Priory Healthcare Limited

The Priory Hospital Bristol

Quality Report

Upper Court
Lower Court
Hill side
Oak Lodge
Garden View
Rosewood
Tel: 0117 952 5255
Website:

Date of inspection visit: 10 and 11 February 2015
Date of publication: 17/06/2015

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 and a review of all information available to CQC including information given to us from patients, the public and other organisations.

Summary of findings

Contents

Summary of findings

Overall summary

The hospital had ongoing issues with the recruitment and retention of staff, resulting in staff being moved around the wards regularly. Several wards regularly failed to meet their 'staffing ladders' (identified staffing levels and skill mix based on the needs of patients).

There was good uptake of mandatory training and specific specialist service training was being planned such as dementia awareness.

There was limited evidence of learning from incidents. For example, risk assessments were not always updated following incidents resulting in a lack of learning so similar incidents happened repeatedly or there was an escalation in severity of incidents. This left some patients feeling unsafe on the acute ward.

The management and monitoring of medicines and control drugs on some wards did not meet recognised good practice standards.

There was a capital investment programme to develop the buildings and environment. Currently, Rosewood was closed for remodelling and plans for redeveloping the service provided from this ward were being consulted upon.

For some patients in complex care with progressive illnesses, the wards are their home rather than a hospital ward from which they will move on. Areas across Complex Care were worn such as the Oak Lodge lounge and carpets across the unit were dirty and smelled of urine. Some areas also lack a personalised homely feel. The hospital managers were aware and provided evidence of longer term plans to rectify.

The risks from ligatures in the acute area of the hospital were not being managed; there were blind spots with unidentified ligature risks in a number of communal areas and within the hospitals' identified 'reduced ligature rooms'.

The privacy, dignity and safety of patients on lower court were not always met as female patients sis not have access to a female only lounge.

The quality of the capacity assessments within complex care were poor, with limited evidence on what had been considered and how any decision had been made.

Most of the service provided good physical health monitoring. However, there were pockets of poor practice and poor recording on fluid charts in complex care which delivered care to a very vulnerable patient group.

The care and support provided to patients by all staff was very good. Patients had one-to-one sessions with staff, were able to go out of the hospital as they wished had an excellent choice of food.

The Priory Hospital Bristol was in the process of developing its senior leadership team. The hospital director had been in post for six months and a number of new senior managers had been appointed. A deputy director of nursing and a clinical director were about to commence to strengthen clinical leadership. The hospital was in the process of restructuring its services, developing its infrastructure and governance arrangements although these were at a relatively early stage of development. Most of the staff we spoke with said that there had been a significant change in the severity of illness of the patients being cared for at the hospital over recent years. The majority of patients were now acutely ill and/or had complex needs.

We found that the hospital was developing an increasingly open culture and delivering and increasing responsive service. Staff said they felt supported and received good supervision. They also felt the hospital director could be approached at any time and that issues were resolved. Following a clearer focus on achieving good outcomes for patients, staff noted that morale had improved in the last six months. Despite the improvements made, we observed poor practice on the wards as outlined in the report.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The majority of incidents were reported although lessons were not always learned. Staff were up to date with safeguarding training. Emergency equipment was regularly checked and was kept in a place where it was readily accessible. However, medicines were not always managed well on some wards. On some wards ligature risks had not been identified in the provider's ligature plan. Risk assessments were not updated following all incidents leading to some care plans not being up to date resulting in patient feeling unsafe. There was not access to a female only lounge in Lower Court.

Are services effective?

Most patients had up to date care plans. People had access to a wide range of therapies. The majority of patients had regular physical health checks. However, there were gaps in the physical health assessments in complex care in particular fluid monitoring. The capacity assessments were of a poor quality.

Are services caring?

We observed thoughtful and caring interactions between patients and staff. Most feedback from patients and carers was positive. The staff on complex care showed a good understanding of their patients' needs and had gone to great lengths to enable patient choice and understanding through pictorial material and food menus.

