a caring attitude and approach.
- We reviewed 34 care records across the wards and all showed evidence of patient involvement.
- When staff spoke with us about patients and during the handover multidisciplinary meetings we observed, they discussed them in a respectful manner and demonstrated a high level of understanding of their individual needs.
- We spoke with 22 patients during the inspection and received patient feedback on 12 comment cards. Patients told us that staff were kind, knocked before entering their rooms, and listened to them when they wanted to talk. All patients we spoke with told us they had a range of groups and activities they could attend for support and to discuss their needs.
- Patients were involved in the planning of their care and attended weekly community meetings to discuss their ward environment, care plan approach meetings, and ward round meetings to discuss their care and discharge plans.

However:

- Some of the young people we spoke with on Garden Court stated they did not know what was in their care plan.

Are services responsive?

Good

- Staff had good links with community teams throughout the region and care co-ordinators in these teams. Discharge planning was well co-ordinated and thought through to ensure a smooth transition home or to a more suitable service.
- Patients and young people had their own room which they could personalise as they wished.
- The patients and young people had access to outside space and could use the ward gardens with staff supervision. On four wards patients and young people could meet their visitors in a quiet space and there were rooms off the ward to meet with families and carers if appropriate.

Summary of this inspection

- When patients required psychiatric intensive care (PICU), the wards referred them to another Priory hospital with appropriate provision or to an available NHS PICU unit.
- Patients had access to their own mobile phones which were charged in the nurses' station on patient request. Private ward phones were also available for patients to make calls.
- Patients told us the food quality was good and that they were happy with the variety, quality and portion size.
- Each ward had activity schedules seven days per week which were developed by the occupational therapist and supported by occupational therapy assistants.
- Patients knew how to make a complaint or raise a concern, and staff knew the action to take in the event of a complaint.

However:

- Lowlands ward lacked sufficient space to enable patients' wheelchairs to move freely.

Are services well-led?

Good

- Clinical audits undertaken by staff were used by management as performance indicators for the unit.
- Ward managers had the necessary skills, experience and knowledge to perform their roles competently. Both ward managers were visible on the wards and available to staff and young people. Staff we spoke with spoke highly of the support given by the ward managers. Staff we spoke with stated they were proud to work for the organisation and on the wards they did.
- Staff had regular appraisals and reported these as being meaningful and productive. Staff reported appraisals were an opportunity to discuss development and further career options. Appraisal rates across all wards were 100%.
- Staff were aware of the process for responding to and learning from complaints. The team discussed these openly when appropriate to ensure any learning was shared across both wards.
- Ward managers had dashboards to support them in their management role. Managers could access staff training records, supervision and appraisal records to ensure these were up to date.
- The young people's service was accredited with the Quality Network for Inpatient CAMHS.
- Staff we spoke with explained that they worked with patients to support the organisation's values of putting patients and safety at the centre of their work and took pride in all they did.
- There was clear learning from incidents on the wards.

Summary of this inspection

- The wards received good governance from the hospital's senior management team.
- Ward managers we spoke with had administrative support.
- Staff spoke with enthusiasm and pride about the work they did. They told us of the good morale they experienced within their ward teams.
- Staff told us they felt able to raise concerns without fear of victimisation.
- We found the wards to be well-led and that there was clear leadership at a local level.

However:

- Not all staff felt connected to the wider organisation and felt that although they received good support from their line manager, they received little above this.

  Some staff we spoke with, on the acute wards, were unaware of clinical audits being undertaken or key performance indicators being reviewed across the wards. This meant there was little evidence that they were aware of how performance and outcomes were.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

- Across the five wards staff training in the Mental Health Act training ranged from 60% to 75%
- Staff understood the MHA and the code of practice. Staff explained patients' rights on admission and, where necessary, repeated them every three months.
- Section 17 leave arrangements were reviewed monthly and stored in patient records for staff reference. Section 17 leave for detained patients was authorised using a standardised system.
- Conditions were clearly detailed and there was evidence that patients were offered copies of the form. Out of date leave authorisation forms were crossed through.
- Patients did have access to an Independent Mental Health Advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had a good understanding of the Mental Capacity Act (MCA) and what capacity meant.
- Consent to treatment and capacity assessments were completed. Patients told us their doctor talked to them about their medication and explained the benefits and side effects of their medication before they consented to treatment.
- One patient had been referred to the local authority for an assessment for standard Deprivation of Liberty safeguard (DOLs) on 20 June 2017. However, this had not been completed but there was evidence the provider had followed up on this overdue assessment.
- Staff encouraged patients to make their own decisions as far as possible.
- On the young people's ward records showed good use and consideration of Gillick competence and staff had clearly recorded and documented any capacity decisions they had made.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good

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

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

Good

Safe and clean environment

- Newington Court 1 and Newington Court 2 were part of the Priory Ticehurst Hospital. The building is listed so there were restrictions on how much of it could be adapted. As a result, the layout of both wards had several blind spots. This meant staff could not always observe all patients in a clear line of sight. Risks were mitigated on both wards by staff patrols and observation levels which were adjusted depending on patient and ward risk. We observed staff checking the ward environments throughout our inspection in accordance with the wards' hourly duty rotas. Staff on Newington 2 also viewed closed circuit television monitors in the nurses' station to observe the ward environment to manage risk.
- Each shift had a nominated security staff member. Security staff conducted daily environmental risk assessments to ensure that there were no areas or items of risk available to patients, that had not been mitigated, to maintain safety on the wards.
- We identified ligature risk points on both wards. Both wards had ward ligature risk assessments which were reviewed every six months by nursing staff and the ward managers. Both assessments were in date and all staff we spoke with were aware of the location of ligature points and how they mitigated the risks during their shifts. Ligature cutters were available in each of the nurses' stations and staff we spoke with knew where they were.
- Both wards were single sex which meant the provider complied with same sex accommodation guidance.
- The clinic rooms on both wards were well equipped and all emergency medicines were in date and checked weekly by the pharmacist. On Newington 2, emergency resuscitation equipment and oxygen was located in the nurse's station. Emergency medicines on both wards were in date and checked regularly. There were procedures in place to regularly check all clinical equipment and we saw evidence that these checks were routinely carried out
- All ward areas were clean and tidy. All patients we spoke with told us that their wards were clean.
- Each member of ward staff had a personal alarm and intercom radio to call for assistance if needed.
- There were no seclusion facilities in the hospital.

Safe staffing

- Both wards operated on a ratio of one staff member to three patients on day and night shifts. One extra member of staff was allocated on ward 1 when bedrooms on the first floor were occupied to manage patient and ward safety. The ward managers booked extra staff when required to cover absence and any additional patient observation levels. Bank and agency staff who were familiar with the wards were booked whenever possible. We looked at the ward staffing rotas and all shifts were fully staffed.

- The services' locum (long-term bank) nurses we spoke with, who had been with the hospital for a number of years, displayed their locum status on their name badges to identify their position to staff, patients, and visitors.
- There were enough staff to ensure that patients had one to one time. Staff and patients told us that activities were rarely cancelled due to staff shortages.
- Care notes showed that staff were carrying out regular physical health interventions such as blood pressure monitoring and electrocardiogram testing. There was adequate medical cover across both wards. Each ward had a consultant and the locum staff grade doctor from ward 1 was covering both wards as ward 2's locum staff grade doctor had recently left. Recruitment was underway to fill that role.
- All permanent and bank staff were required to undertake mandatory training in 11 subjects including Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards, basic and intermediate life support, adult and children safeguarding. The hospital's required compliance level was 100%, however only four out of 11 subjects had this training completion level. Examples of mandatory training subject levels which fell below 100% were Mental Capacity Act (57%), intermediate life support, (78%), safeguarding children (87%). However the provider had a robust action plan in place and post inspection was closer to its 100% compliance rate. For example 95.5% of designated staff had completed their safeguarding children training and a further 89.7% of staff had completed their Mental Capacity Act training.

