Priory Healthcare Limited

The Priory Ticehurst House

Inspection report

Ticehurst
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The Priory Ticehurst House is an independent hospital which provides inpatient mental health treatment to adults and young people.

We undertook an unannounced comprehensive inspection to determine if the service was providing safe and good care to patients and young people and to check if the service had made improvements, we told them they must make.

Since this inspection, the provider decided to close the two child and adolescent mental health wards of the hospital. This was because the provider was experiencing issues recruiting enough nursing and medical staff for this service. This decision was not related to our inspection activity.

The acute wards for adults of working age remain open.

Our rating of this location stayed the same. We rated it as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. However, on the adult wards, some of the patients' care plans were more basic and generic than others. Staff provided a range of treatments suitable to the needs of the patients and young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training. The ward staff worked well together as a multidisciplinary team and had effective working relationships with external teams and organisations. Most staff told us they felt supported and could speak with their manager when they needed to.
- Staff treated patients and young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients and young people. They actively involved patients and families and carers in care decisions. Staff on the children and adolescent wards interacted with young people in a way that appealed to their age group and empowered young people to be partners in their care.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well-led, and the governance processes mostly ensured that ward procedures ran smoothly.

However:

Staff did not understand or discharge their roles and responsibilities under the Mental Capacity Act 2005. Capacity to consent assessments and recording was not always in line with current legislation. Staff did not document their rationales for the decisions they made, and they did not support people who lacked capacity through best interest decisions.

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	Our rating of this service stayed the same. We rated it as good because: • The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well and they minimised the use of restrictive practices. • Staff managed medicines safely and followed good practice with respect to safeguarding. The service treated concerns and complaints seriously. • Staff developed recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received appropriate training. The ward staff worked well together as a multidisciplinary team. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983. • Staff treated patients with compassion and kindness and understood the individual needs of patients. They actively involved patients in care decisions and kept families informed about their loved one's care. All staff interactions that we observed with patients were caring and respectful and most patients spoke positively about staff. • The service managed beds well and patients were discharged promptly once their condition warranted this. • The service was well-led and most of the governance processes ensured that ward procedures ran smoothly. However: • We observed that some ward areas needed repairs and redecoration. • Staff did not always receive regular clinical and managerial supervisions.

Summary of findings

- Staff did not always understand the provider's policy on the Mental Capacity Act 2005 and did not record capacity clearly for patients who might have impaired mental capacity.
- Governance processes specific to the oversight of the Mental Capacity Act were not always effective and did not identify the concerns we found during the inspection.

Child and adolescent mental health wards

Good

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

- The service provided safe care. The service had enough nursing and medical staff and received basic training to keep young people safe from avoidable harm. Staff assessed and managed risks to young people and themselves well. Staff understood how to protect young people from abuse. Managers investigated incidents and shared lessons learned.
- Staff assessed the physical and mental health of all young people and managed medicines safely. They developed individual care plans, which they reviewed and updated regularly. Managers made sure they had staff with a range of skills needed to provide high quality care. Staff from different disciplines worked together as a team to benefit young people.
- Young people were truly respected and valued as individuals and were empowered by staff as partners in their care. Feedback about the way staff treat young people was highly positive. Staff recognised and respected the totality of people's needs and were motivated and inspired to deliver the best care. Staff valued their relationships with young people.
- Staff planned and managed discharge well. The ward environments supported young peoples' treatment needs and privacy and dignity. Staff facilitated young people's access to high quality education throughout their time on the ward. The service treated concerns and complaints seriously.
- Staff felt respected, supported and valued. Ward teams had access to the information they needed to

Summary of findings

provide safe and effective care and used that information to good effect. Most governance processes operated effectively, and performance and risk were managed well.

However:

- Staff did not always support young people to make decisions on their care for themselves. Staff did not always assess and record consent and capacity or competence clearly for young people who might have impaired mental capacity or competence. Staff did not clearly record their reasons for the decisions they made on behalf of young people.
- Governance processes specific to the oversight of the Mental Capacity Act were not always effective and did not identify the concerns we found during the inspection.

Summary of findings

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Summary of this inspection

Background to The Priory Ticehurst House

The Priory Ticehurst House is situated in Wadhurst, East Sussex. It is an independent hospital which provides inpatient mental health treatment to adults and young people.

There were two child and adolescent mental health (CAMHS) wards for young people ages 12-18 years. Keystone is a 12-bed mixed sex, purpose built psychiatric intensive care unit. Upper Court is a 13-bed female only ward which is a general CAMHS ward that provides assessment and treatment for children and young people with emotional, behavioural or mental health difficulties. There was an Ofsted-registered school on site which supports young people with educational needs. At the time of the inspection, the service had voluntarily paused admissions due to medical staff shortages.

There were three acute wards for adults of working age. Newington Court 1 and 2 is a combined 21-bed female only ward. Newington Court 2 is a step-down ward where patients on Newington Court 1 move to. Garden Court is a 13-bed, male only ward. Highlands ward is a 9-bed ward for private paying patients only.

The Priory Ticehurst House is registered to provide the following regulated activities:

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

There is a registered manager at the service.

The child and adolescent mental health wards were last inspected in December 2020. This was an unannounced, focused inspection and we specifically looked at some aspects of the key questions, are services safe, effective and well-led. In September 2019, we had rated the key question safe and well led as inadequate and still had some concerns because of information we had received from young people and parents about whether services were safe. Following the December 2020 inspection, we told the provider to ensure that young people were involved in the decision making about the use of closed-circuit television in their bedrooms and that consent was sought appropriately. We also told the provider to ensure that there was effective governance and oversight of the use of closed-circuit television in young people's bedrooms and that Priory policies were adhered to. We did not rerate the service following the December 2020 inspection as we only looked at specific key lines of enquiry in the key questions are services safe, effective and well-led. Therefore, the previous rating of inadequate remained in place. We found that some elements of these requirements were met during the comprehensive inspection carried out in April 2021.

