The Priory Hospital Heathfield

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

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

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

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

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

Overall summary

On 12 June 2020 we undertook an unannounced focussed inspection at The Priory Hospital Heathfield. On 19 June 2020, following this inspection, we wrote to the provider under section 31 of the Health and Social Care Act 2008 about our serious concerns about the safety and patient care at The Priory Hospital Heathfield. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. The provider responded to our letter with an action plan on the 23 June 2020 that told us what action they were taking to address the concerns raised. We returned to the service on 14 July 2020 to review progress against the actions the provider told us they were taking to address the concerns in the Section 31 letter of intent.

On 15 July 2020, following our second visit, we served the provider an urgent notice of decision to impose conditions on their registration under Section 31 of the Health and Social Care Act 2008. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure

Summary of findings

whereby CQC can vary any condition on a provider's registration in response to serious concerns. We took this urgent action as we believed that a person would or may be exposed to the risk of harm if we did not do so. We have imposed conditions on the provider to ensure they address the concerns we found following both inspections. We suspended the hospitals rating following this inspection.

During the inspections we found:

- The service did not provide safe care. Staff did not understand patients' repositioning needs and there were inconsistencies in ensuring that patients with manual air mattresses had the settings correctly set. The Waterlow risk assessments were incorrectly completed in some cases. This put patients at an increased risks of developing pressure ulcers. Patients were not having their continence pads changed frequently enough
- Staff did not assess and manage risk well and did not follow good practice with respect to safeguarding. Staff had not reported all safeguarding incidents appropriately to the local authority. Staff did not have the correct skills and competence to meet patients' needs. For example, they did not know how to set manual air pressure mattresses or how to complete food and fluid charts accurately. Staff did not report all incidents in line with the provider's policies. Information available to staff on the ward about patients was often out of date and incorrect.
- Patients did not receive appropriate clinical intervention; patients did not receive regular input from clinical psychology, occupational therapy or physiotherapy and there was limited staff engagement with patients. The multi-disciplinary team did not demonstrate good team working to ensure there were no gaps in the patients care. Staff did not always record information correctly.
- Staff did not always ensure the privacy and dignity of patients. Staff left patients undressed in their bedroom with the doors open. Staff did not always encourage patients and their relatives to be involved in planning their care.
- The leadership team at the hospital had not recognised the concerns identified on the inspection and the governance systems they had in place had not identified them either.
- There were no records of best interest decisions in relation to the taking of photographs of patient's intimate areas when they had sustained wounds.
- Staff did not undertake clinical audits to evaluate the quality of care provided. All patients were on food and fluid charts without an identified clinical reason. Food and fluid charts did not have target amounts recorded on them.
- Staff did not understand the individual needs of patients. Staff did not use patients' communication aids for communicating with patients that had communication difficulties.
- Patients spent long periods of time in bed without interaction from staff. No activities were being offered.

However:

- The hospital was clean and tidy.
- The service had obtained training records and completed inductions for agency staff. Staff had received some relevant training since the first inspection visit.
- Mental Capacity Act 2005 assessments were being completed in line with legislation following our second visit.
- Staff had begun to complete do not attempt resuscitation forms correctly following our second visit.
- On both wards staff had added detail about maintaining a patient's privacy and dignity, in their care plans following our second visit.
- Records on both wards showed that staff had maintained and cleaned equipment regularly.

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Background to The Priory Hospital Heathfield

The Priory Hospital Heathfield is a specialist neurorehabilitation service that provides post-acute neurobehavioral rehabilitation for people with an acquired brain injury as well as offering long term care and support to people with complex needs relating to progressive neurological conditions. The service has two wards, Boyce unit provides care and support for people with progressive neurological conditions such as Huntington's disease, stroke, acquired brain injury and mental health problems. Holman unit is focused on providing post-acute neurobehavioral rehabilitation. Boyce ward has 15 beds and Holman has nine. At the time of writing there were eight patients on Holman ward and eight patients on Boyce ward.

The Priory Hospital Heathfield 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.

At the time of the inspection carried out on 12 June 2020 there was no registered manager in post. However, the previous manager had left on 22 May 2020. The Priory group had recruited a new manager who had not yet commenced employment, who intended to apply to become the registered manager with CQC. When we returned to the Hospital on 14 July 2020, the Priory group had ensured that an Interim Hospital Director was covering the post, supported by an Interim Director of Clinical Services and a Priory Operations Director.