Assessing and managing risk to patients and staff

- In the six months prior to March 2018, Newington 1 and Newington 2 collectively recorded 22 episodes of restraint. None of these incidents of restraint were in the prone position or involved rapid tranquilisation. Prone position restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position.
- We reviewed 15 care records which included patient risk assessments. All risk assessments were thorough, current and included any new risks identified following recent incidents on the wards. Staff used a risk assessment template which was stored on their electronic recording system, Care Notes.
- For informal patients information about how to ask for leave was displayed on doors onto the wards. When informal patients wanted to leave the wards staff discussed activities the patients wanted to undertake, they noted what the patient was wearing for ease of identification in the event the patient did not return. Staff made a note of patient leave on the notice board in the nurses' station detailing when the patient left and was due to return to the ward for safety monitoring purposes.
- There were good policies and procedures for use of observation on the wards to minimise risk on the wards. Observation levels were discussed at ward handover and staff were assigned to observation duties listed in the ward duty rota.
- All staff including bank and agency completed competency testing on the service's observation and engagement policy to ensure they were skilled in the use of observation to manage safety on the wards.
- Staff we spoke with were clear about search procedures on the wards. Those we spoke with told us they would search patients if they were concerned the patient was concealing a restricted item. Both wards had metal detector wands for use if appropriate.
- All staff we spoke with told us that they used restraint only when de-escalation had failed, for example speaking with patients and engaging them in activities to distract them. Staff across both wards were trained in de-escalation and conflict management. A senior healthcare worker on Newington 2 was the prevention and management of violence and aggression training lead. They were responsible for ensuring de-escalation techniques were used where necessary and reviewed incident reports to monitor this activity across the hospital.
- The service used the safe wards model which meant that staff were skilled in how to manage conflict on the wards using interventions to calm patients. Newington 1 had a calm box filled with calming items, for example squeezy stress balls, for staff to offer to patients if patients became distressed.
- Staff on both wards attended positive behavioural support training led by the wards' psychologist. This training skilled staff to work with patients to identify unmet needs which led to challenging behaviour and teach patients new skills to manage their behaviour rather than containing it.

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

Good

- On Newington 1 the ward manager told us that rapid tranquilisation was used 12 times with four different patients in the three weeks prior to our inspection, however the ward manager of Newington 2 told us it was rarely used there and the last episode was in March 2018. The wards followed National Institute for Health and Care Excellence guidance by monitoring patient's physical health observations at required intervals following the intervention which was recorded clearly in the records we reviewed. The visiting pharmacist audited the wards' rapid tranquilisation monitoring forms as part of a monthly audit. The ward managers reported these monthly audits at monthly senior management team meetings and monitored actions via the wards' weekly multi-disciplinary team meetings.
- All staff were required to complete mandatory safeguarding children and adults training. Staff we spoke with were confident and knowledgeable about how to make a safeguarding alert when appropriate. We reviewed four safeguarding referrals on the wards to review their alert process. The wards had good links with the local safeguarding team. Safeguarding concerns were updated and noted in the care plans and risk assessments we reviewed. The wards had a safeguarding lead to ensure their colleagues understood their responsibilities in relation to safeguarding practices
- The ward manager on Newington1 developed a flow chart for staff to use so they could progress safeguarding referrals with the duty social care team if required.
- Medicines management was practiced well on both wards. We reviewed 18 medicine records which were all accurate and without errors. Medicines were stored securely, appropriately dispensed and medicines reconciliations were all in order. The clinic room fridge was maintained and we reviewed daily fridge temperature recordings where staff ensured the appropriate temperature was maintained.
- A local hospital pharmacy service was contracted to provide pharmacy support to the hospital. This service dispensed named-patient medication, provided stock medication, medical information, and clinical pharmacy input. We met the specialist clinical pharmacist who visited the wards on a weekly basis and reviewed the prescription charts and carried out a schedule of medicine management audits. The pharmacist was available to meet with clinical staff and also with patients when necessary.
- Children were not permitted onto the wards, however the hospital had a number of rooms off the wards where patients could meet visitors including children if this was risk assessed and approved in line with any relevant safeguarding practices.
- The wards reported four incidents of patient on staff assault in the 12 months prior to our inspection. The ward manager reported these incidents in accordance with the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- **Track record on safety**
- Both wards reported 10 serious incidents in the 12 months prior to March 2018. Three of these incidents involved the death of patient post discharge from the hospital (two of which occurred within seven days post discharge). In response to this, and a Coroner's Regulation 28 report to prevent future deaths, the wards developed and began a discharge checklist pilot in April. Staff used a checklist guide to ensure that relevant community parties were contacted in person and informed of the patient's discharge to ensure a seamless, supported, and safe move on to their next placement. We found evidence of good discharge co-ordination in two discharged patients' files we reviewed. The ward managers monitored the pilot regularly to ensure staff were adhering to the new discharge policy.
- **Reporting incidents and learning from when things go wrong**
- All staff we spoke with knew how to recognise incidents and how to report them using the hospital's electronic incident reporting system. The quality leads on each ward reviewed each incident report and either requested amendments or approved it for submission. The clinical services manager reviewed all submitted incidents reports and produced a weekly report which was sent to all ward managers. The incident reports were also reviewed at the monthly senior management team meeting. Ward and senior management discussed any incidents which occurred during night shifts in the following daily morning 'flash meetings' across the hospital at the beginning of each weekday. A monthly hospital incident bulletin was circulated to all wards detailing incidents, outcomes, and lessons learnt.
- The Director of Clinical Services chaired a monthly 'Learning From Experience' meeting where all incidents

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

Good

were reviewed to identify lessons learned and actions taken. The recorded lessons learned were circulated to all staff on a Learning From Experience bulletin which was displayed in the nurse's station on Newington 2.

- We reviewed four incident reports. They included details regarding the people involved, the incident, next steps taken, outcomes, patient debrief, and lessons learnt.
- Staff we spoke with told us that ward managers debriefed staff and patients separately following incidents on the wards to review the event and check the wellbeing of staff and patients. Further de-briefs were offered individually and in group settings as required. The ward managers told us the wards worked in a transparent way to ensure that incidents led to learning and improved practice wherever possible.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 15 care records and each contained a comprehensive assessment which was completed following each patient's admission.
- All care records showed that physical examination was undertaken on admission and that ongoing monitoring of physical health problems was being undertaken by staff. During our inspection we observed a doctor conducting an electrocardiogram in the clinic room with a patient to monitor their cardiac health. We reviewed one care record for a patient with significant physical health issues who had a comprehensive physical healthcare plan in place to ensure their needs were monitored and met.
- Each patient had an up to date, personalised, holistic, and recovery focused care plan.
- Patient care records were stored on an electronic records system. Staff accessed the system using an identification card and personal password which ensured information was stored securely. Bank and agency staff we spoke with told us they were able to access electronic patient information if they had access approval pertinent to their job. For example a new agency health care assistant did not have individual access but was supported by bank and permanent staff to access relevant patient information to support ward safety.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medicine. For example, we saw evidence of appropriate monitoring and recording of patients' physical health following administration of rapid tranquilisation medicine in line with NICE guidance. The ward manager on ward 1 told us that the ward used The Glasgow Antipsychotic Side-effect Scale (GASS). This was an easy to use self-reporting questionnaire aimed at identifying the side effects of antipsychotic medication in patients. It consisted of 22 questions with points assigned based on answers given by the patient.
- Patients received a range of psychological therapies recommended by NICE, including mindfulness, in individual and group settings. Both ward managers told us that some patients did not stay on the wards for long as they were often recalled to NHS inpatient beds soon after admission. This meant that not all patients were able to engage in psychological support for a planned period. The psychologist across the wards offered individual psychological support to patients to address immediate needs while they were on the wards.
- All patients had access to physical health care while admitted to the wards including access to diabetes and cardiac care.
- Staff assessed and monitored patients' nutrition and hydration needs. A dietician worked with the hospital chef to ensure nutritional meals were prepared for all patients.
- The ward managers told us that staff used the Health of the Nation Outcome Screen rating scale with patients on admission and discharge. This rating scale was used to measure the health and social functioning of people with severe mental illness.
- The visiting pharmacist carried out a weekly medicines audit and issued a report electronically to indicate if any actions were required by the wards to deliver improvement. The pharmacist attended the quarterly clinical governance meetings to present their audit findings.