Are services responsive to people's needs?

An extensive therapeutic and activity programme was provided to patients undertaking the programmes. Good multi- disciplinary team (MDT) and patient focussed hand overs were observed. The food choice and the responsiveness of the catering team were highlighted as extremely good by patients and staff. There were discharge plans documented for patients in acute areas. However, due to the complex needs of patients in complex care area no clear pathway could be provided for the majority these patients. The carpets in areas of complex care were worn, dirty and smelled of urine.

Are services well-led?

The service was in the early stage of developing its senior leadership/management team, infrastructure and governance arrangements. The staff told us it was an increasingly open and increasingly responsive service. The hospital had carried out

Summary of findings

thirteen audits in 2014 to monitor quality and support learning. Most staff told us that they felt supported and supervised and could approach senior management. There was good uptake of mandatory training and an increasing focussed on specific specialist service training to support staff to deliver good quality care to the different patient groups.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve rehabilitation services

- The provider must ensure risk management plans are clear for all identified risks affecting individual patients and that all care plans are reviewed and updated when new risks are identified. The provider must ensure that all fluid and nutritional charts are completed as appropriate a some records we reviewed in the complex care had not been completed. The provider must ensure that all incidents are recorded. Not all incidents on lower court were recorded.
- The provider must ensure that the environment on the complex care unit is clean and safe. Some of the carpets in complex care were worn, dirty and smelled of urine.
- The provider must ensure that management plans for ligatures reflect the ligature risks posed within the ward environment. A number ligatures had not been identified and the risks were therefore not being managed. The provider failed to address the risks associated from not having a line of site i.e. 'blind spots' in several areas across the hospital.
- The provider must ensure that capacity assessments are completed and their reasons recorded accurately. The quality of the assessments on garden view were poor.
- The provider must ensure that all medication, including controlled drugs are stored and administered correctly on oak lodge.
- The provider must ensure the privacy, dignity and safety of patients by ensuring that it complies with same sex guidance in the Mental Health Act Code of Practice. Female patients should have access to a female only lounge.

Action the provider SHOULD take to improve

• The provider should ensure that identified staffing levels are met on lower court. The provider failed to prevent patients detained under the Mental Health Act from leaving the hospital, without leave, as staff were unable to observe patients as required.

Good practice

The catering team provided an excellent choice of high quality nutritious home cooked food. All patients and staff told us how responsive the catering team were to patients' dietary and cultural needs as well as likes.

The Priory Hospital Bristol

Detailed findings

Services we looked at:

Complex Care

Complex care was made up of three wards; the wards were long stay and provided a home for many of the residing patients. Hillside had an established patient group requiring long term care for patients with complex needs such as Huntington disease. Oak Lodge provides longer term care with complex needs some leading to palliative care. Garden View had long term female patients' with complex care or rehabilitation needs.

Acute

The Acute service was made up of three wards. Rosewood is under refurbishment. Lower Court provides support for eating disorders. Upper Court had a group of patients with a mixture of needs including acute, addiction and recovery patients.

Our inspection team

Our inspection team was led by:

The teams that inspected the services consisted of ten people; these included one experts by experience (people with experience of using services or caring for someone using services), two specialist advisors, four inspectors, three mental health act reviewers.

Team leader: Lesley Whittaker, Inspector, Care Quality Commission, supported by Karen Wilson Head of Hospitals.

The team also included one CQC inspection manager, two further

inspectors and two specialist advisors; an expert by experience,

and three Mental Health Act Reviewers.

Background to The Priory Hospital Bristol

The Priory Bristol hospital has 68 beds spread across six wards situated on the outskirts of Bristol. The hospital provides treatment for acute mental health for adults over 18, addiction treatment for adults over 18 years, dealing with trauma, eating disorders, obsessive compulsive disorders, body dysmorphic disorders, personality disorder issues and mental health inpatient services

The hospital split its services into three distinct care areas, across numerous buildings, which vary in age.

