Priory Hospital High Wycombe

Quality Report

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

Ratings

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

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

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

Summary of findings

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

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

Overall summary

We rated Priory Hospital High Wycombe as inadequate because:

- Staff did not have sufficient experience or training to care for young people with learning disabilities and/or autism.
- The ward environment was not well adapted for young people with autism.
- There were very few specialist assessments for young people with a learning disability or autism.
- There was insufficient provision of psychological therapies.
- Where individual needs had been identified these were not always appropriately addressed. For example, care plans were not always in an accessible format where needed and there were not individual programmes for therapeutic activities.
- Young people did not have positive behaviour support plans in place.
- Physical health observations were not always recorded.
- Access to parts of the ward were restricted without clear reasons for this. This meant that some young people could not independently access the toilet or help themselves to a drink.
- Young people were routinely searched when returning from leave, rather than this being based on their individual needs.
- Compliance with mandatory training was very low and supervision was not always recorded.
- Staff had a lack of understanding of Gillick competence.
- Some relatives told us that communication at the hospital was poor and that they struggled to obtain copies of care plans and meeting minutes.
- Staff did not always use appropriate language to describe young people's behaviour.

However:

- All young people had up to date risk assessments in place.
- The provider had good links with a local GP who visited the hospital weekly.
- The hospital supported young people with their discharges and a few had already moved on to other services.
- A young person told us they felt safe and comfortable on the ward.
- Young people were able to personalise their bedrooms which they appreciated.

Following the inspection enforcement action was taken and the hospital was served with two warning notices in relation to Regulation 9 HSCA (RA) Person-centred care and Regulation 18 HSCA (RA) Staffing.

Following the inspection the provider made plans to transfer the young people from the hospital and applied to de-register the service with CQC.

Summary of findings

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Summary of this inspection

Background to Priory Hospital High Wycombe

Priory Hospital High Wycombe is a low secure hospital for males and females aged 13-17 with a diagnosis of learning disability and/or autistic spectrum disorder commissioned for 12 beds. The unit opened in April 2018 and accepts referrals from across the country. The service has been registered with CQC since 11 April 2018 and is registered to provide assessment or treatment for persons detained under the Mental Health Act (1983) and treatment of disease, disorder or injury.

The service had treated 10 young people since opening. At the time of the inspection eight young people were receiving treatment at the service.

The hospital director had applied to become the registered manager and their application was still in progress at the time of the inspection.

We had not previously inspected Priory Hospital High Wycombe.

Our inspection team

The inspection team comprised two CQC inspectors, an assistant inspector, a Mental Health Act reviewer and two specialist advisors; one of whom was a nurse and the other a clinical psychologist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

- looked at the quality of the ward environment
- looked at care and treatment records of all the eight young people currently using the service
- spoke with the operations director and ward manager
- spoke with 12 other staff members; including doctors, nurses, healthcare assistants, occupational therapist, psychologist, pharmacist and chef
- spoke with the education team
- spoke with a young person
- spoke with two relatives
- attended and observed a handover meeting and a multi-disciplinary team (MDT) meeting
- carried out an observation in a communal area using the short observational framework for inspection (SOFI 2)
- carried out a specific check of the medicines management; and
- reviewed minutes from MDT meetings, governance meetings, handover notes, supervision files, staff training records, incident forms, ligature audits and personal emergency evacuation plans.

Summary of this inspection

What people who use the service say

The young person that we spoke to told us that they felt safe and comfortable on the ward. They said that staff were respectful and polite. They liked the size of their bedroom and that they could put pictures on the walls. They told us that the food was very good and that there are plenty of activities available.

The two relatives that we spoke with told us that they had concerns about the staffing on the ward and did not feel the staff were adequately trained to care for young people with learning disabilities and autism. They were also concerned by the lack of staff continuity at the hospital. Relatives told us they had witnessed inappropriate language being used by staff, that portrayed young people as being aggressive and antagonistic.

One relative we spoke with told us they had to request a care plan several times before they were given a copy. When they did receive a copy, it contained incorrect information and was not individualised for their child. The other relative that we spoke with told us that they had still not received a copy of the care plan despite requesting this on multiple occasions.

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?

Inadequate

We rated safe as inadequate because:

- Compliance with mandatory training was very low. Less than half of staff had completed most of the required mandatory training courses. This included courses we consider essential when working with young people with complex needs such as safeguarding children (40%), basic life support (8%) and fire safety (30%).
- Doors between bedrooms and communal areas in the female section of the ward were kept locked with no clear rationale. This meant that a female young person using the lounge had to ask staff if they wanted to leave the area, get a drink of water or use the toilet.
- Young people were routinely searched on admission and on return from section 17 leave rather than this being based on their individual needs. Staff had not completed training in how to carry out searches.
- Lessons learned from incidents were rarely documented and when they were these were very brief and not well formulated.
- Relatives told us that section 17 leave was often cancelled due to a lack of staff, especially on weekends.