Skilled staff to deliver care

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

Good

- A full range of experienced and qualified health professionals including a psychologist, consultants, a doctor, an occupational therapist, an activities co-ordinator, nurses, and health care assistants worked on the wards to deliver care and treatment. An external pharmacist visited each ward once weekly.
- Staff including bank and agency told us received appropriate induction before working on the wards.
- Ward managers and staff told us that staff received 10 supervision sessions per year, were appraised annually, and attended monthly team meetings. All staff we spoke with and paperwork we reviewed corroborated this. We reviewed a selection of 11 supervision records which were in date. Bank and agency staff also received supervision to support and monitor their practice and development. Staff on ward 1 attended monthly reflective practice led by the psychologist.
- Staff had access to a wide range of on-line training and one member of staff was supported to apply for a neuro psychology course. Ward managers told us they reviewed training needs in supervision and appraisal sessions. Some health care assistants we spoke with had been invited by ward managers to train as nurses to further develop their nursing careers.
- Ward managers were supported by the central human resources team to address poor staff performance using personal improvement plans to identify issues, plan required improvements, and review the outcomes.

Multi-disciplinary and inter-agency team work

- The wards held daily weekday nursing and ward manager handovers to review patient progress, risks, new referrals, and patients due for discharge. We observed two handover meetings and observed positive interactions between all staff disciplines. Both wards also held daily weekday multi-disciplinary team meetings which reviewed patients' care and treatment. The ward consultants led twice weekly ward round meetings to review care and treatment with a small number of individual patients. A hospital 'flash meeting' was held each weekday morning with senior management and ward managers to review incidents from the previous evening.
- There were effective working relationships with care co-ordinators, community mental health teams, social services and the crisis team. We saw evidence of collaborative working between the wards and these teams in the care notes and discharge preparation notes in the records we reviewed. Care co-ordinators were not always able to attend ward round meetings due to being based long distances away so they dialled into meetings to take part.

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

- Of the 20 patients who were admitted to both wards, we reviewed the Mental Health Act (MHA) documentation of the seven detained patients. The documentation was filled in correctly, was up to date, and stored appropriately.
- The MHA administrator oversaw the operation of the MHA at the hospital. This role included scrutiny of MHA paperwork and reviewing reminder systems for renewals and consent to treatment paperwork. The administrator also managed applications and renewals of Deprivation of Liberty Safeguards (DoLS). They also carried out monthly MHA paperwork audits to monitor that The Act being applied correctly.
- Records pertaining to detained patients' leave contained clear information about patient risk which was shared with parties such as the patient, staff and their carers when appropriate.
- The completion rate of mandatory MHA training across both wards was 70% which was below the 100% compliance target required by the hospital. All staff we spoke with had a good understanding of the The Act, it's Code of Practice and guiding principles.
- Consent to treatment and capacity requirements were adhered to and copies of consent to treatment forms were attached, where applicable, to the medicine records we reviewed.
- Leave for detained patients was authorised on a standardised form which was clearly completed with details of conditions and escort levels required. We saw evidence that risk assessments had been reviewed before authorisation, and that copies were offered to patients.
- The wards had systems in place to ensure that nominated staff explained patients' Section 132 rights to them on admission to the wards and regularly thereafter. Staff were aware of the need to explain patients' rights to them under the MHA. We saw evidence of this practice in the patient records we reviewed.

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

Good

- Patients had access to an independent mental health advocate (IMHA). Independent advocacy services were readily contactable and available to support patients when needed. Details of the local IMHA were displayed on the wards' notice boards. A general advocacy service also visits once a week.
- A yearly MHA audit was reported to central Priory Healthcare management. In addition, the hospital managers reviewed quarterly reports and the administrator attended monthly clinical governance meetings to raise any issues of concern.
- **Good practice in applying the Mental Capacity Act**

  The wards had a 57% completion rate for mandatory Mental Capacity Act (MCA) training which was below the 100% compliance target required by the hospital. Staff we spoke with had a good knowledge of the principles around capacity. The provider had an action plan in place to address low training compliance and post inspection Mental Capacity Act training has a completion rate of 89.7% across the hospital.
- Ward 1 made one Deprivation of Liberty Safeguards application in the six months prior to our inspection. The application paperwork was up to date and correct.
- The records we reviewed showed that patients' capacity was assessed by staff on admission, formally and in ward rounds. We did not review any records where patients were assessed as having impaired capacity.
- Staff we spoke with understood and worked within the MCA definition of restraint using least restriction and force wherever possible.
- Staff got advice regarding the MCA, including Deprivation of Liberty Safeguards, from the central Priory office and from the hospital Mental Health Act administrator.

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

Good

Kindness, dignity, respect and support

- When staff spoke with us about patients and in the handover multidisciplinary meetings we observed, they discussed them in a respectful manner and demonstrated a high level of understanding of their individual needs. Staff appeared interested and engaged in providing high quality care to patients. We observed staff interacting with patients in a positive, caring and compassionate way and they responded promptly to requests for assistance whilst promoting patients' dignity.
- We spoke with ten patients during the inspection and received patient feedback on seven comments cards. Patients told us that staff were kind, knocked before entering their rooms, and listened to them when they wanted to talk. All patients we spoke with told us they had a range of groups and activities they could attend for support and to discuss their needs.
- Staff we spoke with told us that it could be difficult becoming familiar with the individual needs of patients as they often had short admissions. However it was apparent from our observations that staff worked with patients to understand and meet their needs wherever and whenever possible throughout their admission.

The involvement of people in the care they receive

- A member of staff was allocated to new patients to verbally orientate them onto their ward following admission. All patients received a ward specific welcome pack which contained information about their entitlement to leave from the ward, storing their valuables, banned items such as alcohol, and what they could expect in terms of care during their admission to the ward.
- Patients we spoke with told us that they were involved in planning their care. This was evident in the 15 care records we reviewed where patients' views were recorded.
- Patients were involved in the planning of their care and attended weekly community meetings to discuss their ward environment, care plan approach meetings, and ward round meetings to discuss their care and discharge plans.
- Staff encouraged patients to attend daily ward planning meetings to discuss their daily activity schedules and weekly community meetings to discuss their views on the wards and air any complaints which were appropriate to raise in that forum. The wards displayed

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

Good

small 'you said, we did' notices to show how they responded to feedback raised in the weekly community meetings and listed concerns such as ward maintenance and therapies.
- All patients had access to advocacy in the form of the independent mental capacity advocate, the independent mental health advocate, and the patient forums. Details of these were displayed on the wards' notice boards.
- The consultant on ward 1 held family sessions each Thursday when family members were welcome to attend one to one time or to contact by telephone to review their family member's care. All of this was done with the patients' permission.
- Staff discussed ward round meetings with patients the day before they were due to attend. This arose from an incident where a patient fed back that they forgot to raise some points they had intended to. The preparation before the ward round ensured that patients were supported to list issues they wanted to bring to the consultant the next day.
- Staff involved family members and carers in patients' care if patients permitted this. Discussions about one patient's discharge co-ordination on one ward, which we observed, included information provided by a family member which assisted staff in planning for appropriate move on from the ward.
- Patients gave feedback on the care they received via patient surveys, in community meetings and through the hospital's complaint procedure. We reviewed four complaints from patients which were dealt with within a 28 day period in line with the hospitals' complaints policy.