Prior to the above inspections, the Priory Hospital Heathfield was last inspected in June 2018. At that time The Priory Hospital Heathfield was registered as a care home, therefore it was inspected using our adult social care methodology. Priory Heathfield was rated good overall and good in all five domains. Since the last inspection the provider has redesigned the service and is now operating as a hospital. These rating were suspended following this inspection.

Our inspection team

The team that inspected this service comprised of one inspection manager, two inspectors, one specialist adviser with experience in this clinical area and an expert by experience. An expert by experience is someone who has developed expertise in relation to health services by using them or through contact with those using them, for example, as a patient or carer.

The team that inspected this service on 14 July 2020 comprised of one inspection manager, two inspectors and one specialist adviser with experience in this clinical area.

Why we carried out this inspection

On 12 June 2020, we carried out a focused inspection of the Priory Hospital Heathfield due to concerns noted in the information we collect about the service and information passed to us from other sources.

We received a safeguarding alert regarding the competence of staff working at the hospital. We also received concerns regarding the quality of care provided to patients whilst at the Priory Hospital Heathfield, that included:

- neglect of patients,
- staff attitude towards patients,
- poor governance of the service,
- staff not making safeguarding reports to the local authority following injuries to patients,
- a lack of therapeutic activities,
- a lack of meaningful engagement with patients from staff,
- poor cleanliness of the building and equipment.

Summary of this inspection

On 14 July 2020 we carried out an unannounced focused inspection, to find out if the service had made improvements against the section 31 letter of intent and subsequent action plan submitted by the provider in response to the focused inspection we carried out on 12 June 2020.

How we carried out this inspection

As these were focused inspections, we did not re-rate the service as we only looked at some of the key lines of enquiry across each domain.

Before the inspection visits, we reviewed information that we held about the location.

During the inspection visit on 12 June 2020, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with six relatives of patients using the service;
- spoke with the director of clinical services who was acting as the manager;
- spoke with five other staff members; nurses, occupational therapy assistant and health care support workers;
- looked at nine care and treatment records of patients;
- looked at a range of policies, procedures and other documents relating to the running of the service.

When we returned on 14 July 2020, the inspection team:

- visited both wards at the hospital and observed how staff were caring for patients;
- spoke with 1 patient who was using the service;
- spoke with thirteen staff members; nurses, chef, housekeeper, administrator, occupational therapy assistant and rehabilitation assistants;
- looked at eleven care and treatment records of patients;
- looked at a range of documents relating to the running of the service, such as induction and training records, staffing rotas, handover forms and equipment folder.
- attended the morning multidisciplinary team meeting.

What people who use the service say

We had mixed reports from people who used the service. They told us that most of the staff were kind, but some were mean and they did not get on with all of them. Some of the patients told us that staff would sometimes talk in languages other than English and did not always speak to them. Patients told us that staff used their mobile phones while on the wards.

Patients told us there should be more staff available as there were not enough activities on the ward and they were often bored. Patients said they had very limited opportunities to access the community. During the inspection on 14 July 2020, a patient told us that staff were nice and doing a good job.

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?

During our inspection visits we found:

- Staff did not demonstrate that they understood how to recognise, report abuse and how to apply the local policies on reporting abuse. Staff did not report all safeguarding incidents to the local safeguarding team.
- Staff did not demonstrate that they understood how to protect patients from neglect. Patients were not having their continence pads changed frequently enough.
- Staff did not have easy access to clinical information. It was not easy for them to maintain high quality clinical records. There was out of date and incomplete information about patients on the wards. For example, patients were still on food and fluid charts without an identified clinical reason.
- The service did not manage patient safety incidents well. Staff did not always recognise and report incidents appropriately. Staff had not reported all incidents using the hospital's electronic incident system.

However:

- All wards were safe, clean, well equipped, well-furnished and fit for purpose.
- The service had enough nursing staff who had received basic training to meet the needs of patients. This had improved since our first visit.
- The service had conducted inductions for agency staff and had a record of their training. This had improved since our first visit. Staff had received some relevant training since our last inspection.

Are services effective?