However:

- There were good ligature risk management processes in place.
- Up to date risk assessments were in place for all young people.
- Staff followed best practice when storing, dispensing and recording the use of medicines.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Most staff working at the service did not have any experience working with people with learning disabilities or autism and no specialist training had been provided to them.
- Care plans were generic and not recovery focused.
- Ongoing physical healthcare checks were not always documented and one young person with a physical health condition did not have a plan in place to meet their individual needs.
- Young people did not have positive behaviour support plans in place.
- Young people did not have access to any psychological therapies.

Summary of this inspection

- Few specialist assessments had been completed by the members of the multi-disciplinary team working in the hospital.
- Where specialist assessments had been completed, these were by staff who had a lack of experience of working with young people with learning disabilities and/or autism, and therefore struggled to communicate with the young people they were assessing.
- Managers were unable to provide supervision records for permanent members of staff.
- Only 33% of staff had completed training in the Mental Health Act and 25% in the Mental Capacity Act.
- Many staff had a lack of understanding of Gillick competence.

However:

- Records for all eight young people who were detained under the Mental Health Act were completed appropriately.
- Staff were using a recognised rating scale to monitor severity of symptoms and outcomes.
- The provider had good links with a local GP who visited the hospital weekly to review physical healthcare needs.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Staff used negative language when referring to young people's behaviour, both verbally and in clinical documentation.
- Relatives felt communication at the hospital was very poor. They had to request copies of care plans and meeting minutes several times before these were sent to them.
- Regular community meetings did not take place and there were limited opportunities for young people and their relatives to give feedback to staff.

However:

- We carried out an observation in a communal area using the short observational framework for inspection (SOFI 2) and observed a high number of positive interactions between staff and young people.
- A young person told us they felt safe and comfortable on the ward.
- Relatives told us they found senior medical staff to be professional and courteous.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

Summary of this inspection

- The layout of the ward was disorientating and there were lots of loud noises, meaning the environment was not best suited for young people with autism.
- It had been identified that one young person needed an easy-read version of their care plan but this had not been provided.
- Relatives told us that section 17 leave was rarely offered and when it was, this was often just going outside to the car park or a short drive to a local supermarket. They were concerned about a lack of physical exercise and exposure to life in the community.
- Whilst therapeutic activities took place there were not individual programmes in place to meet each person's individual needs.
- The education team suggested communication aids that staff members could use to communicate with young people with learning disabilities but staff did not use these.
- Managers did not keep a central log of complaints.

However:

- Young people were encouraged to personalise their bedrooms which they appreciated.
- The chef met with young people weekly to plan menu options and a young person we spoke with gave positive feedback about the food at the hospital.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The hospital was not adequately equipped to care for the young people with complex needs who were admitted there.
- Robust governance processes were not embedded at the hospital.
- Records were not always complete or accurate. Inconsistent observation levels were recorded in half of care notes.
- Some staff were unaware of the organisation's vision and values.
- Staff did not have a suitable forum to feedback ideas about service improvement to managers.
- There was no regular audit programme in place to assure quality at the hospital.

However:

- Instances of inappropriate staff behaviour had been dealt with promptly.
- Members of the senior executive team regularly visited the ward.

Detailed findings from this inspection

Mental Health Act responsibilities

- We reviewed detention paperwork for all eight young people and found this was completed appropriately.
- The hospital had recently been allocated a MHA administrator for one day a week. Although staff told us that they read young people their rights on admission and monthly following this, they did not record this and so there was no documentary evidence that staff had reminded young people of their rights. The MHA administrator wrote to each young person to explain their rights but had not considered whether the patients had the ability to understand the letters. The letters were not written in an easy-read format.
- Young people had access to advocacy. A general advocate visited the ward every two weeks and offered to meet with all new young people. An Independent Mental Health Act advocate (IMHA) was also available. People detained under the Mental Health Act are legally entitled to access support from an IMHA. Staff we spoke with did not understand that there were different types of advocacy.
- The Mental Health Act was part of mandatory training but only 33% of staff had completed this.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The Mental Capacity Act does not apply to people aged under 16. For people under 16 their decision making ability is assessed using Gillick competence. If a person under 16 can demonstrate that they have sufficient knowledge and understanding to fully understand what is involved in a proposed treatment then they are deemed to be Gillick competent. The responsible clinician completed capacity to consent to treatment assessments for all young people at the hospital using the same form despite capacity assessments and assessments of Gillick competence being different legal tests. Most staff we spoke with had a good understanding of the Mental Capacity Act, however were unable to explain Gillick competence.
- The Mental Capacity Act was part of mandatory training but only 25% of staff had completed this.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Requires improvement	Requires improvement	Inadequate	Inadequate

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

The entrance to the hospital was via air lock doors which were controlled from reception. All visitors were asked to sign a declaration to confirm they were not taking any prohibited items onto the ward. Visitors to the ward were either escorted by the security nurse or given a personal alarm. Staff carried radios to call for assistance when needed. The hospital was clean throughout.