The adult acute psychiatric service was last inspected as a full comprehensive inspection of the location in April 2018. The service was rated as good overall and good in each domain.

What people who use the service say

People who use the acute adult service were largely positive about their experiences at the hospital. Most of the patients we spoke with reported feeling safe and felt that the staff took a genuine interest in their care and wellbeing. Patients told us that most of the time there were enough staff on the wards and that they had the opportunity to participate in a range of activities. Patients told us that the wards were clean, the quality of the food was good, and that staff were always available. Most of the patients said that they were able to seek advice and support from staff about their physical health.

Summary of this inspection

We also received positive feedback from the families we spoke with, in particular, about the quality of care their family members received from staff.

However, some patients felt that they have not been adequately involved in their care planning and that they would like more information and support around healthy eating and exercise. Some patients also told us that some repairs were needed on the wards.

Young people, relatives and carers were overwhelmingly positive about staff and the quality of care they received. Young people said staff were engaged with them with appropriate humour which they liked. They said staff were caring and supportive and they felt truly respected, involved and empowered to make decisions as individuals in the therapies and treatments offered to them. Some young people were keen to tell us about specific members of staff they felt had provided outstanding care and support to them. Relatives and carers told us they felt staff knew the young people very well. They felt involved in contributing to their relatives' care and treatment and were invited to attend meetings to discuss their care and were aware of plans and goals for discharge. Relatives and carers said that staff communicated well with them and they were kept well informed of every aspect of their relatives' care and treatment. They told us that they felt staff listened to and respected their views and they felt the support received from staff to be invaluable.

How we carried out this inspection

The team that inspected the hospital comprised one CQC inspection manager, four CQC inspectors, one medicines inspector (remotely), two specialist advisors and two experts by experience (one remotely).

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

During the inspection, we looked at the quality of all the ward environments, observed how staff were caring for patients and young people and spoke with patients and young people who used the service and some family members.

We looked at electronic and paper copies of care and treatment records of patients and young people and reviewed a range of documents relating to the running of the service. We also looked at the medicines management on all wards including medicine charts and associated Mental Health Act 1983 documentation and physical health monitoring following administration of rapid tranquilisation.

We observed multidisciplinary team meetings, community meetings and handovers. We also spoke to the hospital's senior managers, ward managers, doctors, clinical pharmacist, Mental Health Act administrator and other staff members, including members of the multidisciplinary team, nurses and health care assistants.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the provider MUST take is necessary to comply with its legal obligations. Action a provider SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

We told the provider that they MUST take the following actions:

Summary of this inspection

- The provider must ensure that capacity assessments are completed in accordance with the requirements of the Mental Capacity Act 2005 and the associated Code of Practice. Consent must be sought appropriately, and specific decisions must be recorded to demonstrate why capacity assessments have been completed. This applies to both the adult and children's wards. (Regulation 11, of the Health and Social Care Act 2008 (RA) Regulations 2014).
- The provider must ensure that where patients or young people lack capacity to consent or do not consent, staff adhere to the Mental Capacity Act 2005 and associated Code of Practice and assess and record best interest decisions. This applies to the children's wards. (Regulation 11, of the Health and Social Care Act 2008 (RA) Regulations 2014).

We told the provider that they SHOULD take the following actions:

- The provider should ensure that staff receive regular clinical and managerial supervisions. This applies to the adult wards.
- The provider should strengthen governance processes to highlight gaps in recording of Mental Capacity Act assessments. This applies to the whole hospital.

Our findings

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	Requires Improvement	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Requires Improvement	☆ Outstanding	Good	Good	Good
Overall	Good	Requires Improvement	Good	Good	Good	Good

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

Good

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

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

Good

Our rating of safe stayed the same. We rated it as good because:

Safe and clean care environments

- All wards were safe, clean well equipped, well-furnished and fit for purpose. However, they were not always well maintained.

Safety of the ward layout

- Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. We saw evidence of environmental and security checks completed by staff. We also saw completed comprehensive ligature risk assessments and enough staff to observe patients in all areas.
- Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

- Ward areas were clean, well-furnished and fit for purpose. Staff made sure cleaning records were up-to-date and the premises were clean. During the inspection, we saw staff cleaning in all wards.
- We found that the provider had in place protocols and procedures to keep people safe from Covid-19.

Clinic rooms and equipment

- Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.
- Staff checked, maintained, and cleaned equipment.

Safe staffing

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.

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

Good

- The hospital employed long term locum agency staff to cover vacancies and managers made sure all bank and agency staff had an induction and understood the service before starting their shift. We saw completed induction checklists for staff. The ward managers could adjust staffing levels according to the needs of the patients.
- Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.
- The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Managers could call locums when they needed additional medical cover. During the inspection, we witnessed a medical emergency incident in Garden Court ward where staff responded in a coordinated, calm and effective way.

Mandatory training

- The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.
- Face-to-face training for the staff had been difficult to organise during the Covid-19 pandemic. However, the hospital has taken advantage of some areas of the hospitals where face to face training could be safely delivered and organised some important core training there, such as prevention and management of violence and aggression.

Assessing and managing risk to patients and staff

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. We saw that staff were completing thorough risk assessments which were regularly reviewed.
- Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The majority of the patients we spoke with, told us that they have not experienced any restraints while at the hospital.
- Levels of restrictive interventions were low. We found that the service had implemented restrictive practices meetings with actions to reduce such practices where possible.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff knew how to make a safeguarding referral and who to inform if they had concerns. We saw evidence that the provider appropriately reported and recorded safeguarding incidents. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff access to essential information

- Staff had easy access to clinical information, and it was easy for them to maintain patients records which were stored securely.

Medicines management

- The service used systems and processes to safely prescribe, administer and record medicines.
- During the inspection we found that the service had policies in place to safely manage medicines and support people to receive them as prescribed. Staff were assessed to ensure they were competent to administer medicines safely. Staff assessed people's mental capacity and completed documentation in line with requirements of the Mental Health Act 1983.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.