During our inspection visits we found:

- Staff did not provide a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. Patients did not receive regular input from a clinical psychologist, occupational therapist or physiotherapist to support self-care and the development of everyday living skills. Staff did not understand patients' repositioning needs and Waterlow risk assessments were incorrectly completed.
- Managers did not make sure they had staff with the range of skills needed to provide high quality care. Staff did not record

Summary of this inspection

information in an effective and meaningful way. Staff did not understand how to set air mattress correctly and they did not complete charts so that they provided the information needed to meet patients' care needs.
- Staff did not support patients to make decisions on their care for themselves. They did not follow the provider's policy on the Mental Capacity Act 2005. This had improved on our second visit.
- There were no records of best interest decisions in relation to the taking of photographs of patient's intimate areas when they had sustained pressure wounds.

However:

- Staff had completed do not attempt resuscitation forms in line with national guidance and these reflected the patient's wishes. This had improved since our first visit.

Are services caring?

During our inspection visits we found:

- Staff did not show a good understanding of patient's individual needs. We observed staff not using communication aids for patients that had communication difficulties. Some patients felt that staff did not always treat them kindly.
- Patients spent long periods of time in bed without interaction from staff. There were no activities being offered.
  Staff did not always involve patients or their families in care planning and risk assessment.

However:

- During our visit on 14 July 2020, we found that detail about privacy and dignity had been added in care plans on both wards. This had improved since our first visit.

Are services responsive?

We did not inspect against this key question domain during this inspection.

Are services well-led?

During our inspection visits we found:

- Leaders did not demonstrate that they had a good understanding of the services they managed and the improvement needed. During our inspections the nurses in charge of the wards could not explain the care of patients to us.

Summary of this inspection

- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level. We found that there were no effective systems in place to identify that staff were incorrectly completing paper work, such as food and fluid charts and Waterlow risk assessments.

However:

- During our second visit, we found that the Priory group had ensured that an Interim Hospital Director was now in place, supported by an Interim Director of Clinical Services and a Priory Operations Director. Additionally, a ward manager had just been recruited and was completing their induction.
- There were some improvements with regards to the paperwork in place, such as the completion of body maps on Boyce ward and the equipment folder.

Detailed findings from this inspection

Mental Capacity Act and Deprivation of Liberty Safeguards

During the inspection on the 12 June 2020, we found that staff did not demonstrate a good understanding of the Mental Capacity Act. Staff did not complete Mental Capacity Act assessments in line with legislation. When staff had doubt that a patient lacked capacity, staff used a single assessment to cover all aspects of the patient's care. Mental Capacity assessments must be decision-specific and only completed when a decision needs to be made. Staff did not complete best interests plans in line with legislation. Staff did not use the best interest checklist to ensure patients' rights were considered and relatives were involved in best interest decisions. The Mental Capacity Act best interest checklist outlines what needs to be considered before taking an action or decision for a patient while they lack capacity.

Seventy six percent of permanent staff had received training in the Mental Capacity Act, but the high vacancies within the service meant that there were not always enough staff within the hospital with a sound understanding of this legislation.

When we returned on 14 July 2020, we found that staff now completed Mental Capacity Act 2005 assessments in line with legislation and the provider's policy. They were now decision specific and patients had individual assessments with regards to their care and treatment, finances and accommodation. However, there were no records of best interest decisions in relation to the taking of photographs of patient's intimate areas when they had sustained pressure wounds. This was an issue we raised at the last inspection.

Long stay or rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

All wards were safe and clean.

All areas we visited, including the kitchen, were clean and we saw housekeeping staff cleaning the ward areas throughout our visit. However, on Boyce ward staff had not completed mattress checks to ensure they were clean and in a good state of repair since 15 March 2020. Staff had not recorded that they had cleaned a patient's wheelchair regularly on Boyce ward. On Holman ward the toilet seat was missing in the main bathroom, there was a broken clinical waste bin in the sluice room and the ceiling in the visitors' toilet was damaged and damp. On Boyce ward part of the ceiling was missing in the corridor, but this had a temporary repair in place. We also saw a broken fence panel leaning against the wall in Holman garden. This had been there for some time as the grass had grown around it.

Safe staffing

During our first visit on 12 June 2020 we identified that the provider had a high number of vacancies. Vacancy rates for registered nurses were 75% and for health care support workers 86%. The provider was addressing this by employing three locum registered nurses and seven locum health care support workers. The vacancy rates with the locum staff included were 50% for registered nurses and 72% for health care support workers. They used ad hoc agency staff to fill any remaining shifts. When we returned on 14 July 2020 we found that the senior manager were addressing staffing issues.