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

Good

Access discharge

- For the six month period to March 2018, the average bed occupancy for Newington 1 was 72% and 79% for Newington 2. The hospital did not provide any information about numbers of delayed discharges, however explained that all delayed discharges were due to challenges in finding appropriate move on placements for patients. Ward managers told us that the hospital worked closely with NHS commissioners to identify appropriate placements. Information provided by the hospital showed that the average length of stay for patients in the year to March 2018 was 17 days on Newington 1 and 11 days on Newington 2.
- Patients were sometimes admitted from local areas and the wider country when beds were unavailable in patients' local NHS trusts. Patients were generally recalled to appropriate NHS inpatient beds as soon as they became available. The wards were able to respond to the needs of patients who sometimes required admission during the night or weekend with the use of an out of hours doctor who lived on site.
- Patients had access to a bed when they returned from overnight leave from the wards.
- Patients were discharged at a time of day which suited them and their move on situation.
- The hospital had a clear admission checklist. Ward managers we spoke with told us they were able to refuse an admission if the ward case mix warranted it to avoid unsettling the ward environment.
- If patients required psychiatric intensive care (PICU) the wards referred them to another Priory hospital or to an available NHS PICU bed.
- The wards were taking part in a patient discharge to the community pilot following the death of a number of patients after they were discharged from the wards. A discharge planning checklist was used by all staff to ensure they had co-ordinated with the appropriate stakeholders in the community to ensure a seamless discharge for patients which included agreed care plans to follow them from the ward. We saw evidence of good discharge planning in accordance with this pilot in the 15 care records we reviewed. Of the 15 care plans we reviewed, three were for patients who had already been discharged. The discharge process supporting the patients' move on into the community was detailed and complete. Staff had recorded that relevant patient documentation concerning their Mental Health Act status, medicine, and risk assessments had been handed over to the receiving wards.
- **The facilities promote recovery, comfort, dignity and confidentiality**

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

Good

- Both wards had a full range of equipment and rooms including clinic rooms, quiet lounges, communal dining rooms, a gym, and communal television rooms to support the treatment and care of patients.
- Each ward had a quiet room and private meeting room where patients could meet visitors on and off the wards.
- Patients had access to their own mobile phones which were charged in the nurses' station on patient request. Ward phones were also available for patients to make calls in private.
- All patients had supervised access to the outside garden areas. There was also an outside smoking area available for patients wishing to smoke.
- Patients told us the food quality was good and that they were happy with the variety, quality and portion size. Food was prepared in the main kitchen on the ground floor of the hospital and brought to the ward on heated trolleys.
- We observed that hot and cold drinks, and snacks including fresh fruit were available to patients 24 hours a day.
- Patients were allowed to personalise their bedrooms, however this was rarely done as patients were often admitted for short periods of time before being recalled to an NHS inpatient bed.
- All patients had access to their bedrooms throughout the day and had a safe in their room to store their valuables if they so wished.
- Each ward had activity schedules seven days per week which were developed by the occupational therapist and supported by two occupational therapy assistants. The activity schedule was displayed on the wards' notice boards. Activities included music, art, board games, relaxation, fitness, and computer games. Ward 1 had an activity co-ordinator every other weekend to ensure that weekend activities were supported. A health care worker, formerly an occupational therapy assistant, supported activities on alternate weekends. Ward cooking sessions and outside walks were being facilitated during our inspection.
- **Meeting the needs of all people who use the service**

- Both wards were accessible by wheelchair users and ward 1 had one adapted bedroom. However the ward could not accept a patient with significant physical support needs as the ward was not designed to meet their needs, for example there was no hoist to safely move a patient.
- Information was made available in a range of languages if patients required this. We observed arrangements being made for a translator to attend to support the communication needs of patient where English was not their first language.
- Information was displayed in ward notice boards and in patient welcome packs regarding their rights, mental health issues, advocacy contact details, available treatments and how to complain.
- A range of food was available to meet the dietary needs of all patients which were developed in collaboration between the kitchen staff and a visiting dietician. One ward manager told us that following a patient request for halal food, they now ensure that all meat on offer is halal. The patient was supported to liaise with the catering staff to ensure the food met their requirements.
- Patients had access to spiritual support and ward managers told us that some patients were supported to attend church at weekends.
- **Listening to and learning from concerns and complaints**

- In the 12 months prior to March 2018 Newington 1 received eight complaints. Two were not upheld, three were partially upheld, and two were upheld, and one was referred to the Ombudsman. Newington 2 received three complaints of which one was not upheld, and two were partially upheld. Complaints received across these two wards were about communication, missing property and staff attitude.
- Patients we spoke with told us they knew how to complain. The complaints procedure was displayed in the ward area notice board. Staff we spoke with was able to explain the complaints procedure for the wards.
- Staff we spoke with told us they received feedback on the outcomes of investigations of complaints in monthly team meetings and in emails from the ward manager if appropriate. The ward manager on Newington 2 told us that a patient had complained there was a lack of awareness of transgender needs. The hospital responded to this by agreeing to develop information resources to increase staff awareness for this patient group. The resources were still undergoing development at the time of our inspection.
- The director of clinical services led on patient experience and the hospital compliance manager led on complaints. This work was supported by a group

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

Good

complaints manager. The monthly learning from experience group reviewed complaints and reviews which fed into lessons learnt which in turn captured quarterly complaint trends.

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

Good

Vision and values

- Staff we spoke with explained that they worked with patients to support the organisation's values of putting patients and safety at the centre of their work and took pride in all they did.
- Ward managers and their teams knew who the most senior managers were in the organisation and that they visited the wards to observe the environment and meet patients and staff.

Good governance

- The wards received good governance from the hospital's senior management team. The hospital held regular governance meetings and reported on how they met training and recruitment requirements.
- Staff we spoke with were unaware of clinical audits being undertaken or key performance indicators being reviewed across the wards. This meant there was little evidence that they were aware of how performance and outcomes were monitored.
- Both ward managers we spoke with had administrative support.
- All staff had the ability to submit items to the hospital risk register. While the risk register
- listed risk themes which applied to the hospital instead of individual wards, ward managers were able to point out which risk areas such as ward ligature risks, lack of closed circuit television coverage in areas which relied on staff observations, and recruitment related to their wards.