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

Good

- Resident doctors checked people's regular medicines when admitted to the service and prescribed for them. A clinical pharmacist reviewed people's prescription charts weekly to ensure medicines were prescribed appropriately. Any interventions made were communicated with prescribers and nursing staff.
- The clinical pharmacist checked that prescribers and nursing staff had acted on any advice given. Medicines used to manage people's behaviour were prescribed in line with the provider's policy and national guidance. People had individual behavioural support plans in place and medicines were only used when other techniques to deescalate a behaviour were unsuccessful. Staff monitored people's physical health when these medicines were given.

Track record on safety

- The service had a good track record on safety and managed patient safety incidents well. Staff recognised incidents and reported them appropriately.
- Managers investigated incidents and shared lessons learned with the whole team and the wider service. We found that managers regularly issued lessons learnt and clinical governance bulletins which were distributed in the hospital for staff to remind themselves of key points and actions.
- Managers debriefed and supported staff after any serious incidents. Staff had the opportunity to discuss feedback during meetings and to look at improvements to patient care.

However:

- Some ward areas needed repairs and redecoration. The provider explained the difficulties experienced because the of the listed building and the current pandemic and told us that there were some ongoing works taking place, such as replacing the heating system, alarms and windows. The provider also told us that there were plans to redecorate the building as the works progress. During the inspection, we observed contractors carrying out works.
- Some staff told us that sometimes it was a challenge to organise cover for all shifts and staffing levels were low mainly because of the impact of the pandemic. Managers told us that staffing levels and recruitment for substantive staff remained an ongoing challenge, but there was a rolling recruitment plan in place. Several healthcare assistants had been recently recruited.
- During the first day of the inspection visit, we found that some items kept in the clinic rooms, such as saline solution and urine testing strips, were out-of-date. The provider took action and rectified this the next day and showed us what measures they had put in place to mitigate any future risks.

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

Requires Improvement

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

- Staff on Newington Court ward did not always record capacity clearly for patients who might have impaired mental capacity. We reviewed six capacity assessments and found that all of them were incorrectly completed. Some assessments did not have a specific decision recorded to demonstrate why the capacity assessment was completed. There was either general decisions recorded, for example agreement to admission and treatment, or no decision in the specific decision box.
- Some staff told us that they did not receive regular clinical and managerial supervisions and the supervisions matrix we reviewed reflected this, although most of the staff we spoke with told us that they felt supported, could approach managers when needed and regularly participated in team meetings.

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

Good

However:

Assessment of needs and planning of care

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. During the inspection we saw evidence of thoroughly recorded multidisciplinary team meetings. We reviewed 18 patient care plans and we found that they reflected the assessed needs of the patients.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. During the inspection we saw that there were therapeutic activity timetables in place in all wards which included a range of activities led by various members of the multidisciplinary team. Staff ensured that patients had good access to physical healthcare. During the inspection we found that staff identified patients' physical health needs appropriately and recorded them on their care plans. We found evidence of comprehensive escalation plans for physical health conditions and saw that physical health audits were taking place. We also found that on some ward's doctors ran effective medical emergency practice sessions for staff.
- Staff used recognised rating scales to assess and record severity and outcomes, such as Health of the Nation Outcome Scales. Staff also participated in clinical audit and we saw thorough minutes of regularly held clinical governance meetings.

Skilled staff to deliver care

- The ward teams had access to a range of specialists required to meet the needs of patients on the wards. We found that there were consultants and speciality doctors on the wards, and we spoke with some of them. We also found that on Highlands ward patients were benefiting from substantial psychotherapy and occupational therapy input.
- Managers gave each new member of staff a full induction to the service before they started work. During the inspection we found that a group of new staff members were receiving induction training.

Multi-disciplinary and interagency teamwork

- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.
- We found that staff held regular multidisciplinary meetings to discuss patients and improve their care. We attended a morning multidisciplinary meeting and a handover meeting, and we observed that staff were sharing detailed information about patients and any changes in their care. We also observed that staff teams from different wards were supporting each other and responded to emergencies when needed.

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

- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from a Mental Health Act administrator who also provided regular training to staff.
- The service had relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

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

Good

Good

Our rating of caring stayed the same. We rated it as good because:

Kindness, privacy, dignity, respect, compassion and support

- Staff treated patients with compassion and kindness. During the inspection we saw staff interacting with patients and supporting them with various tasks. The atmosphere on the wards felt calm and settled. Most of the patients we spoke with told us that staff treated them well and behaved kindly.
- All the staff we spoke with told us that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients and that any complaints were appropriately investigated.

Involvement in care

- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. We found that patient involvement in assessment and care planning was documented in their care plans and there were regular multidisciplinary reviews. We also found that the service conducted patient surveys and produce relevant action plans.
- We observed two well-attended by staff and patients' community meetings in Newington Court and Garden Court wards. We felt that patient involvement was good and staff handled well the situation.
- Staff ensured that patients had easy access to independent advocates. We saw that sessions with the advocates have been incorporated into activity timetables.
- Staff informed and involved families and carers appropriately. A parent told us that staff keep her updated about her daughter's care and was given information about the ward and how they planned to care for her daughter. Another family member told us that the hospital had arranged a video call for them to attend a review

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

Good

Our rating of responsive stayed the same. We rated it as good because:

Bed management

- During the inspection there were 15 patients in both Newington Court wards, 12 in Garden Court and four in Highlands ward. Staff managed beds well. This meant that a bed was available when needed and that patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. For example, staff told us that the Newington Court 2 ward was used as a stepdown ward for Newington Court 1 ward. Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to.

Discharge and transfers of care

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

Good

- Discharges were overall planned and managed well. We saw documented evidence that consultants were appropriately reviewing patients prior to discharge and found that comprehensive admissions and discharge checklists were in place for staff in charge to follow. Managers told us that the hospital continued to monitor patients 48 hours after discharge.