When we inspected on July 14 2020 the Interim Hospital Director informed us that the they had developed a new staffing model that would include a ward manager on duty Monday to Friday, to provide support to the nurses in charge. The hospital would also employ a third registered nurse on night shifts to provide extra clinical support. The provider had started to include this on their rota.

At the time of the first inspection, 73% of permanent staff had completed mandatory training in line with the provider's policy. During our second visit we found that staff had received some relevant training, such as tissue viability training.

During the first visit the provider did not have assurance of agency staff's training and skills. One locum registered nurse had no training record and we checked 15 ad hoc agency health care support workers and the provider did not have a record of their completed training. Paramedics expressed concern around the competence of one registered nurse to administer oxygen, the provider did not have a training record for that member of staff. When we returned on 14 July 2020 we checked 11 agency staff induction files and found that 10 of them had a copy of their completed local induction and training record. This demonstrated that the staff team had the basic skills needed to meet the patients' needs.

Safeguarding

During our inspection visit on 12 June 2020 the provider had not ensured that staff reported all safeguarding incidents to the local safeguarding team. We identified six incidents of injuries to patients that staff had not correctly reported through the provider's incident reporting system. This meant that the hospital's safeguarding lead was not aware of all incidents in the hospital that they should have reported as safeguarding incidents. As injuries had not been correctly described and recorded by staff, we could not be sure of how serious they were, and which injuries would have met the threshold to report to the local authority safeguarding team and to CQC. When we

returned on the 14 July 2020 staff were completing safeguarding referrals in line with guidance and the provider's policies. During our inspection on 14 July 2020 we found that patients were not having their continence pads changed frequently enough. There were large gaps between continence pad changes in the recently archived elimination records. For example, on Boyce ward we checked five patients' records and found that their pads had not been changed or checked for periods of time between 7 to 17 hours.

Staff access to essential information

During our inspection on the 12 June 2020 we found that staff kept monitoring forms for each patient on a clip board. We found that lots of this information was out of date and on occasions staff had contradictory information about a patient's care. We found that patients' nutrition and hydration intake was monitored through staff completing food and fluid charts. Staff had not recorded the reason for using a food and fluid chart to identify if a patient had a high risk of malnutrition. Food and fluid charts did not always record the amount of food the patient had eaten or describe the type of food they had eaten. This meant that there was a risk they would not be able to identify patients at risk of malnutrition. Food and fluid charts did not have target amounts of daily fluid intake, therefore staff did not know why patients were on food or fluid charts or when the patient had not had enough. All patients were on charts to record their use of the toilet. We found one chart that indicated a patient had not had a bowel movement for two months. We asked staff about this and they told us the patient used the toilet independently and therefore they were unaware of when they used the toilet.

During the inspection on 14 July 2020 we found that all patients were still on food and fluid charts without an identified clinical reason. Food and fluid charts still did not have target amounts recorded on them. Targets were written in care plans, but staff did not have easy access to them. Staff did not always describe the food or how much of it the patients had eaten. For example, staff would simply write 'soft diet'. This meant that staff still may not have been able to identify if patients were at risk of malnutrition. We saw a report from a senior manager stating that they had identified patients were unnecessarily on charts and staff should stop recording on these charts, but no action had been taken to address this.

Reporting incidents and learning from when things go wrong

During our inspection visit on 12 June 2020 we found the provider did not ensure that when patients had injuries staff completed incident forms and that staff appropriately monitored and managed all injuries.

We reviewed 13 records of patients that had injuries that staff had recorded on a body map chart, used to identify injuries and how they were healing. None explained how the injury had occurred or gave information that would enable staff to identify if the injury was healing. For example, staff had recorded a pressure ulcer but did not give other details such as grading or size. We checked six of the more serious wounds in the care records of the patients and checked that staff had completed an incident form. We found that staff had not reported any as incidents and had only recorded two of the wounds in the patient's care record. This meant that senior managers were not aware of what and how many injuries were occurring on the wards and could not identify any patterns or trends to address this. During our inspection on July 14 2020 we reviewed three body maps on Holman ward and on two of them there was no evidence of investigations being carried out or continuing monitoring of the injury. However, on Boyce ward the completion of body maps had improved and staff were appropriately completing the forms. Staff were also following up on the progress of the injury.