The ward complied with guidance on mixed sex accommodation for mental health services. There were separate sleeping areas, lounges and outside spaces for male and female young people as well as a communal lounge, dining room and outside space.

Fixtures and fittings were well maintained but prior to the inspection a young person with complex needs had managed to swallow objects such as screws, wire and a part of a radiator grill. In one of these incidents staff were unsure where the swallowed object had come from. Staff increased the level of observation of the young person and carried out extra security checks to identify any objects that the person might be able to ingest.

A ligature audit was completed in October 2018 and there was an allocated security nurse every shift to check for environmental risks and ligatures. We reviewed incident reports and, where ligatures had been tied, these had been using items such as clothing wrapped around their necks rather than attached to a fixed anchor point. The induction for new staff covered ligature management. Ligature cutters were kept in the nursing office and some staff also carried these on their person in a pouch on a belt.

The provider used a closed circuit television (CCTV) system monitored by an external agency in all areas of the ward. This included in young people's bedrooms where they or their relatives had consented to this. Signs were on display in the service entrance and on the ward to notify people that CCTV was in use within the hospital. The agency who monitored the system rang the ward if an incident was taking place and managers also used footage from the system to support incident investigations.

Fire safety was part of mandatory training but only 30% of staff had completed this. Fire safety processes were in place and fire drills were regularly carried out. Personal emergency evacuation plans (PEEPS) were in place for all young people. A fire drill in October 2018 had identified that the PEEPS had not been used, so these were reviewed and a further drill was carried out in November 2018.

There was a seclusion room on site although this had not been used since the unit opened. There were two blind spots in the seclusion room to the right of the door and in the bathroom. Managers told us that mirrors had been ordered to mitigate this risk. A two-way communication system was in place. There was no clock on display.

The clinic room was clean and tidy and medication was stored securely. A member of staff checked the temperature of the fridge and clinic room daily and this was recorded. All staff had a master key which opened the clinic room. The keys for the medicines cabinet were held by the nurse in charge.

Safe staffing

The minimum staffing level on the ward was two registered nurses and four healthcare assistants. Staffing levels were reviewed daily to ensure that enough extra staff were requested to meet the needs of young people who were on enhanced observations. On the day of our inspection there were nine extra staff on duty.

Staff told us there was always at least one qualified nurse in the ward area, and that they could summon assistance from them using their radios when needed.

The staffing establishment for the service was 11.6 nurses and 30 healthcare assistants. At the time of the inspection the service had a 60% vacancy rate for qualified nurses and all healthcare assistant posts had been filled. The provider had block booked agency nurses to help maintain staff continuity while recruitment was taking place. The sickness rate since the unit opened in April 2018 was 11%. The provider had a recruitment plan in place and from July 2018 had been offering incentives to encourage applications.

Relatives we spoke to said that section 17 leave was sometimes cancelled due to lack of staff, particularly on weekends. Staff we spoke with told us they try to re-arrange leave rather than cancelling it but that this could be difficult on days when multiple young people requested leave at the same time.

Doctors were available to attend the ward 24 hours a day. There was a consultant psychiatrist and junior doctor who worked full time at the hospital and two on-call doctors who were available out of hours.

Agency staff received an induction from the director of clinical services and a handover from the nurse in charge. They were also allocated a mentor for their first two shifts. The provider checked with their agency to ensure they were up to date with their mandatory training.

With the exception of four new members of staff, all staff had received training in prevention and management of violence and aggression (PMVA) in a CAMHS setting. Those staff who had not completed the training did not restrain young people.

Compliance with mandatory training was very low. Records showed that eight percent of staff had completed training in basic life support, 16% infection control, 20% introduction to health and safety and 23% moving and handling. CQC took enforcement action in relation to this following the inspection.

Assessing and managing risk to young people and staff

Up to date risk assessments were in place for all eight young people. These included both current and historical risks. Risk assessments were completed prior to admission, reviewed in MDT meetings and updated following incidents. We attended a morning handover session where staff discussed incidents which had occurred the previous day and any risk issues.

There was a list of items which were restricted on the ward in reception which included mobile phones and laptops. If young people wished to make phone calls they could access a cordless phone from the nursing office.

Staff told us that young people were routinely searched on admission and when they returned from leave. This was not based on each young person's individual needs. The provider had a search policy in place but staff we spoke with were not aware of this. The search policy stated that decisions to search must be documented and for people under 18, consent from the person with parental responsibility must be sought prior to a search being attempted. Despite this, there was no record of the reasons for searches, or of consent being sought from parents. Staff had not completed training in search techniques.