Detailed findings

Complex care was situated in a modern building within the grounds. There were three wards within complex care:

- Hillside: a 9 bedded mixed wards providing long term care for patients with complex needs such as Huntington disease;
- Oak Lodge: a 10 bedded male ward providing longer term care with complex needs in particular dementia or palliative care; and
- Garden View: a 10 bedded female ward for patients' with complex care or rehabilitation.

The inpatient/psychology services, including a variety of therapy sessions, yoga and one to one psychological sessions were delivered within the main building.

The acute services were provided in the main building and in a modern extension to the main site. These wards included:

- Lower Court: a mixed ward providing treatment for acute mental ill health and addiction; and
- Upper Court: a mixed ward providing treatment for eating disorders.

A major refurbishment was under way on Rosewood ward; once completed this will result in a change to the service structure.

We had inspected the Priory Hospital Bristol six times in the previous eighteen months. There was no current enforcement action against the provider at the time of inspection."

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit we reviewed information that we held about these services and asked other organisations for information.

During the inspection visit the inspection team:

- Visited the service;
- Spoke with 14 patients;
- Spoke with two carers/relatives;
- Spoke with six managers and senior staff within the organisation;
- Spoke with the service's regional manager;
- Spoke with the service's GP;
- Attended a therapy session;
- Attended a multi-disciplinary ward round; and
- Attended two nursing handovers.

We also:

- Looked at 14 care and treatment records of patients;
- Observed how staff were caring for patients;
- Carried out focus groups for a nurses, health care assistants, therapists, ward managers and non –clinical staff;
- We also received comment cards from across the hospital;
- Carried out a specific check of medication management in the services; and
- Looked at a range of records and documents relating to the running of the services.

Is the service safe?

Our findings

SAFE

Safe and clean ward environment

- The hospital had a good system to identify and resolve infection control issues, including regular meetings run by infection control leads. There was an infection control action plan dated 14 September 2014 with clear examples identifying that issues had been resolved and followed up. Despite these processes we observed dirty wheelchairs in corridors and complex care's service director told us that there was no proactive cleaning process in place for patient slings..
- Whilst Hillside was a mixed gender ward, men and women had been separated to different sides of the ward. In the acute setting, Lower Court was a mixed gender ward where patients had en-suite bathrooms. However, there was no separate female only space/ lounge area. The current and revised Mental Health Act (MHA) Code of Practice states that all sleeping and bathroom areas should be segregated and woman-only day rooms should be provided, due to the increased risk of sexual and physical abuse towards women.
- There were patient lounges available on all wards. On Upper Court the patient lounge was small. However, the facilities were due to increase in size following a planned move. Work was in progress at the time of our visit. Lower Court had two lounges, neither of which could be seen from the nursing station. One lounge was behind double doors with doors to the garden. This lounge was cold and smelt strongly of cigarettes.
- We saw that the ward layout did not enable staff to observe all areas of the ward. For example, on Upper and Lower Court stairways, the acute lounge, laundry and garden and oak lodge bedroom corridor. Vulnerable patients from both wards had access to these areas. Staff could not be sure that patients were always safe in these acute care areas. Steps had been taken, within the complex care unit, to ensure observation of identified areas.
- Clinic rooms were fully equipped and the equipment was accessible, checked daily and the emergency medication was in place and in date.
- There were no seclusion facilities in the hospital.
- Staff from adjoining units were able to respond to calls for assistance, as needed, in response to alarms. Patient calls were answered promptly. There was at least one staff member on floor at all times.