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

(for example, treatment is effective)

Assessment of needs and planning of care

During the inspection on the 12 June 2020 we reviewed nine patient records and saw that staff did not always involve patients in planning their care. For example, we saw that patients had do not attempt resuscitation forms in their files, but we could not find documented evidence of the patient or their family being involved in discussions around this in three out of the nine patient records.

Long stay or rehabilitation mental health wards for working age adults

When we returned on 14 July 2020 we found that the 'do not attempt resuscitation' status of patients had been addressed. We reviewed seven patient records and saw that staff had now involved patients in planning their care.

Best practice in treatment and care

During the inspection on the 12 June 2020 we found that the provider had not ensured that patients received all appropriate therapeutic input. For example, patients did not receive regular clinical psychology intervention, occupational therapy intervention or physiotherapy. There was no individual or ward programme of activities in place on the day of the inspection.

The provider had not ensured that staff repositioned patients at risk of skin breakdown in line with their care plans. Repositioning charts did not include an assessment of the patient's skin integrity and staff only recorded limited information on the charts. For example, which side staff had positioned the patient on. We saw in one record that a patient should have been repositioned every two hours and had not been repositioned for seven hours and then subsequently a further nine hours on the day prior to the inspection. This patient was assessed as being at high risk of skin breakdown.

During our inspection on 14 July 2020, we were told that no patients had repositioning needs and so they were not being repositioned at all despite spending lengthy periods of time in their beds or in chairs. A staff member informed us that four patients did require repositioning, but not all knew this and the patients' care plans were not clear on the frequency of repositioning. This put patients at an increased risk of developing pressure ulcers.

On Boyce ward, we reviewed four Waterlow risk assessments and found that staff had not calculated the risk score correctly on three of them. On one risk assessment the risk should have been recorded as high, but it was incorrectly recorded as low and on another two the risk should have been recorded as very high, but it was incorrectly recorded as high. This put patients at an increased risks of developing pressure ulcers.

On Boyce ward, patients spent long periods of time in bed without interaction from staff. There were no activities being offered at all. On Holman ward, we saw printed weekly activity plans for three patients, but one of these patients was sitting all morning in the lounge watching TV, and we did not see any staff encourage the patient to follow their timetabled activities.

Skilled staff to deliver care

During the inspection on the 12 June 2020 the provider had not ensured that the staff team had the correct skills to meet the needs of the patients admitted to the hospital. The provider had not ensured staff knew how to use and record the setting of manual air mattresses. Air mattresses are used for patients at a high risk of developing a pressure ulcer, if incorrectly set they could cause the patient's skin to break down and to develop a pressure ulcer. Staff did not recognise when mattresses were incorrectly set and were recording that they were safely set for the patient. Staff should have recorded the patient's weight and that the mattress was set to this weight but were just marking it as correct. We checked both manual air mattresses on Boyce ward on the day of our visit and both were incorrectly set but staff had recorded they were correctly set. When we returned on 14 July 2020 we found that staff were still not setting manual air mattresses correctly. On Boyce ward, a patient's manual air mattress was incorrectly set to 10kg lower than the patient's weight. We also identified that on four other days the mattress was recorded as being incorrectly set. On Holman ward, a patient's manual air mattress was incorrectly set to 5kg lower than the patient's weight for seven days and 15kg higher for four days.

Good practice in applying the MCA

During the inspection on the 12 June 2020 the provider did not ensure that staff completed Mental Capacity Act assessments in line with the Mental Capacity Act 2005. Mental Capacity Act assessments were not decision-specific and did not follow the best interest checklist.

We reviewed completed Mental Capacity Act assessments in patients' records, completed when staff felt a patient lacked capacity to make decisions. We found that the provider was using a single assessment to cover every aspect of a patient's care rather than assessing a patient's capacity to make a particular decision when it was necessary. This is not in line with the Mental Capacity Act Code of Practice and the provider's policies that state capacity is time and decision-specific.

Long stay or rehabilitation mental health wards for working age adults

We did not see any evidence that staff used the best interest checklist when making decisions about patients' care when staff needed to make a decision in the patient's best interest. The Mental Capacity Act best interest checklist outlines what needs to be considered before taking an action or decision for a patient while they lack capacity. The best interest checklist ensures that staff consider patients' rights and involve the correct people in deciding for patients. For example, families could be involved in agreeing what treatment a patient would have liked to receive before the patient lost capacity.