Leadership, morale and staff engagement

- Sickness rates for Newington 1 and Newington 2 for the 12 months to January 2017 were 5% and 6% respectively. The vacancy rates for ward 1 was 43% and ward 2 was 58% for the same period. The hospital director told us that recruitment and staff retention was a priority and initiatives were being developed attract new employees.
- At the time of our inspection there were no harassment or bullying cases known to the provider. All staff were aware of the whistleblowing policy and process.
- All staff we spoke with were enthusiastic about and proud of the work they did. They told us of the good morale they experienced within their ward teams. Staff also told us that their teams were strong, they supported each other on the wards, and that they had good levels of job satisfaction.
- Both ward managers told us they had received leadership training to develop them in their roles.
- Staff told us they felt able to raise concerns without fear of victimisation.
- We found the wards to be well-led and that there was clear leadership at a local level. The ward managers were visible on the wards during the day and were accessible to staff and patients. Staff described strong leadership across the wards and said that they felt respected and valued.
- The culture of the wards was open and transparent with a drive for continual improvement. The service had a duty of candour (DoC) policy. Staff we spoke with were familiar with the policy and informed us that they were aware of their individual responsibilities to be open and transparent in respect of patients care and treatment. They also told us that they felt well supported by the managers to be open and honest. Serious incidents requiring investigation were subject to a Situation, Background, Assessment, Recommendation (SBAR) process. Part of this process included ensuring the DoC was considered. The senior management team monitored this process through the incident reporting system.
- Staff we spoke with told us they are offered the opportunity to feedback on services to improve clinical practice. The ward manager on ward 1 told us that they got the ward a new medical emergency bag for both wards, drew up a contents checklist and colour coded the contents. A new process on the ward now ensures that a health care assistant audits the bag checks using a new hospital-wide audit check list. One nurse we spoke with was a night shift co-ordinator and created a folder which contained a log of incidents which

occurred each night to provide an instant overview of activity on the wards. They also developed a process whereby a patient list was given to reception each morning so they were aware of who was in the hospital.

Commitment to quality improvement and innovation

- The service contributed to a number of quality improvement projects which included improving staff dining experience, providing a convivial environment, enhancing support for staff who were victims of patient assault to prevent 'burnout' and to maintain engagement with the service and Priory values, and to expand participation of quality walk round.

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

- The Priory Ticehurst House had closed two of its long stay and rehabilitation wards. The remaining service was provided to four patients accommodated in Lowlands unit. Lowlands was a four bedroom detached bungalow situated in the grounds of the hospital.
- The corridor leading to three of the bedrooms had a blind corner. The lounge and dining area was one space and provided staff clear lines of vision to observe patients. Parts of the unit such as the shared bathroom was fitted with anti-ligature taps. Other areas presented ligature risks such as windows and equipment for the assisted bath.
- The ligature risks were mitigated by staff observation. Staff had completed a detailed risk assessment that identified and rated the level of ligature risks in Lowlands. The audit directed staff to patient care plans where individual patient observation levels were recorded. We observed staff undertaking their visual checks on patients throughout our visit.
- Lowlands unit was a single sex service which meant that the provider complied with the Department of Health guidance on mixed sex accommodation.
- Lowlands had no clinic room so all patient health checks were undertaken in their bedrooms. The small and cramped staff office was used to store medication, clinical equipment, emergency equipment and drugs, patient records and personal finances.
- Medication was stored in locked cupboards and emergency equipment was accessible. Patient records were held securely.
- Staff maintained a record that showed emergency drugs and equipment were checked regularly. Patients had their medication as prescribed and all charts were properly completed and signed.
- There was no seclusion room on Lowlands. Staff told us that seclusion was not used on the unit.
- Lowlands was clean and tidy. Staff followed the units cleaning schedule and these were up to date.
- Furniture was well maintained and appropriate to the individual needs of the patients. The living area was small for the aids patients required; we observed staff moving an armchair to allow for a wheelchair to be manoeuvred.
- The provider had procedures to guide staff on the control of infection. Staff adhered to hand washing guidance.
- Risk assessments that identified, assessed and managed environmental risks within the unit were undertaken and readily available to staff.
- Patient's areas had a call system by which they could summon staff assistance if required. Staff also carried radios which were used to communicate with each other or if they needed to call for assistance from another ward in the main hospital.

Long stay/rehabilitation mental health wards for working age adults

Good

Safe staffing

- The staffing requirements for Lowlands unit was calculated by using an agreed regional staff patient ratio, reviewing the risks within the unit and the level of observation of each patient.
- In Lowlands the establishment staffing level of qualified nurses was 3.5 whole time equivalent (WTE), with 0.5 WTE vacant. This meant that for qualified nurses the vacancy rate was 14%.
- The establishment level of Health Care Assistants (HCA) was 5 WTE with 1 WTE vacancy. This meant that there was 20% vacancy for HCAs.
- The Priory Ticehurst House operated on a two shift pattern. The day shift was from 7.30am to 8pm and the night shift from 7.30pm to 8am. This pattern allowed for a 30 minute handover at the beginning of each shift. On Lowlands there was one qualified nurse and two Health Care Assistants. We checked the staff rota and saw the staffing levels were consistent. Bank and agency staff were used to cover the staff vacancies but these staff were booked to work regularly on the unit. We spoke to bank staff and found they had a good understanding of patients needs. Patients also knew the bank staff providing care to them.
- We saw from the rota that the ward manager was able to adjust staffing levels to suit the needs of the patients or planned activities. We checked care records and saw that staff provided and recorded one to one time with patients.
- Staff reported that ward activities were never cancelled because of staffing levels. However we observed that patients had not always wished to take part in the activities scheduled. The unit had access to the hospital's car and this was used to support patients have escorted leave.
- We were advised that the one RMN on duty often drove patients when they went out however this left no qualified staff covering the unit for this period of time. Staff were clear about the arrangements should qualified staff be needed in an emergency. Although there was no risk assessment in place to show how the provider had considered the risks of leaving the unit without qualified staff for a period of time.
- The unit had a consultant psychiatrist who was the responsible clinician, there was medical cover during the day and an out of hours doctor. Patients were also registered with a local general practitioner.
- Most staff had received and were up to date with their mandatory training. 100% of staff had been trained in managing aggression, 92% had completed their safeguarding adults training and 75% their Mental Health Act and Mental Capacity Act training.

Assessing and managing risk to patients and staff

- There were no recorded incidents of seclusion or restraint on Lowlands ward in the period 1 July 2017 to 1 December 2017.
- We reviewed all 4 patients' risk assessments and care plans. Patients risk assessments were completed on admission and updated monthly or more frequently if there was a change. We found assessments that identified and rated individual risks; care plans that addressed how to manage the risk were thorough and individualised. We saw that where a patient was identified as at risk of falling there was a full falls risk assessment with corresponding care plan in how to reduce the likelihood of falls.
- We reviewed all four medicine charts which showed that patients were prescribed their medicines in line with National Institute for Health and Care Excellence.

Track record on safety

- There had been no serious incidents on Lowlands.

Reporting incidents and learning from when things go wrong

- All staff we spoke to were able to provide examples of incidents that may occur and how to report these electronically.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Long stay/rehabilitation mental health wards for working age adults

Good

- We looked at the care records of all four patients. Their care plans were at a range of stages of discharge planning to other in-patient services.
- All the care plans were detailed, thorough and addressed identified physical health needs. They were up to date and regularly reviewed.
- Staff undertook regular physical health checks which included monitoring patients' weight and blood pressure.
- Patients records were held electronically, staff also held paper copies of assessments and care plans. We found there was some variance in the paper care plans and those held electronically. For example, staff were not able to show us patient discharge planning care plans but senior staff later provided us with electronic copies.

Best practice in treatment and care

- Patients were registered with the local GP practice and were supported to attend appointments by staff. They also had access and treatment from podiatrists and continence advisors as needed.
- A designated health care assistant worked with patients to plan and deliver activities. Activities included outings, 'mindfulness walks' and pastimes such as colouring or unit games. There was no meaningful rehabilitation or recovery program in place.

Skilled staff to deliver care

- The staff team comprised three mental health nurses, a consultant and five health care assistants. Managers and senior staff were available via an on call rota to provide additional support to staff.
- Staff records showed that continuing professional development was available. Staff told us that they were able to access training opportunities.