Facilities that promote comfort, dignity and privacy

- Each patient had their own bedroom, which they could personalise. Patients could keep their personal belongings safe. The service had quiet areas and rooms where patient could meet with visitors in private and an outside space that patients could access easily. Patients could make phone calls in private.
- The food was of a good quality and patients could make drinks and snacks at any time. We found that the hospital provided a variety of food to meet the dietary and cultural needs of individual patients. We observed that patients were given menus every day to choose their preferred meals.

Patients' engagement with the wider community

- Staff helped patients to stay in contact with families and carers. We saw that there were facilities for patients to make phone calls. Some staff and carers told us that the service could organise video calls for patients who wanted to keep in contact with families and friends. The service provided wi-fi for access to the internet.

Meeting the needs of all people who use the service

- The service met the needs of all patients. Staff helped patients with communication, advocacy and cultural and spiritual support. Managers told us that occupational therapists ensured that appropriate support was available for any patients with additional needs and there was access to interpreters when needed.
- Staff made sure patients could access information on treatment, their rights and how to complain.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously, investigated them, learned lessons from the results and shared these with the whole team and the wider service. During the inspection we saw the hospital's complaints records and found that staff had responded appropriately. No particular themes were identified. We also saw that the hospital kept a compliments record and found that they had received a number of compliments since January 2021.
- Patients knew how to complain or raise concerns. The service displayed information about how to raise a concern in patient areas, however we observed that in Garden Court ward this information was missing. We raised this with the ward manager who told us that he was aware and explained that staff were reviewing the information on the ward's notice boards.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good

Our rating of well-led stayed the same. We rated it as good because:

Leadership

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

Good

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Ward managers worked shifts on the wards as and when required.
- We spoke to members of the senior management team and found that they were open and honest and clearly described their vision and plans for the hospital. They clearly explained their roles and how the teams worked to provide quality care.

Culture

- All staff we spoke with felt respected, supported and valued. They told us that leaders are responsive and felt able to raise concerns with them.
- Staff also reported that despite the challenges with staffing levels, staff morale was good and positive changes have been implemented since the current leaders commenced employment at the hospital.

Governance

- Team leaders and senior management had daily meetings to discuss the day's running of wards and clinical governance meeting monthly to discuss clinical risk. We attended a comprehensive multi-disciplinary morning meeting and a handover and found that there were a range of other meetings taking place regularly, such as staff meetings and therapy staff meetings. Monthly learning from experience meetings ensured that change in practice was identified based upon previous learning from incidents hospital wide and disseminated to ward level staff.
- Various audits were in place at ward level and feeding into the hospital governance framework. Incidents, safeguarding and complaints were appropriately logged, investigated and learned from.

Management of risk, issues and performance

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner.
- The service had an electronic risk register where highest risks were clearly identified, all with actions to mitigate.

Information management

- Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed.
- Managers had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and service performance data.

However:

- There was a lack of clear governance processes to highlight gaps in relation to the recording of the Mental Capacity Act assessments.

Good

Child and adolescent mental health wards

Safe	Good
Effective	Requires Improvement
Caring	Outstanding
Responsive	Good
Well-led	Good

Are Child and adolescent mental health wards safe?

Good

Our rating of safe improved. We rated it as good because:

Safe and clean care environments

Safety of the ward layout

- Staff completed and regularly updated thorough risk assessments of all ward areas and removed or reduced any risks they identified. Staff's daily environmental checks included checking the security of the ward and looking for hazards, such as furniture that needed repair or faults within the building. Staff escalated concerns appropriately to the ward managers and maintenance department, and issues were resolved in a timely way. Environmental risk was also reviewed as part of the monthly clinical governance framework. At the time of the inspection, the heating and air-conditioning system on Upper Court was being repaired/replaced. Managers also told us about plans to replace over 40 windows on Upper Court to improve safety. Managers ensured that when building/maintenance was needed on the wards, they tried to minimise disruption to the young people and staff and communicated with them, so they knew about it.
- Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The furniture and facilities on both wards were designed to reduce or eliminate the risk of ligature anchor points. Keystone was a purpose-built ward which met the national criteria needed to support the function of the ward.
- Staff could observe young people in all parts of the wards. The layout of Keystone allowed the nursing staff to have a good line of sight from the nursing office into the communal areas and bedroom corridors and outside secure garden space. The layout of Upper Court made it more difficult for good lines of sight with no direct view from the nursing office into communal areas or bedroom corridors. Upper Court was located on the first floor of the main building and did not have direct access to garden space. They shared a garden area with one of the adult wards and had a system in place to ensure people were safe when accessing the garden. Closed circuit television covered both wards, excluding bathrooms. This was continuously monitored by an external company who had a direct dial and designated phone for each ward so they could escalate any concerns for staff to follow up on. We observed staff on both wards were visible in the communal areas. Bedroom doors were anti-barricade and had a vision panel which enabled young people to have privacy whilst allowing staff to carry out observations in an unobtrusive way.

- The wards complied with guidance on mixed sex accommodation. Upper Court was a female only ward. Keystone was for both males and females. All bedrooms were en-suite so young people did not have to walk past someone of the opposite sex bedroom to access bathroom and toilet facilities. At the time of the inspection, all young people on the ward were female. Staff told us no males had been admitted to Keystone since last year.
- Staff had easy access to alarms and young people had easy access to nurse call systems. All staff signed for their ward keys and carried them safely and they were attached to them at all times. All staff were issued with personal alarms. Nurse call alarms were throughout the ward, including in young people's bedrooms and en-suites. Staff alarms and nurse call alarms on the wards were checked by staff daily to make sure they worked. Both wards had an intercom and entrance area prior to accessing the ward environment which provided added security on entry and exit to the wards.