We reviewed five do not attempt resuscitation forms and saw that the provider had not always ensured staff had completed the forms following national guidance. For example, staff had not always ensured that all relevant people were involved in completing the form. Staff had completed one form without sound clinical rationale. Another 'do not attempt resuscitation' form stated the patient lacked capacity to decide if they wanted staff to attempt to resuscitate them if needed or not. However, the patient's record did not include a Mental Capacity Act assessment to support this judgement. We saw two do not attempt resuscitation forms where the patient's end of life plan clearly stated the patients wanted staff to attempt resuscitation.

When we returned on 14 July 2020, we found that staff now completed Mental Capacity Act 2005 assessments in line with legislation and the provider's policy. They were now decision specific and patients had individual assessments with regards to their care and treatment, finances and accommodation.

However, On Boyce ward we found a photograph of a small open wound in a patient's file, but there was no record of best interest decisions in the care plan. This was an issue we also raised at the last inspection.

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

Kindness, privacy, dignity, respect, compassion and support

During the inspection on 12 June 2020 we observed a patient being nursed on one to one support in their bedroom. The patient was nursed in their bed with the door left open throughout our visit. This meant staff, patients and visitors could see the patient lying in bed often exposed.

We did not see the staff member providing support or interacting with the patient during the visit. We did not observe staff engaging with patients in a meaningful way. We saw patients placed in front of the television in the lounge areas. Staff in those areas did not engage with them and the same television channel was left on all day at a high volume. Another patient was left in a bedroom with no interaction with staff. When we spoke to this patient, they told us that no one had spoken to them and they did not have a remote control to change the TV channel. A member of the inspection team found the remote control and gave it to the patient.

Some of the patients had significant communication issues, we did not observe staff using any communication aids or see information for ward staff to assist them to communicate with the patients.

Patients gave us mixed reports about the staff team. They told us that most of the staff were friendly and caring, but some were unpleasant to them. Some patients reported staff did not speak to them at all during a shift and would speak to each other in languages other than English. Patients also complained that staff used their mobile phones while on the wards.

Patients told us there should be more staff available as there was not enough activities on the ward and they were often bored. Patients said they had very limited opportunities to access the community.

When we returned on 14 July 2020 patients on Boyce ward still spent most of their time in front of a TV in the lounge or in their beds. We did not observe staff using communication aids for patients that had communication difficulties. We did see a thumbs up and thumbs down card in a patient's bedroom, but it was not used during the interactions we observed and that patient had significant communication difficulties. On Holman ward there was a menu on the wall in the dining area, but no pictures. On Boyce ward there was a picture of the main meal for the day and a sign that said patients could have baked potatoes and omelettes every day, but no pictures. Additionally, we did not observe staff explaining to patients who were on soft diet what they were eating.

Long stay or rehabilitation mental health wards for working age adults

However, we found that there was now added detail about privacy and dignity in care plans on both wards.

Involvement in care

During the inspection on 12 June 2020 staff did not always involve patients in decisions about their care. We reviewed patient records and saw that staff did not record how patients were routinely involved in their care planning.

We spoke with six relatives of patients at the hospital and they told us that outside of six-monthly review meetings staff did not encourage them to be involved in their relatives' care. Patients' relatives also told us that the hospital rarely communicated with them outside the six-monthly review meetings. Relatives said that once the service became a hospital, in July 2018, that staff no longer allowed them to visit their relative on the wards and they could only see them in the visitors' room.

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

We did not inspect against this key question domain during this inspection.

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

Leadership

During the inspection on 12 June 2020 we did not review the leadership processes at the Priory Hospital Heathfield. However, our findings in the other key questions demonstrate that there was not strong leadership at the Priory Hospital Heathfield at the time of our inspection. During our inspection the nurses in charge of the wards could not explain the care of patients to us. We did not see senior leaders on the wards during our inspection. Leaders were not aware of all the concerns we found during the inspection and had not identified concerns through spending time on the wards.

When we returned on 14 July 2020, we found that the nurses in charge of the wards could still not explain the care of patients to us. For example, there was no clear understanding of how to support a patient experiencing a seizure, or where to locate patients' epilepsy care plans. We were told that these were kept in the patients' files on the wards, but we could not find them there. We did not see senior leaders on the wards during our inspection.