The door between the female bedroom corridor and the female lounge was locked but the door from the male bedroom corridor to the male lounge was open. Staff told us this was because young people had requested the door be kept open. They were unaware of any specific risks which meant the female door should not be kept open. The door between the female lounge and the kitchen was also locked. We observed a young person alone in the female lounge with the door locked and no staff present which meant that she was unable to leave the room, use the toilet or get a drink of water without staff intervention. CQC took enforcement action in relation to this following the inspection.

Between April and July 2018, there were 61 instances of restraint used on the ward involving six different young people. Staff told us that they would always try to verbally de-escalate the situation and utilise the de-escalation

spaces on the ward before using restraint. However, staff had not received training in positive behavioural support or communicating with young people with learning disabilities. Where restraint was used, this was usually the seated arm hold restraint. Prone restraint was not used.

Safeguarding

The service had safeguarding procedures in place and flowcharts were on display in staff offices. Any safeguarding concerns were reported to the designated safeguarding officer or the hospital director who would then make referrals to the relevant local authority. Staff we spoke with explained how they would recognise abuse and most staff knew how to report this. Some staff did not know who the designated safeguarding officer was as this had recently changed, but said they would inform the ward manager. Forty percent of staff had completed training in safeguarding children and 33% of staff had completed training in safeguarding vulnerable adults.

Staff access to essential information

Care records and information were stored electronically on password protected systems. All staff, including agency staff, could access the system. Each young person also had a paper file which was stored securely in the nursing office.

All young people admitted to the hospital were detained under the Mental Health Act. Copies of their treatment authorisation forms were kept with their prescription charts and so were readily available to staff administering medicines.

Medicines management

Staff followed best practice when storing, dispensing, and recording the use of medicines. We reviewed medicines charts for all young people and found that these were clear and contemporaneous. Where young people had allergies these were clearly documented on medicine charts, or if they had none this was also stated.

Senior medical staff took care to explain the risks and benefits of different medicines with young people and their family members and family members told us they felt included in the decision making around the medicines used to treat their children. Easy read versions of medicines leaflets created by the British Institute of Learning Disabilities were available for young people who needed them.

Staff ordered medicines online and they were checked by two nurses when delivered. A pharmacist attended the ward every week to audit medicine charts. They had also delivered training in medicines management to nurses on the ward.

There had been four incidents where nurses had administered the wrong dose of medication to young people. The provider had put an action plan in place to ensure that medication was being administered by two nurses. Nursing staff were also re-completing their medication competencies. Staff informed the young people affected and their relatives of these errors, ensuring they met their obligations under the statutory duty of candour.

Track record on safety

Staff we spoke with were aware of their responsibilities to report incidents and near misses. Between 25 September 2018 and 14 November 2018 there were 12 incidents reported at the hospital. These included medication errors, patient assaults on staff and an incident where an agency member of staff had allegedly assaulted a patient. This member of staff was stopped from working at the hospital and their agency was informed of the allegations.

Reporting incidents and learning from when things go wrong

Any member of staff could report an incident and complete an incident form. Staff we spoke with told us they completed the form with support from the nurse in charge. The incident and any lessons learned were then reviewed in the handover meeting the following day. Staff told us that if they weren't on shift the day following an incident then they wouldn't usually be made aware of any lessons learned. Staff were unaware of any learning from incidents within the wider organisation.

Staff and young people were debriefed following incidents and family members were notified.

We reviewed 11 incident forms from November 2018 and the lessons learned section had been completed on two of these. These were very brief and not well formulated, for example "be prepared to be spat at" and "be vigilant at all times".

Inadequate

Child and adolescent mental health wards

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We reviewed care records for all eight young people who were detained at the hospital. Admission assessments were completed by the ward manager and consultant psychiatrist and included a review of both current and historical information.

All young people had up to date care plans in place but only one of these included the views of the young person. The care plans were not holistic or recovery-focused. Where needs had been identified the plan to address them was often generic, for example "[name] needs to communicate effectively" but there were no specific strategies for how they could achieve this.

Young people did not have positive behaviour support plans in place and staff had not received training in positive behaviour support. Positive behaviour support is a framework for delivering a range of evidence-based supports to increase an individual's quality of life while reducing the occurrence, severity or impact of behaviours that challenge. We would expect all young people with a learning disability or autism to have a positive behaviour support plan in place and for staff to be appropriately trained and supervised to deliver these effectively. Behaviour that challenged the service, including physical aggression, was not understood by most staff to be a means of communication, and was approached as a risk issue only. We did not find evidence of psychology or occupational therapy input to understand the function and causes of behaviour that challenged. CQC took enforcement action in relation to this following the inspection.