Maintenance, cleanliness and infection control

- Ward areas were clean, well-furnished and fit for purpose.
- Staff made sure cleaning records were up-to-date and the premises were clean. Both wards had dedicated house-keeping assistants. They followed a planned cleaning schedule. Cleaning materials were safely transported on a trolley throughout the wards and were stored in a locked cupboard when not used. Young people told us the wards were always kept clean and staff encouraged and supported them to keep their bedrooms clean and tidy.
- Staff followed infection control policy, including handwashing. Staff used equipment and control measures to protect young people, themselves and other people from infection. All staff were wearing masks and underwent regular testing to minimise the risks of Covid-19.

Seclusion room

- On Keystone, there was a seclusion suite and de-escalation room which allowed clear observation and two-way communication. It had a toilet and a clock, which young people could see easily. The seclusion suite and de-escalation room had been designed to allow young people direct access to a secure outside space.

Clinic room and equipment

- Staff checked, maintained, and cleaned equipment. Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. The location of the emergency grab bags and oxygen was signposted, centrally located on the wards and easily accessible. Staff we spoke with all told us where they could find it if needed.

Safe staffing

- The service had enough nursing and support staff to keep young people safe. During our inspection, we observed sufficient numbers of staff on both wards. Staff worked 12 hour shifts and the number of staff needed was calculated depending on the number and needs of the young people. Staff told us and we are aware of shifts where staffing numbers were sometimes low. Managers told us that sometimes, staffing numbers were affected due to staff sickness, injury or agency staff cancelling shifts. They told us that they would always try and get cover from another agency or bank staff and the wards would always be supported by the ward manager and members of the multidisciplinary team working on the wards when needed. Staffing levels were reviewed by the senior managers daily at the hospital wide 'Flash' meeting and where wards had additional staff they could be used to support wards who needed help. Staff told us their breaks were rarely affected. Young people did not raise any concerns about the numbers of staff on the wards and said it did not affect activities on the ward or their leave from the ward.
- The provider had responded to the ward managers and consultant psychiatrists in restricting the number of young people admitted to the wards to support staff managing the high acuity of the young people. On Keystone, the service was currently admitting no more than six young people onto the ward at any one time. On Upper Court they were admitting no more than five young people.

- The service had enough staff on each shift to carry out any physical interventions safely.
- The ward manager could adjust staffing levels according to the needs of the patients.
- Managers made sure all bank and locum staff had a full induction and understood the service before starting their shift. Both the ward managers were locum staff and told us they received good training and induction from the hospital. Agency staff received training via their agency and a ward orientation and ward induction. Agency staff we spoke with confirmed this. Most agency staff had worked on the wards previously and said they were familiar with the wards.
- Young people had regular one-to-one session with their named nurse. Young people told us staff were always available to speak with them and their conversations were meaningful and helpful.
- Levels of sickness across the wards were relatively low. Staff told us they felt well supported by their managers when returning to work after time off due to sickness or injury.

Medical staff

- The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. Each ward had one full-time, permanent consultant psychiatrist and they were supported by a locum junior doctor. Although the junior doctor was not a specialist in mental health, they specifically took a lead on monitoring the young peoples' physical health. The consultant psychiatrists shared out of hours on call with consultant psychiatrists from another Priory service, located closely, who also worked with children and young people. There was also out of hours general medical cover provided by a locum agency.

Mandatory training

- Staff completed their mandatory training. Training was across 19 mandatory courses which included safeguarding, basic and immediate life support, diversity and inclusion and fire safety. Across the hospital just over 78% of staff were up to date with their training. There were additional courses for staff to also complete, which included bribery and recording incidents on the electronic recording system.
- Managers monitored mandatory training and alerted staff when they needed to update their training. Where there were gaps in training, staff were informed when they needed to complete the training by. Training needs were discussed with staff during their individual supervision and was also monitored regularly and via the providers central training academy. Checks were in place to ensure that agency staff had completed mandatory training prior to them working shifts on the wards.

Assessing and managing risk to patients and staff

Assessment of patient risk

- Staff completed risk assessments for each young person on admission, and reviewed this regularly, including after any incident. Records contained up-to-date risk assessments and management plans which were comprehensive. Risk information was discussed during each shift-to-shift handover, at daily multidisciplinary team meetings and as part of the wider hospital daily 'Flash' meeting. Information about young peoples' risks was also discussed as part of their weekly ward round. This meant staff could identify and respond to any changes in risks to, or posed by, young people.

Management of patient risk

- Staff knew about any risks to each young person and acted to prevent or reduce risks. Staff we spoke with had good working knowledge of the risks of all the young people. They described to us the strategies they used to help manage patient risk and support the young people to manage their own risk. This included the making and the use of coping cards, which young people made in collaboration with staff.

- Staff followed the provider's policies and procedures when they needed to search young people or their bedrooms to keep them safe from harm. On each shift a member of staff was allocated as a designated security lead. Staff had a good understanding of relational security which focussed on the quality of relationships between staff and young people to improve safety on the wards. They clearly described the reasons why a search of a patient or their bedroom may be necessary. Young people told us that when their rooms had been searched, staff would let them know the reasons why and would make sure they left their belongings as they found them.

Use of restrictive interventions

- Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.
- Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained young people only when these failed and when necessary to keep the patient or others safe. In the last twelve months, on Keystone the number of restraints ranged between 38 to 231 per month. On Upper Court they varied between 11-94 per month. We spoke to staff and managers who told us the closed-circuit television, which was both visual and sound, was continuously monitored by an external agency. They provided feedback to the hospital on how well staff used de-escalation and if restraint was used, if it was appropriate and in line with national guidance and policy. The wards had recently received praise when using de-escalation particularly well during a challenging incident which averted the need for restraint. The service also reviewed closed circuit television when reviewing incidents.
- Staff followed NICE guidance when using rapid tranquilisation. Where young people had been administered medicines via rapid tranquilisation, records were complete and detailed with reasons why recorded. Together, young people and staff developed individual behavioural support plans and medicines were only used when other techniques to de-escalate a behaviour were unsuccessful. Staff monitored people's physical health when these medicines were given.
- When a young person was placed in seclusion, staff kept clear records and followed best practice guidelines. In the last 12 months there had been 34 episodes of seclusion on Keystone. Seclusion was not used on Upper Court.