However, we found that the Priory group had now ensured that an Interim Hospital Director was in place, supported by an Interim Director of Clinical Services and a Priory Operations Director. Additionally, a ward manager had just been recruited and was completing her induction.

Governance

During the inspection on 12 June 2020 we did not review the governance process at Priory Hospital Heathfield. However, our findings from the other key questions demonstrated that there was not a robust governance system in place. There were no effective systems in place to identify that staff were incorrectly completing paper work, were not always reporting incidents via the providers electronic incident reporting system, were not reporting safeguarding incidents to the local authority, were not always involving patients in planning their care and were not following the Mental Capacity Act 2005 when assessing patients' capacity.

When we returned on 14 July 2020 we found that there were no effective systems in place to identify that staff were incorrectly completing paper work, such as food and fluid charts and Waterlow risk assessments.

However, we found some improvements with regards to the paperwork in place. For example, staff had received relevant training, best interest decision made under the Mental Capacity Act 2005 were now made in line with national guidance, the completion of body maps on Boyce ward had improved, there was an up to date equipment folder on both wards which showed that equipment was being maintained and cleaned regularly, the service had obtained training records and conducted inductions for agency staff and the records were in a better order.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider MUST ensure that there are enough staff on duty who have the knowledge, skills and competence to meet the needs of all patients admitted to the hospital
- The provide MUST ensure that they have an accurate up to date record of the skills and training of agency staff.
- The provider MUST ensure that staff complete do not attempt resuscitation forms in line with legislation, national guidance and that the forms reflect the wishes of the patient.
- The provider MUST ensure that Mental Capacity Act assessments are completed in line with the Mental Capacity Act Code of Practice.
- The provider MUST ensure that all staff follow patients' care plans and involve the patients in planning their care.
- The provider MUST ensure that staff are aware of patients' communication needs and use any tools needed to aid communication with patients.
- The provider MUST ensure that staff know how to use medical devices correctly and how to record and check that they are being used safely.
- The provider MUST ensure that all staff know how to complete accurate and meaningful records.
- The provider MUST ensure that all staff complete incident forms and report safeguarding incidents in line with their policy.
- The provider MUST ensure that patients' privacy and dignity is always maintained.
- The provider MUST ensure the multi-disciplinary teams work together to provide safe care for patients and the patients have appropriate therapeutic input, meaningful activities and that staff engage with them to meet their needs.
- The provider MUST ensure that local governance systems are robust and identify areas for improvement.

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 Regulation 9 of the Health and Social Care Act 2008 (RA) Regulations 2014: Person-centred care Patients were not always involved in planning their care. This was a breach of regulation 9(1)(a)(b)(c)(3)(a)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Regulation 10 of the Health and Social Care Act 2008 (RA) Regulations 2014: Dignity and respect Staff did not always ensure patients were given privacy when in their bedrooms or communicate with them appropriately. This was a breach of regulation 10(1)

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 Regulation 11 of the Health and Social Care Act 2008 (RA) Regulations 2014: Need for consent Staff did not complete Mental Capacity Act assessments in line with the Mental Capacity Act Code of Practice. This was a breach of regulation 11(1)(3)

This section is primarily information for the provider

Enforcement actions

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose Regulation 12 of the Health and Social Care Act 2008 (RA) Regulations 2014: Safe care and treatment Staff did not always have the skills, knowledge and competence to meet patients' needs. The hospital did not keep a record of the skills and training of agency staff. Do not attempt resuscitation forms did not follow national guidance and did not always correctly reflect patients' wishes. Staff did not know how to complete paperwork correctly. Care records did not demonstrate how the multi-disciplinary team worked together to provide safe care. The provider did not ensure that patients had appropriate therapeutic input to meet their needs. Staff did not provide meaningful activities for patients. This was a breach of regulation 12(1)(2)(c)(e)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 CQC (Registration) Regulations 2009 Financial position Regulation 13 of the Health and Social Care Act 2008 (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment Staff did not complete incident forms for all injuries to patients. Staff did not report all safeguarding. This was a breach of regulation 13(1)(4)

This section is primarily information for the provider

Enforcement actions

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 **Regulation 17 of the Health and Social Care Act 2008 (RA) Regulations 2014: Good governance** **The provider's governance systems had not recognised the concerns identified in this report.** **This is a breach of regulation 17(1)**