The care records contained no evidence that staff had undertaken a physical health examination of three of the eight young people when they had been admitted to the hospital and only four young people had evidence of ongoing physical healthcare documented within their care records. Staff told us that vital signs were monitored daily but this was not always recorded. Where the physical healthcare document had been completed, there were often gaps. The provider had good links with a local GP who attended the service on a weekly basis to review and advise on physical healthcare issues. Staff referred young people to the local acute general hospital when needed. Young people could also access a local dentist and staff had arranged for an optician to visit the hospital.

We found that one young person had a serious physical healthcare need identified but there was no physical health care plan in place for this. This was fed back to managers who ensured a care plan was put in place and we observed this being discussed with staff in the morning handover session the following day.

Best practice in treatment and care

Staff used the Health of the Nation Outcome Scale for Children and Adolescents (HONOSCA) throughout admission to assess severity of symptoms and record outcomes. This is a recognised rating scale.

Printouts of National Institute for Health and Care Excellence (NICE) guidelines were available in the nursing office however there was no forum for staff to discuss these.

Young people did not have access to psychological therapies. A locum clinical psychologist had recently joined the team but was not offering any therapies at the time of the inspection. A speech and language therapist worked with the service one day a week. They had carried out some assessments and attended MDT meetings. A family therapist was also available however was not working with any families at the time of the inspection.

A locum occupational therapist worked Monday to Friday 9am-5pm. They had carried out some functional assessments but due to their lack of training in working with young people with learning disabilities and/or autism had found it difficult to communicate with the young people. One young person had a model of human occupation screening assessment completed. This is an assessment which allows the therapist to assess a person's level of occupational functioning.

Although a few of the staff had previous experience of working with this client group, few specialist assessments had taken place. We reviewed all specialist assessments carried out by the clinical psychologist, occupational therapist, speech and language therapist and family

therapist in November 2018 and found that only five occupational therapy assessments and two speech and language therapy assessments had taken place. Three young people had had initial meetings with the new locum clinical psychologist. Where assessments had taken place these did not demonstrate a good understanding of young people's individual needs.

Staff promoted a healthy lifestyle by encouraging young people to eat healthily and offering nicotine replacement therapy to young people who smoked. Physical education was provided as part of the education curriculum and was facilitated in the outside spaces or the lounges.

Staff had participated in a medication audit.

Skilled staff to deliver care

Most staff working in the service did not have previous experience of working with young people with learning disabilities and/or autism. The ward manager and one of the newly recruited members of staff were learning disabilities nurses who also had experience of working in child and adolescent mental health services (CAMHS). Other nurses had either a CAMHS or forensic background. The clinical psychologist had a community CAMHS background and the locum occupational therapist had experience of working in CAMHS and forensic services. A permanent occupational therapist with CAMHS and autism experience was due to join the team in January 2019.

The provider had not ensured that staff received specialist training in working with young people with learning disabilities and/or autism. Staff received basic learning disability and autism awareness training as part of their induction but staff we spoke with, who did not have previous experience of working with young people with learning disabilities, told us this was insufficient for their roles at the hospital. They told us that they had requested further training. Managers told us that further training was in the process of being arranged in collaboration with the autism lead at the Priory group however there was no date set for this. CQC took enforcement action in relation to this following the inspection.

The provider had a target for 95% of staff to receive monthly supervision. We were told that staff received monthly supervision but managers were unable to provide supervision records for permanent members of staff. We were provided with supervision files for six agency members of staff and the chef, which all had supervision sessions documented in November 2018 but nothing prior to this. Where supervision records were available, these were sparse and where staff had raised issues there was little evidence of how these would be addressed. Managers told us they were still in the process of embedding a robust supervision process at the hospital, which opened in April 2018. CQC took enforcement action in relation to this following the inspection.

The psychologist had recently started facilitating weekly reflective practice sessions but staff told us they been unable to attend due to demands on the ward. We reviewed the attendance list from the first session and only members of the senior management team had attended.

At the time of the inspection, the unit had been open eight months so appraisals had not yet been carried out, however managers informed us these were scheduled to take place between January and March 2019.

Multi-disciplinary and inter-agency team work

Members of the MDT attended the morning handover meetings where staff discussed risk, incidents from the previous day and staffing levels. MDT meetings took place weekly. The head of education also attended the handover sessions and MDT meetings. Members of the MDT told us they felt their opinions were valued, however that the meetings were often medically dominated.

Staff invited members of the community teams that would provide aftercare following the young person's discharge to attend MDT and care programme approach (CPA) meetings to discuss discharge planning. All young people had a care, education and treatment review (CETR) within two weeks of admission and every three months following this. This was in line with national guidance.

There was a social worker in the team who was the key contact with the local authority.