Safe staffing

Key Staffing Indicators/ward in last 12 months

- Each ward had a staffing compliment called 'staffing ladders', these were provided centrally by the Priory Group. We observed the required complement of staffing on each shift. The 'ladders' could be increased locally based on patient needs, for example one-to-one care. We looked in detail at staffing rotas for Lower Court and Oak Lodge between December 2014 and January 2015. On many occasions the number of qualified nurses on the ward did not meet the 'staffing ladder'. Lower Court's staffing 'ladder' was identified as two qualified nurses for each day and night shift. Between 05 and 31 January 2015 on 15 night shifts there was only 1 qualified nurse was on duty; 58% of shifts. On Oak Lodge 22 daytime shifts in January 2015 had only one qualified member of staff and on three days that member of staff was the ward manager; 71% of shifts.
- Staff told us, and rotas confirmed that they were frequently moved around the hospital to cover unfilled shifts. Consequently, staff were concerned about the impact on patient care. For example, when administering medicines to unfamiliar patients outside their specialist areas such as in the eating disorder unit.
- Patients told us that they were able to have time with staff. Escorted leave was often carried out by occupational therapy staff. We received no complaints from patients about lack of access to leave.
- There was adequate medical cover provided throughout the week including by a newly appointed staff grade psychiatrist on Lower Court.

Assessing and managing risk to patients and staff

- On complex care patients had up to date risk assessments and this informed the level of observations completed by staff. Patients' risk assessments on Upper Court were reviewed regularly and patients had daily physical checks to monitor for consequences of an eating disorder.

Is the service safe?

- Risks to patients and others had not always been re-assessed following incidents on Lower Court. In illustration, following a series of incidents, the risks identified were documented. However, it did not result in changes to their care plan. Staff failed to identify the escalation in this patient's behaviour and increase observation appropriately. The risk assessment also failed to address the effect of this patient's behaviour on other patients. Patients told us they felt unsafe on occasions. For a second patient, who was detained under the Mental Health Act we found that following their abscontion from the hospital, their risk assessment was not updated. A third patient had been assessed as needing two staff to escort them to leave the hospital but without a further risk assessment this had been changed to one member of staff.
- There was information available on each ward to inform informal patients they could leave at will.
- There were policies and procedures in place to observe patients. The majority of bedroom doors did not have viewing panes which meant staff had to go into patients' rooms to carry out night-time checks. Some patients told us this disturbed their sleep.
- Staff were trained in restraint techniques and staff on Upper Court, the eating disorders unit, had received adapted training suitable for restraining physically frail patients.
- We observed several different approaches to assessing the risk posed by ligatures in care plans. In acute areas, each patient had a ligature assessment for their bedroom but several ligature points were not included. There were no environmental ligature assessments for communal areas. We saw A number ligature points in these areas. For example, the unsupervised lockable laundry and the courtyard garden. There were no plans in place on the ward to identify risks in communal areas or to mitigate ligature risks across the area. We also found A number ligature points in the four bedrooms referred to as 'reduced ligature' including widow fittings. In complex care there were individual patient and environmental ligature assessments.
- We identified several concerns with the management of medicines on Oak Lodge. These include:
  - nursing staff did not always follow the Priory's policy concerning the dispensing of all controlled drugs by two nurses.
  - correct procedure had not been followed in reporting a controlled drugs incident.
  - procedure for administering medicines via percutaneous endoscopic gastrostomy (PEG) feed was unclear. The formulation of the medicine was not always specified within medication charts. On one occasion, the prescription was changed from a liquid to a tablet not suitable for crushing. There wasn't a rationale recorded for this change. Some staff nurses administering the PEG feed told us they had not received training to carry out this procedure.

The hospital director told us that there were plans in place to review the controlled medicines policy in the near future.

Track record on safety

- There had been a number of safeguarding incidents within the hospital. Commissioners told us that they had not always been informed of safeguarding incidents but this had improved recently. Two patients had been the subject of more than one safeguarding referral.
- Reporting of safeguarding incidents had recently increased;, as had notifications to CQC following a 'dip'. Hospital managers told us that the volume of reporting had improved.

Reporting incidents and learning from when things go wrong

- Staff knew about the electronic reporting system and how to use it. Staff gave positive feedback on the reporting system which prompted staff to record initial lessons learnt for every incident. There was limited evidence of any learning being shared on the wards, or between wards in complex care.
- Not all incidents that should have been reported were. We found evidence of incidents which had happened on Lower Court which should have been reported as incidents but had not. One patient who was detained under the Mental Health Act had absconded on two occasions. This was not recorded as an incident or notified to the CQC. Staff on Lower Court failed to identify escalation of incidents and to report appropriately, resulting in patients feeling unsafe.