Multi-disciplinary and inter-agency team work

- Doctors, nurses, activity coordinators and support workers worked together to provide care and treatment for patients. Staff received comprehensive handovers at the beginning of their shift.
- The provider was working with external agencies and providers to identify appropriate in patient placements for patients to be discharged to.

Adherence to the Mental Health Act (MHA) and the MHA Code of Practice

- 75% of staff had received training in the Mental Health Act and Mental Capacity Act training.
- Staff understood the MHA and the code of practice. Staff explained patients' rights formally on admission and, where necessary, repeated them every three months.
- Section 17 leave arrangements were reviewed monthly and stored in patient records for staff reference. Section 17 leave for detained patients was authorised using a standardised system.
- Conditions were clearly detailed and there was evidence that patients were offered copies of the form. Out of date leave authorisation forms were crossed through.
- One patient had been referred to the local authority for an assessment for standard Deprivation of Liberty safeguard (DOLs) on 20 June 2017. However this had not been completed but there was evidence that the provider had followed up on this overdue assessment.
- Patients did have access to an Independent Mental Health Advocacy service.

Good practice in applying the Mental Capacity Act (MCA)

- Staff had a good understanding of the MCA and what capacity meant.
- Consent to treatment and capacity assessments were complete. Patients told us their doctor talked to them about their medication and explained the effects and side effects of their medication before they consented to treatment.

Staff encouraged patients to make their own decisions as far as possible.

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

Good

Kindness, dignity, respect and support

Long stay/rehabilitation mental health wards for working age adults

Good

- Staff were polite, respectful and addressed patients in their preferred way. They showed a good understanding of patients individual care and treatment needs. We observed several examples where staff showed good insight and understanding of patients' physical and emotional needs.
- Staff displayed a good level of insight into the individual needs and abilities of patients. We observed how staff skilfully and appropriately intervened to de-escalate patients' distress on two separate occasions.
- Patients were very positive about the staff team that provided their care, they confirmed that staff respected their privacy and dignity.

The involvement of people in the care they receive

- Staff described the transfer of patients form a closing ward to Lowlands unit. Patients and their carers were consulted, visits were arranged to the new unit and patients had the opportunity to choose their bedrooms. The provider ensured staff known to the patients were also transferred to the unit so this eased the transition.
- We looked at all four care plans and they had comments from, or evidence of patient involvement. Patients told us that staff offered them a copy of their care plan. Patients were provided with information about treatments during their 1:1 and when they attended ward round.
- Patients attended community meetings and were able to give feedback on the service provided. We saw they had full involvement in scheduling the unit activities.
- An independent mental health advocate visited the unit weekly to see patients.

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

Good

Access and discharge

- The bed occupancy rate over the previous six months was at 100%. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients.
- There was patient discharge planning, at various stages. This was undertaken in a methodical way. We saw there was consultation with patients and their families. Staff were making attempts to ensure advocacy services supported patients during the discharge process.

The facilities promote recovery, comfort, dignity and confidentiality

- Lowlands unit was a bungalow with a homely interior. There was no clinic room which meant that patient examinations and health tests took place in the patient bedroom. The staff office appeared cluttered however this was due to its small size and lack of storage space for medical equipment. Patient activities took place around the dining table.
- The office door was propped open into the patients living and dining area and this created a risk that patients privacy could be undermined. It also meant that the activity within the small office undermined any quietness in the living area. One patient's bedroom opened into the living area.
- The unit provided wheelchair accessible outside space and a large garden area. We observed patients making good use of this outdoor space. We noted that garden surrounded by hedging was only partially secure.
- Patients told us the food was good and in line with their care plans, they could make snacks and drinks in the unit kitchen.
- Patients had the same level of activities over the weekend as during the week as these were provided by unit staff.

Meeting the needs of all people who use the service

- The bungalow had step free access. Although, access inside the building was undermined by the small living and dining areas. We observed a staff member moving furniture to enable a wheelchair be manoeuvred out of the room.
- The hospital had access to an interpreting service.

Long stay/rehabilitation mental health wards for working age adults

Good

Listening to and learning from concerns and complaints

- From 1 May 2017 until 1 January 2018 there had been one compliant. This was not upheld.
- Patients described to us the action they would take if they wanted to make a complaint about the service. There was information on how to make a complaint published on the unit noticeboard. They told us they would feel confident in raising a concern.
- Staff knew how to handle complaints appropriately and there was a procedure in place to guide them. Formal complaints were handled by the complaints manager. Staff told us that they received feedback on complaints including the results of investigations that were undertaken.
- The hospital's clinical director led on a monthly "learning by experience" group which reviewed all complaints received in the hospital, this learning was then cascaded back to ward staff.

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

Good

Vision and values

- Staff knew the values of the provider. They quoted putting people first, being like a family and being positive as the values that underpin their work. They knew the hospitals senior management team.

Good governance

- All staff on Lowlands had their annual appraisal for the year 2017/2018. There was a supervision tree that showed supervision roles for designated staff. All records showed that staff had monthly supervision.
- Incidents were reported appropriately and there was evidence of learning from incidents.
- Staffing levels on Lowlands were sufficient to meet the needs of patients. The service was not heavily dependent upon agency or bank staff to ensure the unit was covered. When non-permanent staff were used this was usually blocked booked locum staff who were familiar with the unit and patients needs.
- The ward manager had sufficient authority to undertake their role and they were supported by senior managers.
- Staff took part in clinical audits for example monitoring the update of patient risk assessments and care plans. In turn these figures were used by the management team to monitor the performance of the unit.
- **Leadership, morale and staff engagement**
- The ward manager for Lowlands also managed an acute ward, so they split their time between both units. Although not based on the ward staff told us that the manager visited twice daily and was easily accessible by phone. The ward manager had undergone leadership training.
- Staff told us that morale was good on the unit and that there was a strong ethos of teamwork. Staff were receiving monthly supervision and all the team had had their annual appraisal.
- Staff we spoke with told us they felt able to raise concerns without fear of victimisation and they knew how to use the whistle-blowing process.
- Lowlands held regular team meetings and all staff described morale as good with their senior managers being highly visible, approachable and supportive.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

- The child and adolescent wards were safe and clean. Although there were blind spots on both wards staff were aware of these and mitigated any risks by use of observations and convex mirrors in corridors.
- Any potential ligature points were recorded on the ward ligature risk assessment and there was a mitigation action plan in place for each one. Staff were aware of the higher risk areas on the ward.
- Both wards at the time of the inspection were all female, however, Garden Court had three bedrooms downstairs which could be used as male bedrooms if needed to ensure compliance with guidance on gender segregation.
- Staff carried alarms at all times on the wards. We observed a good staff response to these when they were used on the wards. Young people had access to nursing staff call systems which they reported were effective.
- Both wards were clean, well furnished and well maintained.
- Cleaning records were up to date, although some young people on Garden Court told us that the wards were not always cleaned thoroughly.
- Clinic rooms on both wards were fully equipped with appropriate resuscitation equipment which staff checked regularly.
- Any emergency drugs were appropriately labelled and stored.
- Staff maintained the equipment in the clinic room, staff checked it all regularly and it was kept clean.

Safe staffing

- Both wards had current staff vacancies. The hospital provided figures that showed Upper Court had three qualified nurse vacancies and three health care assistant vacancies and Garden Court had four qualified nurse vacancies and one health care assistant vacancy. Both wards used agency staff to cover shifts and we saw that shifts were always filled. The ward managers of both wards could book agency cover in advance which ensured they could use the same staff who were familiar with the ward practices and policies.
- There were always two qualified nurses on each shift and five health care assistants during the day and three for the night shift. The wards had a two shift pattern of 7.30am – 8pm, and 7.30pm – 8am.
- We spoke with three agency health care assistants who were in the process of being recruited to join the team as permanent employed members of staff. Regular agency staff were used as much as possible to ensure consistency and familiarity with the wards and hospitals policies and procedures.
- Staffing numbers could be adjusted depending on the acuity of the young people on the ward. If there were more than one young person on enhanced one to one observations then an additional health care assistant could be requested to provide cover to ensure the observations could take place whilst maintaining the overall safety of the ward.