Safeguarding

- Staff received training and understood how to protect young people from abuse and the service worked well with other agencies to do so. Staff completed both face-to-face and e-learning training in safeguarding adults and children at risk. Information given to us by the provider showed 94% of staff were up to date with their combined face-to-face training.
- Staff knew how to make a safeguarding referral and who to inform if they had concerns. The provider had a named nurse and doctor for child safeguarding and the social work team took a lead on supporting staff with safeguarding. Safeguarding logs were in place across the wards and actions taken were appropriately reported through the clinical governance framework and to organisations outside of the hospital where necessary. Safeguarding was discussed daily as part of handovers, multidisciplinary team meetings and hospital wide 'Flash' meetings. This ensured ward and senior leadership oversight and that the right action could be taken at the right time to minimise or prevent harm to people.
- Managers took part in serious case reviews and made changes based on the outcomes. They worked with other agencies, including commissioners and the local authority safeguarding team to protect young people. Managers told us about some investigations that were currently taking place.

Staff access to essential information

- All staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- Records were stored securely. Each ward was supported by a ward clerk who helped to maintain records.

Medicines management

Good

Child and adolescent mental health wards

- Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Room and fridge temperatures were monitored to ensure they were within the recommended ranges. Wards had appropriately labelled waste containers for the safe disposal of unwanted medicines, which they also recorded. Staff were assessed to ensure they were competent to administer medicines safely and regular audits took place and action taken to improve practice.
- Staff reviewed young peoples' medicines regularly and provided specific advice to young people and carers about their medicines. A clinical pharmacist reviewed young people's prescription charts weekly to ensure medicines were prescribed appropriately. Any interventions made were communicated with prescribers and nursing staff. The clinical pharmacist checked that prescribers and nursing staff had acted on any advice given.
- Staff followed current national practice to check young people had the correct medicines. Resident doctors checked young people's regular medicines when admitted to the service and prescribed for them.
- The service had systems to ensure staff knew about safety alerts and incidents, so young people received their medicines safely.
- Staff reviewed the effects of each young person's medication on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. Staff carried out regular physical health checks, including vital signs, blood pressure and electro-cardiograms. Doctors reviewed young people who had complex health needs, including eating disorders.

Track record on safety

Reporting incidents and learning from when things go wrong

- Staff raised concerns and reported serious incidents and near misses in line with provider policy. Staff we spoke with knew what incidents to report and how to report them.
- Managers debriefed and supported staff after any serious incident. Staff spoke positively about the support they received. They also told us they ensured young people were supported following an incident. Young people we spoke with confirmed this.
- Managers investigated incidents thoroughly. Young people and their families were involved in these investigations, where appropriate. Investigations and actions were regularly reviewed during monthly clinical governance meetings to track progress.
- Managers shared learning and feedback about serious incidents or near misses in handovers and staff meetings. A one-page bulletin was shared with staff regularly and was printed off, displayed on the wards, and in the staff canteen. Staff we spoke with were able to tell us about changes that had been made following incidents, including those on other wards.
- Ward managers shared details of incidents with the other ward managers and the senior team at the daily flash meeting. This meeting allowed ward managers and clinical staff to quickly share information relating to safety, risk and safeguarding for the whole hospital and identify any actions that needed to be taken and assign actions to staff.

However:

- The service had high vacancy rates. The provider told us they had an 80% vacancy rate for registered nurses across the hospital, which also included some deputy ward manager posts. Because of this the service had high rates of bank and agency nurses. Where possible, the service tried to recruit locum staff in the absence of permanent staff or use agency staff who were familiar with the service. The provider told us about their ongoing recruitment plan to address the staffing shortages, including discussions with the commissioners about potentially trialling new recruitment approaches.

Good

Child and adolescent mental health wards

- We found out of date items of stock and gaps in checks. On Keystone, we found out of date urinalysis testing strips and other medical supplies (not medicines). We raised this immediately with managers during the inspection and they told us they would take action. The next day staff showed us the checking system they had put in place which had been implemented across all the wards at the hospital with checks already completed and out of date stock all removed and replaced. Following the change, we checked back on Keystone and could see improvements had been made.
- The ward was not always well maintained. Both wards had general decoration work needed, including paint work that needed to be refreshed. On Keystone, the nursing office had two doors, one directly exited onto the lounge communal area on the ward and the other to the corridor just outside the ward. One of the doors was broken and had been for some time. However, we spoke with head of maintenance and were informed a specialist company who installed the doors needed to come out and fix the issue and this had been impeded due to the Covid pandemic. There was no direct impact on either staff, or the young people and we were assured action was being taken to resolve the issue.

Are Child and adolescent mental health wards effective?

Requires Improvement

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

- Staff did not always give young people all possible support to make specific decisions for themselves before deciding a young person did not have the capacity to do so. Specific to the decision to activate the closed-circuit television in young peoples' bedrooms, where young people did not consent or lacked capacity to consent, staff were not clear under what legislation they were acting in accordance with. On Upper Court, staff began by assessing their capacity under the Mental Capacity Act. All five young people did not consent or lacked capacity to consent. Staff then used the Mental Health Act to ensure that all patients had closed circuit television switched on in their bedrooms. Staff did not make decisions in the best interests of the young people and did not have discussions or record their decisions clearly as to why they did not act in accordance with the young people's best interests and wishes. We discussed this with the ward manager and the consultant psychiatrist on Upper Court. They confirmed no best interest decisions had been made for any young people and the provider wide paperwork for recording best interests had not been used on any occasion.
- The service did not always effectively monitor how well it followed the Mental Capacity Act. Although the service had made some improvements since the last inspection, their oversight had not identified the concerns we found during the inspection. For example, where a young person was assessed as lacking capacity to consent or declined to consent for something specific that related to their care of treatment, staff did not discuss or record their decisions when making a decision in the young person's best interests. The monitoring had not identified that there was zero use of the providers paperwork required to make a best interest decision.