Is the service safe?

- There was evidence that staff were able to raise concerns about the practice of colleagues and that this was taken seriously by hospital managers. Where concerns were raised we found that the hospital managers took appropriate action.
- Investigations in incidents and safeguarding did not always happen swiftly. The local authority safeguarding team told us that it found it difficult to always obtain all the information requested in a timely way. Senior staff at The Priory told us that staff were reporting more safeguarding which was why there was a higher rate of referrals.
- Staff told us they were offered the opportunity for debrief after incidents.
- Staff had received training in safeguarding, 2013-14 safeguarding vulnerable adult training was at 95% and children 97%. Staff told us they felt confident in raising concern about other practice if needed.
- We noted that on Lower Court a potential safeguarding situation had not been recognised.

Is the service effective?

Our findings

EFFECTIVE

Assessment of needs and planning of care

- All patients had an assessment and care plan completed on admission. On Upper Court we found care plans were detailed and holistic. There were detailed physical health care plans on both Upper Court and Garden View.
- Physical examinations took place as needed and there was good consideration of physical healthcare in most areas in line with NICE guidance. There was detailed discussion of physical health needs in the multi-disciplinary team meeting. Upper Court monitored patients' health closely using an adapted version of the Modified Early Warning Signs (MEWS). Some gaps and poor recording practice in physical health assessments such as fluid charts were identified in complex care.
- The majority of care plans were up to date and had been reviewed. We found that progress notes did not always reflect the care plan. On Lower Court incidents had not always been used to inform and update the care plan.
- Some information was available to staff both electronically and on paper, however not all records were available at all times. For example, on the first day of our inspection we were not able to access any electronic notes. Information was not always stored securely; a patient's notes were left unattended in a corridor on Garden View. The two systems also led to different plans being in place at the same time. For example, nursing staff were producing paper manual handling assessment while occupational therapists producing patient movement plans.

Best practice in treatment and care

- There was very good access to psychological therapies across the hospital the service available were CBT based and were delivered in line with NICE or other good practice guidance.
- Most patients had good access to physical healthcare. There were regular physical health checks and staff on the eating disorders unit had specialist knowledge about physical healthcare for this patient group
- One person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNCPR) in place without consultation with either their family or an advocate.

Skilled staff to deliver care

- There was a range of qualified and unqualified nursing staff, medical staff and therapists. Patients had access to occupational therapists and psychologists.
- The provider responded quickly to staff performance issues. Where concerns were raised about staff conduct the provider took immediate action. Staff told us they were confident to raise concerns.

Multi-disciplinary and inter-agency team work

- Handovers were effective. They were structured and person-centred, covered risks and physical health, other important information about patient care was discussed and it was evident that staff were interested in patients' needs and progress.
- Multi-disciplinary meetings were held regularly. The MDT review on Garden View was thoughtful, respectful and sensitive to the needs of the individual. Staff were able to advocate well on behalf of patients. All patients had complex care needs and there was a wide range discussion on each with consideration of both mental and physical health needs. There was a detailed review of physical health needs on patients which included weight, bloods, pain relief and referrals to specialists.
- The service had developed a positive working relationship with the local authority safeguarding team and held regular meetings. Local commissioners told us that, in the past, there had been incidents of poor communication but this had decreased recently. There were a number of patients from other areas and staff told us that it could be difficult to obtain a consistent history but that measures had been put in place to improve this. The hospital had also recently appointed a social worker who would be able to liaise with local authorities to support patients who had been at the hospital a long time to move on.

Adherence to the MHA and the MHA Code of Practice

Is the service effective?

- We found that staff were operating the MHA effectively. Staff understood and gave regard to the Code of Practice.
- People told us that they had their rights under the MHA explained to them on admission and routinely thereafter.
- Detention paperwork had been filled in correctly, were up to date and stored appropriately.