- Bank and agency staff told us they received the same induction as permanent members of staff. This ensured they were up to date with the latest training developments and processes on the ward.
- We observed there being sufficient staff and there always being a trained nurse in communal areas and enough staff to be spending time with the young people doing activities and facilitating leave from the ward.
- Each ward had a dedicated consultant and access to on call medical care in an emergency. There was an on call doctor who covered the whole hospital.
- The hospital provided staff mandatory training figures for the period up to December 2017. These showed that staff were 100% compliant with some mandatory training, such as basic life support and prevention and management of violence and aggression, however this was reduced in other areas. For example Mental Health Act and Mental Capacity Act training was at 60% and safeguarding children at 49%. The provider had an action plan in place to improve compliance and post inspection 91.1% of staff working on the child and adolescent wards had completed their Mental Health Act and Mental Capacity Act training. 94.2% of child and adolescent staff had completed their safeguarding children training.

Assessing and managing risk to patients and staff

- We reviewed 15 care records across the two wards. Staff had completed a thorough risk assessment of each young person at the point of admission. Staff reviewed and updated these regularly, at each ward round and routinely following any incident.
- Staff used a recognised risk assessment tool, appropriate for the age of the young people on the ward.
- Staff followed policies regarding use of observation. Staff could increase the level of patient observation at any time if they felt that risks had increased sufficiently. The ward doctor needed to authorise any reduction in patient observation levels.
- Staff were working towards least restrictive practice and any blanket restrictions were only applied when justified. Patients could not access their bedrooms during the day until four o'clock in the afternoon, but staff could individually risk assess patients to give them access prior to this if required.
- Neither of the wards had a seclusion room, although they had soft rooms. These were safe spaces for patients to go which were filled with weighted, padded cushions which the patients could take themselves to, with or without a staff presence.
- Staff used appropriate de-escalation techniques and would always try to engage with patients verbally before using any physical intervention. All staff had been trained in the use of non-prone restraint techniques.
- All staff we spoke with had received safeguarding training and were aware of the process for making a safeguarding alert. Staff knew how to raise the concern with the lead social worker for the service and ward manager.
- Staff demonstrated a good understanding of identifying abuse or if the patients were at risk of harm. The hospital had good links with the local authority and worked in partnership with other agencies whenever appropriate.
- Staff had access to essential information that was recorded on the electronic recording system. We spoke with agency staff that did not have the appropriate log in to be able to access this so they were reliant on verbal handovers from staff to be kept updated with any incidents on the ward.
- The teams also had paper copies of assessments which were easily accessible. This did not cause any issues within the staff team.
- Staff followed appropriate National Institute for Health and Care Excellence in all aspects of medicines management. Staff regularly reviewed young people's physical healthcare in relation to any psychiatric medicine they were prescribed.

Track record on safety

- In the 12 months to February 2018, the child and adolescent mental health services for inpatients reported 15 serious incidents. These included young people absconding from the wards, aggression towards staff, physical ill health and episodes of self harm.
- **Reporting incidents and learning from when things go wrong**
- Staff demonstrated an awareness of which incidents to report and how to do so. Staff used the electronic reporting system and were aware of the process for completing the relevant forms. However, agency staff we

spoke with did not all have the same access and so had to complete a Word document for this to be uploaded to the incident reporting system by a member of permanent staff.
- The provider had a duty of candour policy which clearly laid out staff responsibilities to the young people on the ward in the case of something going wrong or mistakes being made.
- Staff received feedback from incidents at team meetings and through individual supervision and one to one sessions. Staff met monthly as a team to discuss incidents and any learning from incidents.
- Staff had de-briefs following any serious incident and could access additional support through reflective practice sessions and one to one meetings.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed 15 care records across the two wards. Staff had completed a comprehensive mental health assessment at the point of admission.
- Staff had completed an assessment of young people's physical health needs when they were admitted and at regular intervals thereafter.
- Care plans were thorough, personalised and holistic and met the needs that had been identified during the admission assessment. Staff reviewed and updated these at wards weekly rounds to ensure they were up to date.
- Young people on the wards all had behavioural support plans which were individualised to meet their needs.

Best practice in treatment and care

- Staff provided a range of care and treatment for the young people on the ward. This included psychological intervention, occupational therapy and daily attendance at school.
- The young people on the ward had access to physical activity, although some of the young people told us there was not enough of this.
- Staff supervised the young people on the wards to use the ward kitchen to make drinks during the day. The young people were not able to access this without staff support.
- Staff used rating scales such as Health of the Nation Outcome Scales that had been specifically designed for child and adolescent mental health services.

Skilled staff to deliver care

- The staff team included doctors, nurses, health care assistants, occupational therapists, psychologists, a family therapist and a social worker. The hospital also had close links with a local pharmacy and a pharmacist visited the wards frequently. Staff could also refer to specialists such as nutritionists and dieticians if needed. An appropriate education department supported both wards and the young people attended school every weekday.
- Staff were experienced and received appropriate training for their role.
- New staff reported they received a thorough induction to the organisation and the ward. Agency staff also reported they received the same initial induction to the service as employed permanent staff to ensure all staff knew the correct policies and procedures on the ward.
- Managers provided staff with supervision and staff reported that supervision was relevant and useful. The staff team had regular team meetings to ensure all staff were kept updated of any developments or incidents. Staff also attended reflective practice sessions facilitated by the psychologist to provide additional support.
- All staff received an annual appraisal and appraisal rates for the service were 100%.

Multidisciplinary and interagency team work

- Staff attended regular multidisciplinary team meetings. These provided an opportunity for staff from all disciplines to share learning and developments and update the rest of the staff team.
- There was a handover between each shift, and a daily morning meeting to plan for the day. This included managers and members of the senior management team.
- The ward demonstrated good working relationships with other agencies including community teams, local authorities and schools.

Good

Child and adolescent mental health wards

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

- Staff received training in the Mental Health Act and demonstrated a good understanding and awareness of the legislation and how it could be applied to the young people in their care.
- Staff had access to the Mental Health Act Code of Practice and appropriate administrative support. Staff knew who to ask for Mental Health Act support and guidance within the hospital.
- Staff ensured that the young people were aware of their rights under the Mental Health Act and knew the process for appealing against their detention.

Good practice in applying the Mental Capacity Act

- Mental Capacity Act training was a mandatory training course for all staff, however figures the hospital provided showed only a 60% compliance rate, however post inspection this had improved to 91.1%. Staff we spoke with did demonstrate a good understanding of the Mental Capacity Act and Gillick competence. Gillick competence is a test in medical law to decide whether a young person of 16 years or younger is competent to consent to treatment without the need for parental permission or knowledge.
- We reviewed 15 care records which showed good use and consideration of Gillick competence and staff had clearly recorded and documented any capacity decisions they had made.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect, and support

- We saw numerous examples of staff interacting with the young people on the ward with kindness, respect and empathy. Staff treated the young people with compassion demonstrating a caring attitude and approach.
- Young people told us that staff always had time for them and would stay with them as long as needed to provide emotional support and encouragement.
- Staff gave young people information about their condition and the treatment for it, as well as discussing options and alternatives.
- Young people told us they felt confident to raise any issues with the staff team without fear of recrimination, and felt confident in the staff team that any concerns they raised would be responded to appropriately and confidentially.
- The majority of the young people told us that staff treated them well, although we were also told that staff did not show understanding of their mental health problem at all times and did not always treat them with respect.