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

We reviewed detention paperwork for all eight young people and found this was completed appropriately.

The hospital had recently been allocated a MHA administrator for one day a week. Staff told us that they read young people their rights on admission and monthly following this, however it was not documented that staff had reminded young people of their rights. The MHA

administrator wrote to each young person to explain their rights, however there was no consideration of their ability to understand the letters and they were not written in an easy-read format.

Young people had access to advocacy. A general advocate visited the ward every two weeks and offered to meet with all new young people. An independent mental health act advocate (IMHA) was also accessible. People detained under the Mental Health Act are legally entitled to access support from an IMHA. Staff we spoke with did not understand that there were different types of advocacy available.

The Mental Health Act was part of mandatory training but, however only 33% of staff had completed this.

Good practice in applying the Mental Capacity Act (MCA)

The Mental Capacity Act does not apply to people aged under 16. For people under 16 their decision making ability is assessed using Gillick competence. If a person under 16 can demonstrate that they have sufficient knowledge and understanding to fully understand what is involved in a proposed treatment then they are deemed to be Gillick competent. The responsible clinician completed capacity to consent to treatment assessments for all young people at the hospital using the same form despite capacity assessments and assessments of Gillick competence being different legal tests. Most staff we spoke with had a good understanding of the Mental Capacity Act, however were unable to explain Gillick competence.

The Mental Capacity Act was part of mandatory training but only 25% of staff had completed this.

Are child and adolescent mental health wards caring?

Requires improvement

Kindness, privacy, dignity, respect, compassion and support

Relatives told us that staff used negative language to describe young people's behaviour, often inferring that they were being aggressive and violent. We also found examples of this in handover notes and care notes we reviewed. For example staff described young people as "lazy" and "antagonistic". Some staff we spoke with used inappropriate terms to describe young people's behaviour, for example repeatedly using the word "flipped" when referring to a young person becoming distressed.

There was no evidence that staff provided support to relatives; some of whom lived a substantial distance from the hospital. One relative told us they would really appreciate some peer support.

The young person we spoke with told us that they felt safe on the ward. They said staff are polite and responsive when they request anything from them.

We carried out an observation at lunchtime using the short observational framework for inspection (SOFI 2) tool and observed a high number of positive interactions between staff and young people. Staff were engaging young people in conversation and a pleasant atmosphere was observed.

Involvement in care

The young person that we spoke with told us they felt involved in developing their care plan but there was no evidence of this in the care plan itself. Relatives we spoke with told us they had difficulties obtaining copies of care plans. One relative had not received a copy of the care plan despite requesting this on several occasions. Another relative told us they had to request a copy of the care plan multiple times, and when they were given a copy this contained the wrong name and pronoun and was not personalised to their child. No regular audits were carried out to ensure the quality of care plans.

The ward manager and consultant psychiatrist met with relatives on admission to get feedback from them about their views. Relatives were told to call the hospital at any time but relatives told us that communication was "abysmal" and that it was often difficult to get through to staff on the telephone. Relatives gave positive feedback about communication with senior medical staff who they found to be professional and courteous.

Young people and their relatives were invited to attend MDT and CPA meetings. Relatives told us that if they were unable to attend the meetings it was very difficult to get minutes afterwards and that when the minutes were sent they often contained errors.

Inadequate

Child and adolescent mental health wards

Young people and relatives we spoke with were unaware of being allocated a named nurse. Young people knew the names of the staff members looking after them on the ward.

Staff told us that community meetings took place occasionally but that these were not regular. Community meetings would provide young people with an opportunity to share their experiences of being on the ward, highlight any issues and review the quality and provision of activities with staff members.

Young people and their relatives had not been invited to take part in any surveys about their experiences of the service. They had also not been involved in the recruitment of new members of staff.

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

Requires improvement

Access and discharge

The hospital was commissioned to provide 12 beds and accepted referrals from across the country. At the time of the inspection, there were eight patients on the ward. Records showed that the time between referral and assessment for young people ranged from two to 10 days. Most young people had been admitted to the hospital within 14 days of their initial assessment. There was a delayed admission for one young person due to personal circumstances.

Two young people had been discharged from the hospital since it opened in April 2018. The average length of stay for those young people was 44 days. Where young people had been discharged staff had offered to facilitate joint visits with key workers from their new teams and kept their beds open for a week post-discharge in case of any unforeseen problems.

The facilities promote recovery, comfort, dignity and confidentiality

All young people had their own bedrooms with en-suite shower facilities. A bathroom was also available on the ward with supervised access. There was a quiet room, a de-escalation room, a sensory room and a seclusion room. Art work created by young people was on display in reception and a water cooler was available for visitors.

Many areas of the ward looked identical which could be disorientating. There were no signs on display to help direct people around the unit. There were also bright pictures on display and lots of loud noises. This meant the environment was not therapeutic for young people with autism. There was no evidence that young people had been consulted about the ward environment.