Good practice in applying the MCA

- On Garden View we found capacity assessments were of very poor quality. There was limited information on the capacity form and the evidence section contained the statement 'MDT discussion and direct observation'. For example, a patient on Lower Court was assessed as not having capacity however there was no record of how this decision had been reached.

Is the service caring?

Our findings

CARING

Kindness, dignity, respect and support

- Staff were respectful, kind and patient. Staff were relaxed and stopped to listen when patients spoke to them. When staff spoke with us about individual patients they were professional and concerned to respect patients' dignity. Staff told us that they all enjoyed seeing patients recover or having the opportunity to make patients comfortable.
- Patients told us that staff were kind and supportive. Feedback from our conversations with patients and from the comments boxes[MC1] that we placed around the hospital to gather feedback from patients was very positive. Many of the patients in the hospital took the opportunity to tell us that they were very satisfied with the individual care they received. We saw staff actively attempt to involve patients in one to one sessions.
- On Upper Court and complex care the permanent staff had a detailed knowledge of individual's needs. For example, on Upper Court, staff understood the philosophy and ethos of eating disorder treatment and most spoke enthusiastically about their role on the ward. Staff demonstrated understanding of the difficulties for patients whilst being clear about the need for clear boundaries. On complex care staff demonstrated commitment to supporting people in a person-centred and individualised manner. On Lower Court, staff were committed to patient care but we were concerned that the acuity of patients was increasing but that the staff had not caught up with this.
- Staff on complex care demonstrated a high level of awareness of patients and their likes and needs. Staff told us how the provision of plastic wine glasses had improved patient's acceptance of their medication. The menus provided in the complex care were pictorial to support patients' ability to choose. We observed staff engaging with patients at meal times using positive communication and humour to encourage patients to eat well.
- Steps had been taken to provide patients with easy read and pictorial material across complex care.
- The complex care wards lacked a homely/personalised feel for their long stay patients and had an institutional feel about them in some areas. We observed measures being taken to address this. During the inspection, bedrooms doors were being personalised to reflect the patients' interest and colour choices. There was little in the way of sensory equipment/environment for people with poor cognitive functioning.
- Patients, visitors and staff were able to see directly into several patients' bedrooms from gardens in areas of the complex care unit.

The involvement of people in the care they receive

- On Upper Court there was strong evidence of patients engaging in the planning of their care. In other wards some patients told us they had been involved in their care planning, whilst others said they were unsure. On all wards patients were oriented to the ward and given information as part of their admission.
- Patients had access to the MDT and their views were taken into account. On complex care there was limited evidence of patients being involved in their care planning; however staff discussed with us the difficulty of engaging some patients in care planning or activities.
- There was confusion about the delivery of Independent Mental Health Advocacy (IMHA) services. There were no IMHA notices up on the acute ward, although there was a general advocacy notice. There was lack of clarity as to whether the advocate was the IMHA as well. Ward staff told us that they were but the advocate told us they were not. There was no information for patients or staff about MIND who provide a Bristol-wide IMHA service.
- Carers and families for patients on Upper Court told us they appreciated the support they had received and that they had been able to understand more about their relative's illness. We saw some evidence of carers being involved in discussion about patients' needs.

Patient meetings were held regularly and feedback about services was sought. Wards have service user forums, through which issues get escalated to the monthly senior management team's monthly user forum

[MC1]How many

Is the service responsive?

Our findings

RESPONSIVE

Access, discharge and bed management

- The Priory Bristol does not have a specific catchment area from which it takes patients. It takes patients from the local area and nationally, both private and NHS. There were beds available (vacant) on some wards. Staff told us that if NHS patients were to be transferred to a bed in their local area they tried to do this during the day. Hospital managers told us they carried out assessments to ensure they could meet patient needs before agreeing admission. Although the provider admitted the acuity of patients had increased recently, staff training was yet to meet the needs of these new patient group.
- Patients on Upper Court had discharge plans in place and Lower Court negotiated with local services where necessary to support patients' discharge. We were told this could be difficult sometimes as different areas had different systems but The Priory Bristol tried to work with them. There were some patients on complex care who had been at the hospital several years.
- We were informed that there was a six week waiting list for one-to-one psychological therapy during the time of the visit. Hospital managers had sourced funding for a further full time post to support the delivery of the service.