The involvement of people in the care they receive

- We reviewed 15 care records. Each showed evidence of patient involvement and contribution to the care plan. However, some of the young people we spoke with on Garden Court stated they did not know what was in their care plan.
- Young people were routinely invited to attend the monthly clinical governance group meeting, although none of the young people we spoke with had attended this.
- On discharge staff gave the young people surveys and questionnaires to complete to give their feedback on the service. Staff could then use this to make changes and improvements to the service if possible and appropriate.
- Both wards held a weekly community meeting for young people to attend and give feedback on the service. This also gave the young people the opportunity to make suggestions for the ward. We saw minutes of these meetings which showed that actions had been taken and followed up by the ward staff.
- Staff invited carers to ward reviews and care programme approach meetings, however one carer told us that these reviews can be cancelled at short notice.
- Families and carers were involved in discharge planning to ensure there was suitable provision for the young person on leaving the hospital, or transferring to another service.
- Staff gave families and carers a feedback questionnaire when their cared for person or family member was discharged from the hospital. This gave them the opportunity to provide feedback on the service which staff could use to make changes or improvements to the service.

Good

Child and adolescent mental health wards

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

Good

Access and discharge

- In the six months to December 2017 the average bed occupancy for Upper Court was 77% and for Garden Court this was 72%. Bed occupancy levels are the rate of available bed capacity. It indicates the percentage of beds occupied by patients.
- Young people were not moved between the wards unless there was a clinical need. Young people did get moved from Garden Court to the high dependency unit, Upper Court, if this was felt most appropriate by their consultant and full multidisciplinary team.
- The average length of stay of young people who had been discharged in the previous 12 months was 119 days on Upper Court, and 41 days on Garden Court.
- Staff had good links with community teams throughout the region and care co-ordinators in these teams.
- Discharge planning was well co-ordinated and thought through to ensure a smooth transition home or to a more suitable service. Staff were able to support young people if they required a transfer to a different hospital and these transfer were well planned and managed.

Facilities that promote recovery, comfort, dignity and confidentiality

- Young people each had their own room which they could personalise as they wished. The young people did not have access to their rooms from 9am – 4pm, unless individually risk assessed. Staff ran the ward activities during these times and the young people were at school every morning or afternoon. Ward managers were aware of the restrictive nature of this policy and this was being reviewed by the wider hospital senior management team.
- There was secure storage on the ward for young people to be able to store their possessions.
- The wards both had a full range of rooms and equipment. There were quiet rooms for young people to use, a well-equipped clinic room, therapy rooms and activity areas. The young people on the ward also had access to outside space and could use the ward gardens with staff supervision.
- Young people could meet their visitors in a quiet space and there were rooms off the ward to meet with families and carers if appropriate.
- The wards had a phone for young people's use, although the young people also had access to their own mobiles phones if needed.
- Both wards had a kitchen space for the young people to make hot drinks and snacks, although kitchen access was supervised by a staff member at all times.
- All the young people on both wards had access to and were encouraged to attend school daily. We spoke with a teacher from the school who told us of the timetable and programme of teaching activities. The school had suitable resources to meet the needs of the young people.
- Staff encouraged the young people to maintain contact with their families. Staff routinely invited family members to attend ward reviews and care programme approach meetings.

Meeting the needs of all people who use the service

- The service had made adjustments to the ward environment as much as was practicable. There was a lift on Upper Court for young people who were not able to use the stairs.
- Information was available to all young people on local services, advocacy, their rights and how to make a complaint. This was all available in easy read formats if required and staff could access interpreters for those young people for whom English was not their first language.
- The young people on the ward had a choice of meal options and the service could cater for specialist dietary requirements to meet the young people's needs.

Listening to and learning from complaints

- The hospital provided figures which showed that in the 12 months to February 2018 the service had received 12 complaints. These ranged from personal belongings going missing or being damaged on the ward; concerns

regarding communication with families and the general level of acuity on the ward. Of the 12 complaints three were not upheld, five were partially upheld and four were upheld.
- Staff reported being aware of the complaints process and received feedback regarding any complaints that were made. Patients described being aware of how to raise a formal complaint with the service and felt that staff would investigate any complaints they made.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Ward managers had the necessary skills, experience and knowledge to perform their roles competently. They had a clear understanding of the service they managed and could explain the processes and working practices of the teams and how the two wards worked together to provide appropriate care.
- Both ward managers were visible on the wards and available to staff and young people. Staff we spoke with spoke highly of the support given by the ward managers.
- Staff understood the values of the provider organisation and how they applied in their day to day work. However, not all staff felt connected to the wider organisation and felt that although they received good support from their line manager, they received little above this.
- Staff on the ward did not demonstrate any knowledge of the wider implications of budgets and provider strategy. However, this did not appear to adversely affect the care they provided on the ward.
- Staff we spoke with stated they were proud to work for the organisation and on the wards they did. They reported feeling valued by the ward manager and supported by colleagues in the team. We observed a sense of real team work and commitment from all staff we spoke with.
- All staff told us they would feel comfortable to raise any concerns with their manager without fear of retribution. They felt confident that any issues they raised would be properly investigated and they would receive feedback from this.
- Staff had access to occupational health services to support their own health and wellbeing.
- Staff had regular appraisals and reported these as being meaningful and productive. Staff reported appraisals were an opportunity to discuss development and further career options.

Good governance

- There were clear frameworks and arrangements for information to be passed from directorate level to ward level. However not all staff felt confident of these arrangements and said they did not always feel up to date with what was happening within the provider organisation at more senior levels.
- There were processes in place to discuss outcomes and learning from incidents.
- Staff had a good understanding of working with other teams, both internally and externally to ensure they were meeting the needs of the young people throughout their admission and discharge process.
- Staff were aware of the process for responding to and learning from complaints. The team discussed these openly when appropriate to ensure any learning was shared across both wards.
- Ward managers maintained up to date risk registers for their wards. Staff could raise concerns and escalate risk as required. The risk register was easily accessible and staff could refer to this when needed.
- Staff were aware of the environmental risks on the ward such as blind spot and any ligature anchor points and knew of action plans to mitigate these.
- Staff had access to appropriate technology systems to complete their work without this being over burdensome. Staff had access to incident reporting systems, risk registers, young people's care records and any Mental Health Act paperwork. Agency staff did not have the same access, but the wards had good systems in place to ensure agency staff could contribute to care records and incident reporting. Staff also kept agency staff up to date with developments with use of comprehensive handovers.

Good

Child and adolescent mental health wards

- Young people's care records were confidential and could not be shared.
- Ward managers had dashboards to support them in their management role. Managers could access staff training records, supervision and appraisal records to ensure these were up to date. The dashboards also showed when a young person's care plan was due to be renewed or any change in Mental Health Act status.
- The service made appropriate notifications to external agencies, such as local authority safeguarding teams and the care quality commission.

Leadership, morale and staff engagement

- Staff were kept up to date with service developments in regular newsletters and bulletins.
- Young people and carers could offer feedback on the service in the form of discharge questionnaires and surveys, and informally throughout an admission.
- Young people were invited to join the monthly clinical governance group meeting to give their views on the overall running of the service.

Commitment to quality improvement and innovation

- The service was accredited with the Quality Network for Inpatient CAMHS.
- Staff were working on reducing any restrictive practices, such as access to bedrooms during the day and access to the kitchen. The wards had also reduced restrictions regarding young people's access to the television and DVD player, which had resulted in fewer incidents on the wards.