However:

Assessment of needs and planning of care

- Care plans were personalised, holistic and recovery orientated. Staff collaborated with young people to develop a comprehensive care plan to ensure they could express their views. Care plans recorded young people's strengths and what they could do to support themselves and what they needed and wanted staff to help them with and how they would like the support from staff to be given. Staff regularly reviewed and updated care plans when patients' needs changed, and they were discussed in the weekly ward rounds.

- Young people had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The wards were supported by a locum junior doctor who specifically oversaw all the young people's physical health needs.

Best practice in treatment and care

- Staff provided a range of care and treatment suitable for the young people in the service. This included access to psychological therapies such as dialectical behavioural therapy and cognitive behavioural therapy. Interventions were based on individual need and assessment and delivered on a one-to-one basis with the young person.
- Staff identified young peoples' physical health needs and recorded them in their care plans. Young people had their physical health regionally monitored and oversight was monitored by the multidisciplinary team. Staff made sure patients had access to physical health care, including specialists as required.
- Staff met young peoples' dietary needs and assessed those needing specialist care for nutrition and hydration. We saw nutrition charts completed, discussed at handover and reviewed as part of ongoing multidisciplinary meetings to monitor young people who they were concerned about due to eating disorders. Where support was needed from a dietician, referrals were made.
- Staff took part in ward based clinical audits, quality improvement initiatives. For example, during the inspection the consultant psychiatrist told us about a corporate wide steering group set up to review headbanging incidents among young people, with a view to see how they could reduce the number and severity of incidents. Managers used results from audits to make improvements.

Skilled staff to deliver care

- The service had (access to) a full range of specialists to meet the needs of the patients. In addition to qualified nurses and nursing assistants, the multidisciplinary team on both wards included a consultant psychiatrist, locum junior doctor, psychologist, and occupational therapist. The wards were further supported by a social work team who supported across the hospital. They had a family therapist who supported relationships between young people and their families.
- Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new permanent or locum member of staff a full induction to the service before they started work. Agency staff were given a shorter ward-based induction.
- Managers supported medical and non-medical staff through regular, constructive clinical and managerial supervision of their work. Staff we spoke with confirmed they had regular supervision and they felt it was supportive and beneficial for their needs and development.
- Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff reported team meetings followed an agenda, were recorded and staff were sent a copy. Staff meetings included discussions about ward audits, governance, incidents, lessons learnt, training and complaints and compliments.
- Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. This included staff taking on champion roles on the wards in an area they had a keen interest in. Staff received specialist training in suicide and self-harm and trauma informed care. Some of the clinical staff were fully trained in dialectical behavioural therapy.

Multidisciplinary and interagency teamwork

- Staff held regular multidisciplinary meetings to discuss young people and improve their care. There were regular face-to-face and virtual (due to Covid) meetings, with professionals, young people, and their families invited to attend or contribute prior to the meeting. This included daily ward meetings, attended, when possible, by the psychiatrist,

psychologist, occupational therapist, nurse in charge, ward manager and social worker. We observed a meeting on both wards, and each contributed to the delivery of care and treatment to young people. They were structured and discussions included assessment of current presentation, risk information, medicine changes and leave from the ward, including discharge planning.

- Staff made sure they shared clear information about young people and any changes in their care, including during handover meetings. We observed shift-to-shift handovers on both wards which followed a set format and included information about the young person's observations, risks and mental health and physical health needs.
- Ward teams had effective working relationships with external teams and organisations. This included the visiting GP, commissioners, case managers and local authority safeguarding team.

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

- Staff received training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. However, at the time of the inspection, only 62% of permanent and bank staff were up to date with their training.
- Staff had access to support and advice from their Mental Health Act Administrator on implementing the Mental Health Act and its Code of Practice. Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.
- Young people had easy access to information about independent mental health advocacy and young people who lacked capacity were automatically referred to the service. Posters were displayed on both wards.
- Staff explained to each young person their rights under the Mental Health Act in a way that they could understand. They made sure young people could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Good practice in applying the Mental Capacity Act

- There was a clear policy on Mental Capacity Act and Deprivation of Liberty Safeguards, which staff could describe and knew how to access. Staff told us they could get advice from the Mental Health Act administrator if needed. Staff received training in the Mental Capacity Act. However, at the time of the inspection, only 62% of permanent and bank staff were up to date with their training.

Are Child and adolescent mental health wards caring?

Outstanding ☆

Our rating of caring improved. We rated it as outstanding because:

Kindness, privacy, dignity, respect, compassion and support

- Staff were discreet, respectful, and responsive when caring for young people. They knew the young people extremely well and discussed their needs and risks with other members of staff in a positive and non-judgemental manner. Staff were compassionate whilst engaging with young people. They appeared interested and engaged in providing high quality care to young people. We observed staff interacting with young people in a manner that appealed to them. For example, young people told us, and we saw, staff used appropriate humour when supporting them which made them laugh. They felt staff were genuinely interested in helping them and staff wanted to be with them.

Good

Child and adolescent mental health wards

- Relationships between young people, families and staff were strong, caring and supportive. These relationships were highly valued by young people and staff and promoted by the multidisciplinary team. Young people were keen to tell us about specific members of staff they felt had provided outstanding care and support to them.
- Staff gave young people help, emotional support and advice when they needed it. Young people, and their carers were universally extremely positive about the care and treatment they received. They said staff went the extra mile to ensure young people received the care they needed and deserved.
- Staff supported patients to understand and manage their own care treatment or condition. Care plans were collaborative and identified young peoples' strengths to promote prolonged independence. Staff told us it was important young people were active partners in their care and young people told us staff supported and motivated them so they could be.
- Staff recognise and respect the totality of people's needs. They always take people's personal, cultural, social and religious needs into account. Young people's individual preferences and needs were always reflected in how their care was delivered.