The ward optimises recovery, comfort and dignity

- Patients told us that Lower Court and Upper Court wards were cleaned regularly. These wards were clean and welcoming. Areas on Oak Lodge and Hillside wards smelt of urine and carpets were stained and dirty. We also saw large numbers of cigarette ends in communal outside spaces and gardens for these wards. We were shown an approved capital investment plans to replace the flooring across this area.
- There were clinic rooms across the hospital where patients could be examined and receive medicines in private.
- Private rooms were available where patients could speak with staff or visitors in privacy. The lounge on Oak Lodge lacked any homely finish.
- Patients could use their mobile phones on the ward and were able to make telephone calls in private.
- There was access to outside space on each ward and pleasant grounds that patients could access. We were concerned that the Lower Court courtyard garden was not easily supervised and had ligature points and was easy for patients to abscond.
- There was a great deal of praise for the quality of the food. Catering staff worked hard to ensure patients received very high quality meals. There was a dining room which could be used by staff and patients in the main building. Staff told us of examples of how they had promptly responded to patients' cultural food needs as well as how they took into account of allergies and food texture.
- There were facilities on all wards for patients to make hot snacks. In addition, patients could visit the main dining room.
- Patients had their own bedrooms with ensuite bathrooms. Bedrooms and bathrooms were furnished to a good standard and patients told us they were satisfied with their bedrooms.
- Patients were unable to lock their bedrooms on Lower Court but there was no rationale for this.
- Activities were available on all wards. Staff told us that it could be difficult to get people to attend from complex care due to motivation. However, staff were observed taking patients from complex care to the shops in the morning and to the cinema in the afternoon. While others who did not wish to engage in activities or group activities were offered one-to-one time. There was a range of therapeutic groups available.

Meeting the needs of all people who use the service

- Wards were accessible to disabled people and adapted bathrooms were available.
- On complex care, a good range of pictorial and written material on making a complaint, services the hospital provides and patients' rights were available.
- All patients told us about the quality and choice of food was excellent.

Is the service responsive?

- During our visit a local clergyman was on site enabling patients to access to appropriate spiritual support if they wished.

Listening to and learning from concerns and complaints

- Patients knew how to make complaints. Pictorial material was available on complex care to support patients' understanding of how to make a complaint. Staff on Upper Court told us they supported patients to make complaints.

Is the service well-led?

Our findings

Well Led

Vision and values

- Not all staff could recall the vision, 'be the best that we can be'. However the majority of staff believed that the hospital director was focussed on improving clinical delivery.
- There was strong leadership from the new hospital director who was implementing a system of stronger staff engagement and improved governance. However, the director had only been in post for six months and although had developed a clear strategy for improving services was in the early stages of delivering of the quality improvement plans. Two new appointments, a medical director and deputy hospital director/director of nursing had recently been filled to further strengthen the clinical leadership.

Good governance

- The hospital had moved away from a purely compliance system to a quality improvement system. The Priory Group had developed a list of twenty key priorities to address for 2014. The hospital was then required to develop three further prioritise – these three were focussed on patient engagement and implementing a recovery model.
- Ward managers undertook quality walk around in each other's wards with the senior management team. They focussed on four key themes to look at each week.
- Staff received regular supervision and appraisal. Staff had regular supervision and this was recorded. Staff were able to choose their own clinical supervisor.