When young people were newly admitted to the ward they were shown to their bedroom and then given a tour of the rest of the ward and introduced to other young people once they felt settled. They were also given a handbook containing information about the ward.

Young people were able to personalise their bedrooms. A young person told us that they liked being able to put lots of pictures of things they liked on their wall.

Young people had lockable storage spaces in their bedrooms but did not have keys for these. They also had extra storage in a spare bedroom which was kept locked. This meant that they needed to ask staff if they wanted to access their belongings.

Cleaning staff cleaned clothes and bedding using laundry facilities available on the ward. Staff told us that name labels were added to clothing items to ensure they were returned to the correct person after washing, however a relative told us that items of clothing were frequently mixed up. All property belonging to young people was documented on a property list.

Two activity co-ordinators facilitated activities seven days a week. These included painting, colouring, computer access, baking and nail painting. All of the activities took place on the ward; the young people had not participated in any group activities or outings in the community. We requested individual timetables for each young person, however the timetables were identical.

Young people's engagement with the wider community

There was a school on-site which was staffed by a head of education, two teachers and a teaching assistant. The school was registered with the Office for Standards in Education (OFSTED) and provided 25 hours of education

during the week. The classroom could accommodate up to six young people. Computers were also available for supervised access. If young people were unable to go to the classroom staff would deliver teaching to them on the ward. A young person and relatives we spoke with gave excellent feedback about the education team.

Relatives we spoke to said that section 17 leave was rarely offered and when it was this was sometimes cancelled due to lack of staff, particularly on weekends. They told us that when leave was granted this was often just out to the car park or a drive to the local supermarket. They had concerns about lack of access to physical exercise and exposure to the wider community.

Meeting the needs of all people who use the service

The hospital was fully accessible and could therefore admit young people with physical disabilities.

Most staff were not adequately trained in communicating with young people with learning disabilities and/or autism. Some young people struggled to communicate verbally and this meant that staff struggled to communicate with them. Staff we spoke with did not use Makaton. Makaton is a method of communication using signs and symbols. Clinical staff members told us that they did not use resources which were available to help them to communicate with young people with learning disabilities. Staff told us that the education team had suggested communication aids such as picture cards or pointing devices they could use but they felt these would "de-skill" young people and so did not use them.

It was documented that four young people had been given a copy of their care plan. For one young person it had been identified that an easy read copy of their care plan was required, however this had not been provided. Staff told us that they were awaiting software to be able to produce easy-read versions of care plans which they were expecting to have installed in January 2019.

The young person we spoke with told us that the food at the hospital was very good. The chef met with young people every Friday and used recipe cards with pictures on to plan menu options for the following week and take into account any preferences they had. The chef had lists of young people's preferences on display in the kitchen and had a good understanding of their likes and dislikes.

There were no notice boards on display. Staff told us there had been previously but that these were taken down due to a number of incidents. There was also no staff photo board on display.

Listening to and learning from concerns and complaints

Complaints were investigated by the director of clinical services. When a complaint was received it was acknowledged in writing and responded to within 28 days. Recent complaints related to communication and temperature on the ward. Managers did not keep a central log of complaints.

Staff told us that if young people wished to complain they would be given a complaints form and a meeting would be arranged with the nurse in charge. Staff were unaware of any complaints that had been made or any feedback from outcomes from complaints.

A young person we spoke with said they knew how to make a complaint. Relatives said they would speak to the hospital director. One relative said they had made a complaint but the person investigating it left the service and it was not followed up.

Are child and adolescent mental health wards well-led?

Inadequate

Leadership

The hospital was not adequately equipped to care for young people with complex needs. The provider did not ensure that the service was managed by suitably competent staff; provide staff with the training needed to effectively carry out their roles; ensure that assessments were carried out by experienced professionals who could take into account the highly complex needs of young people or ensure that young people received care which was individually tailored to their needs.

The hospital director had overall responsibility for quality and safety within the hospital. They were supported by a senior management team comprising the consultant psychiatrist, support service manager, director of clinical services, ward manager, clinical psychologist and head of education.

Staff were aware of recent changes in the management team however felt this had not impacted on them. Staff told us that members of the senior executive team had regularly visited the ward.

Managers had a small budget dedicated for staff wellbeing which they had used to purchase extra furniture and a stereo for the staff room.

Vision and strategy

The provider had a list of values which underpinned the service. These were: putting people first, being supportive, acting with integrity, striving for excellence and being positive. These were covered as part of the staff induction. We spoke with new inductees during the inspection and they told us that vision and values had been covered on the first day of their employment, however other staff we spoke with did not know what these were.

Culture

The majority of staff we spoke with said they felt respected and valued although there were sometimes differences in opinion which could cause conflict. Staff were not aware of any instances of bullying or harassment within the team.