Involvement in care

- Staff involved young people in care planning and risk assessment and actively sought their feedback on the quality of care provided. We found care plans to be person-centred and truly, recovery orientated with young peoples' strengths and goals clearly identified. Young people's emotional and social needs were a fundamental part of their care and treatment, were highly valued by staff and embedded into care plans. Staff supported young people to maintain and develop their relationships and social networks with those close to them

Involvement of patients

- Staff introduced patients to the ward and the services as part of their admission.
- Staff enabled young people to be active in their care. They supported young people to attend their multidisciplinary meetings and plan ahead of time what they wished to discuss. For those who did not wish to attend, staff would discuss any issues they would like raised and then feedback to the young person in a one-to-one meeting the outcome of the discussions. We observed a daily meeting on Upper Court ward. Staff and young people engaged well, everyone participated in discussions and young people told us staff always listened to what they said.
- Staff involved patients in decisions about the service, when appropriate and young people could give feedback on the service and their treatment and staff supported them to do this.
- Staff made sure patients could access advocacy services. All patients had an independent mental health advocate. We saw details of local advocacy services were displayed on all the wards and patients told us they were supported to access an advocate if they wished.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

- Staff supported, informed and involved families or carers. Input from carers and family members were evident in young peoples' care plans. Family members told us they felt staff knew their relatives very well. They felt involved in contributing to the young person's care plans, were invited to attend meetings about their relative's care and treatment and were aware of plans and goals for discharge. They said staff communicated well with them and they were kept well informed of every aspect of their relative's care and treatment. They felt this was invaluable. They told us that they felt staff listened too and staff respected their views.
- The service had a dedicated family therapist who offered family therapy for young people and their families.

Good

Child and adolescent mental health wards

Are Child and adolescent mental health wards responsive?

Good

Our rating of responsive stayed the same. We rated it as good because:

Access and discharge

- Managers and the consultant psychiatrists triaged and assessed all referrals. At the time of inspection, both wards were only taking planned admissions (not urgent) as agreed with the commissioners. Managers told us this was due to limited medical cover.
- Discharge planning was discussed as part of multidisciplinary meetings, ward rounds and care programme approach meetings to ensure young people did not stay longer than they needed to. Staff regularly communicated with commissioners, case managers and social services to support planned, safe discharge.

Facilities that promote comfort, dignity and privacy

- Young people had their own bedroom, which they could personalise. On Keystone all bedrooms were en-suite.
- Staff used a full range of rooms and equipment to support treatment and care. There was a range of rooms on the wards, including quiet rooms and a sensory room on Upper Court which was well furnished. There were rooms available off the wards where family and external visitors could meet with young people.
- The service had an outside space that patients could access easily. Young people on Keystone had access to direct, secure outside space. Young people on Upper Court shared a garden with one of the adult wards.
- The service offered a variety of food. Young people were able to select their daily meals and a healthy, seasonal menu provided. Young people told us the food was mostly very good and they could always order something they liked to eat. They could also access drinks and snacks with staff support.

Patients' engagement with the wider community

- Staff made sure young people had access to opportunities for education on site and were encouraged and supported by staff on the wards and staff in the education department to progress with their studies.
- Staff helped young people to stay in contact with families and carers. Young people were encouraged by staff to meet with family, where appropriate, and to go on home leave or meet with relatives for activities outside of the hospital. Staff also contacted relatives and carers (where young people consented) to give daily updates as to how the young people were and what they had done during the day. Relatives we spoke with praised the staff for their communication.

Meeting the needs of all people who use the service

- The service could support and adjust for disabled people and those with communication needs or other specific needs. Staff made sure young people could access age appropriate information on treatment, local services', their rights and how to complain. The service provided a variety of food to meet the dietary and cultural needs of individual people. Young people had access to spiritual, religious and cultural support.

Listening to and learning from concerns and complaints

Good

Child and adolescent mental health wards

- Young people, relatives and carers knew how to complain or raise concerns. Information was clearly displayed about how to raise a concern in areas young people accessed. Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints, identified themes and shared feedback appropriately. The service used compliments to learn, celebrate success and improve the quality of care.

Are Child and adolescent mental health wards well-led?

Good

Our rating of well-led improved. We rated it as good because:

Leadership

- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Ward managers worked shifts on the wards as and when required.
- We spoke to members of the senior management team and found that they were open and honest and clearly described their vision and plans for the hospital. They clearly explained their roles and how the teams worked to provide quality care.

Culture

- All staff we spoke with felt respected, supported and valued. They told us that leaders are responsive and felt able to raise concerns with them.
- Staff also reported that despite some challenges with staffing levels, staff morale was good and positive changes had been implemented since the current leaders commenced employment at the hospital.

Governance

- Team leaders and senior management had daily meetings to discuss the day's running of wards and clinical governance meeting monthly to discuss clinical risk. We attended a comprehensive multi-disciplinary morning meeting and a handover and found that there were a range of other meetings taking place regularly, such as staff meetings and therapy staff meetings. Monthly learning from experience meetings ensured that change in practice was identified based upon previous learning from incidents hospital wide and disseminated to ward level staff.
- Various audits were in place at ward level and feeding into the hospital governance framework. Incidents, safeguarding and complaints were appropriately logged, investigated and learned from.

Management of risk, issues and performance

- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner.
- The service had an electronic risk register where highest risks were clearly identified, all with actions to mitigate.

Information management

- Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and to review when needed.

Good

Child and adolescent mental health wards

- Managers had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and service performance data.

However:

- There was a lack of governance processes to highlight gaps in relation to the use of and recording of Mental Capacity Act assessments and reasons for decisions made.

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 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure that capacity assessments were completed in accordance with the requirements of the Mental Capacity Act 2005 and the associated Code of Practice. Consent was not sought appropriately, and specific decisions were not recorded to demonstrate why capacity assessments were completed. This applies to both the adult and children's wards. The provider did not ensure that where patients or young people lacked capacity to consent or did not consent, staff adhered to the Mental Capacity Act 2005 and associated Code of Practice and assessed and recorded best interest decisions. This applies to the children's wards.