Leadership, morale and staff engagement

- In the 2014 Bristol Priory's staff survey, 81% stated that the feel they are able to do their job to a standard they are personally pleased with.
- Staff were confident in raising concerns about practise and risks to patients. They told us that their concerns were always taken seriously. The staff described an increasingly open culture. They told us that if they raised any issues with the director they felt listened to and confident action would be taken. There had been an increase in the numbers of staff raising poor practice which indicated the culture of reporting had begun to improve.
- The Priory Bristol had an ongoing program to engage with staff to find out how things could be improved. Staff were able to give feedback anonymously if they wished. Staff had raised concerns about the quality of assessments and incomplete medication chart relating to contract agency doctors. The hospital director provided evidence of a protracted response with the agency between October 2014 and January 2015 where she had attempted to address these issues.
- Staff morale was mixed. Some staff were satisfied whilst others felt overstretched and unsupported. A common theme was the lack of availability of ward managers, particularly on Lower and Upper Court where there had been significant periods of time with a permanent ward manager. The role had been covered by the deputy ward manager but this had taken a senior nurse support away from direct care delivery the wards. Health care assistants felt that their role was very limited, particularly on complex care. All the staff we spoke with were very committed to providing the best patient care they could and spoke of finding it rewarding to improve patients' lives.
- The staff turnover rate for 2014 was 33%. The hospital director recognised that retention was a key issue for the hospital. In the 2014 staff survey only 51% felt they will still be working for the Priory Bristol in 12 months' time. A number staff told us that they were aiming to leave and were actively seeking other jobs elsewhere. A minority of staff told us that this was due to senior management failing to recognise the increasing risks from the increased acuity of patients on Lower Court and that they felt unsafe. The hospital had not received any resignations in January 2015. The management team had put plans in place in the last six months including financial incentives to aid recruitment and retention.
- Staffing was a key concern for the hospital. Shifts were not always covered by a sufficient number of staff and some staff told us they had to provide cover in areas where they did not feel confident and competent. Most, but not all, staff felt they had sufficient time to deliver care effectively.

Is the service well-led?

Commitment to quality improvement and innovation

- The hospital used a scorecard to monitor training and looked at confidence intervals – if there was 10% outside the set confidence intervals then it would consider it had a problem. The uptake of mandatory training had been consistently high over the last two years. In 2014 attendance rate had varied from 91% - 98%. When training was due to expire, an update was booked automatically; its system didn't rely on individual staff members booking themselves onto training courses. A member of staff on Upper Court told us that they had been supported to undertake additional training in eating disorders.
- The hospital had carried out thirteen audits in 2014 (safeguarding twice). These varied from clinical audits on therapy or care plans to fire evacuation.
- The eating disorder unit on upper court had participated in a Royal College of Psychiatrists Quality Network (QED) in November 2014, a national quality audit
- Staff were enthusiastic about recent national training that had been delivered for eating disorders and training in dementia scheduled into the years training programme.

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
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 9 (b)(i)(ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12(1) (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **We found that provider had not protected people against risk. The provider failed to ensure risk management plans capture and are clear for all identified risks affecting individuals and that all care plans are reviewed and updated when new risks are identified. The provider had failed to ensure that incidents were being reported. The provider had failed to ensure that fluid monitoring chart had been recorded**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises **Regulation 15 (1)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 e Act 2008 (Regulated Activities) Regulations 2014.** **We found that provider had not protected people against risk from environmental ligature risks and areas where there were no visible lines of sight.**

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control

This section is primarily information for the provider

Requirement notices

Regulation 12 (20 (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 (1) (a) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that provider had not provided suitable and safe environment on complex care unit as the carpet were dirty and worn.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation11(1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found the provider did not have suitable arrangements in place to ensure they always obtained, and acted in accordance with, the consent of service users in relation to the care and treatment provided for them. We found examples were the person's capacity to consent to an individual decision was not decision-specific.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found that the provider had not followed appropriate procedures for the storage and administration of medicines.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Accommodation for persons who require nursing or personal care Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider must ensure the privacy, dignity and safety of patients by ensuring that it complies with same sex guidance in the Mental Health Act Code of Practice. Female patients should have access to a female only lounge.