Staff were aware of the whistleblowing process, although some staff said they would hesitate to raise concerns as they weren't sure how these would be received. Where whistleblowing concerns had been raised, these had been investigated by a senior manager from another hospital within the Priory group.

Governance

The provider had a governance policy in place but local governance processes were still being devised and embedded. Minutes from governance meetings in June 2018 and October 2018 were available. Managers told us that a meeting also took place in September 2018 but no minutes had been taken. Because the meetings had been infrequent, there was little evidence of actions being followed up. Where minutes were available these had been placed in a communication folder in the staff room. Governance meetings for 2019 had been arranged to take place once a month with an allocated chair and minute taker.

There were inconsistencies in care notes. For example, four young people had inconsistent observation levels recorded. At the top of the screen it stated what level of observation they were on, but in the text it stated a conflicting level of information. This meant it could be difficult for staff to ascertain what level of observation young people should be on.

There was no regular local audit programme in place to assure quality at the hospital.

The provider had a site improvement plan in place which senior staff reviewed in weekly teleconferences with the director of nursing. A named individual was responsible for each action on the plan.

Management of risk, issues and performance

The provider had a risk register and business continuity plan in place. This meant that the delivery of care and treatment could continue in case of an unexpected event, for example flooding or power failure.

Managers told us that performance issues would be addressed within meetings with staff and that there was a capability procedure which would be followed. There had been some incidents where agency staff had acted inappropriately which had been investigated, agencies informed and those staff no longer booked to work at the hospital.

Information management

Care records were stored electronically on a password protected system. Staff had access to the information technology needed to carry out their roles, however only 13% of staff had completed training in data protection and confidentiality and 43% had completed training in IT security.

Engagement

The hospital did not have any mechanisms in place for staff to provide feedback about the service or suggest improvements. A staff member told us about some innovative ideas they had to improve the service, however they didn't have a suitable forum to raise these ideas or know who they could speak to about them.

Learning, continuous improvement and innovation

There was no evidence of innovation or quality improvement methodologies being used at the hospital.

Inadequate

Child and adolescent mental health wards

The hospital was not a member of the Quality Network for Inpatient CAMHS (QNIC). QNIC is a quality improvement initiative which peer reviews services against a set of evidence-based standards. The provider told us they intend join QNIC in 2019.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there is a clear process in place for sharing lessons learned from incidents with staff, including lessons learned from the wider organisation.
- The provider must develop mechanisms for young people and their relatives to provide feedback about the service.
- The provider must ensure there is sufficient provision of psychological therapies.
- The provider must ensure that care plans are personalised and where specialist needs are identified these are sufficiently met.
- The provider must ensure that staff use appropriate language and terminology to describe young people's behaviour.
- The provider must develop positive behaviour support plans for young people and ensure that staff are appropriately trained and supervised to deliver these.
- The provider must develop individual activity timetables for young people.
- The provider must individually risk assess restrictive practices on the ward.
- The provider must ensure that young people have access to water at all times.
- The provider must ensure that staff are suitably trained to care for young people with learning disabilities and/or autism.
- The provider must ensure that specialist assessments are carried out by staff who are appropriately skilled and competent in communicating with young people with learning disabilities and/or autism.
- The provider must ensure that staff are compliant with mandatory training.
- The provider must implement a robust supervision process.
- The provider must ensure the environment is suitable for young people with autism.
- The provider must work to improve communication with relatives.
- The provider must ensure staff are trained in search techniques and the reasons for this recorded for each young person with appropriate consent where needed.
- The provider must ensure there are mechanisms in place for staff to provide feedback and suggestions.
- The provider must ensure there are robust governance systems in place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have robust governance processes in place. There was no clear process in place for sharing learning from incidents. There were no formal mechanisms in place for staff, young people or relatives to give feedback about the service. Regulation 17 (2) (a)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The provider did not offer sufficient provision of psychological therapies or specialist assessments carried out by competent professionals to ensure that young people's individual needs were met. Where specialist needs had been identified these had not been met. Staff used negative language to describe young people's behaviour. The environment was not well adapted for young people with autism. Regulation 9 (1) Young people did not have positive behaviour support plans in place. There were blanket restrictions in place around locked doors which meant young people were sometimes unable to access water. Restrictive practices were not individually risk assessed. Young people did not have individualised activity timetables in place. Care plans were not personalised. Communication with relatives was poor. Regulation 9 (3) (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not recruit staff with the relevant experience nor provide sufficient training to ensure staff were competent to care for and communicate with young people with learning disabilities and/or autism. Regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

The provider did not have a robust supervision process in place. Compliance with mandatory training was very low. Staff searched young people but had not received training in conducting searches.

Regulation 18 (2)(a)