The Priory Hospital Roehampton

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated this service as requires improvement.

- At the previous inspection in February - March 2016, we identified that there were insufficient staff employed and deployed at the hospital to ensure the safety and consistency of patient care. At the current inspection there remained high vacancy rates for nurses across the hospital and particularly on the eating disorder service. This resulted in high use of bank and agency staff and there were also a significant number of shifts with below safe staffing levels. Records indicated that there were more incidents on shifts with insufficient staff on Priory Court, the eating disorders unit for children and adolescents. There had been 95 incidents on Priory Court in the six months prior to the inspection. Following the inspection the provider sent us revised data indicated higher staffing levels than recorded above. We undertook enforcement action against the provider serving a warning notice regarding staffing levels. Staff compliance with mandatory training was low.
- At the previous inspection in February - March 2016, we identified that the hospital environment was unsafe for patients at risk of suicide or self-harm. The provider sent us an action plan, with some improvements to the environment not due to be completed until 31 December 2016. At the current inspection, the hospital environment, particularly on the acute wards, remained unsafe, due to poor sight lines, ligature anchor points, and access to vacant corridors and staff offices. The hospital had introduced 'safer rooms' to accommodate patients presenting a heightened level of risk, but these were not yet completed to full specification. Risk assessments of the safety on wards were not sufficiently robust to include all areas of high risk. Risk assessments and care plans varied in consistency and detail, so that there was a risk that staff would not meet patients' needs.
- At the previous inspection in February - March 2016, we identified that staff undertook naso-gastric feeding in an inappropriate environment, and there were insufficient facilities across the hospital, for the physical examination of patients. At the current inspection, we found that on Upper Court, staff carried out naso-gastric feeding in a therapy room. This was in line with the action plan provided indicating that this would be completed by 31 March 2017. However, there was no appropriate seating provided for the purpose in the therapy room being used. On East Wing and Upper Court there were no clinical rooms available for staff to conduct physical examination of patients. This usually took place in their bedrooms.
- At the previous inspection in February - March 2016, we found that agency staff used log-in details of permanent staff on shift. This was still happening at the current inspection.
- Feedback from patients on Priory Court was that seeing staff restrain other patients on the ward distressed them. Staff and patients from other wards walking through Garden Wing to access the canteen, affected the privacy and dignity of patients on Garden Wing. There were no quiet areas available to patients on Priory Court, and no privacy for patients who were distressed. Restraint of patients took place in full view of other patients. There were blanket restrictions on patients on Priory Court. For example, most patients were not able to access their bedrooms during the day.
- Staff undertook checks of emergency drugs and equipment sporadically on the eating disorder units, and there was no documentation to show that they cleaned equipment in the clinic rooms regularly. Staff did not carry out and record observations of patients' vital signs routinely and at regular intervals after administering rapid tranquilisation.
- Staff did not always record patients' involvement in their care plans to ensure that their views were taken into account.
- The provider had not displayed the current CQC inspection rating for each core service prominently as required.

However:

- At the previous inspection in February - March 2016, we identified that improvements were required in reporting and learning from incidents. The hospital

had introduced a new system to ensure that staff recorded serious incidents quickly and consistently. Managers held a 'learning and outcomes' group once a month to review all incidents that had taken place and identify areas for improvement.

- At the previous inspection in February - March 2016, we identified that staff engagement should be reviewed to ensure that staff working on the acute wards are able to raise concerns. This had improved at the current inspection. Senior managers regularly visited the wards and there was a governance system in place to monitor the quality and safety of care provided. There were daily meetings of senior managers to discuss incidents and immediate issues of concern.
- An occupational therapist on Priory Court was helping patients to create self-soothing boxes with items the patient found comforting and could distract them from distress. Upper Court had recently achieved accreditation by the Quality Network for Eating disorders.
- At our previous inspection in February - March 2016, we identified that the provider should consider whether they should admit patients with a high risk of self-harm to an environment where it is hard for staff to observe patients. At the current inspection, we noted that the provider had implemented a pre-admission risk assessment. This included a handover system for ensuring staff noted risks.
- The wards provided a comprehensive range of psychological therapies, including dialectical behavioural therapy, mindfulness, and family therapy. Occupational therapists and dietitians facilitated activities and discussion groups.
- At the previous inspection in February - March 2016, we identified that informal patients were not always able to leave the hospital in line with their legal status. This had improved at the current inspection

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Acute wards for adults of working age and psychiatric intensive care units; Specialist eating disorders services;

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Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides support and treatment for people with mental health needs, eating disorders and drug and alcohol addictions. It has 99 inpatient beds. The hospital provides care and treatment for adults and children experiencing acute episodes of mental illness, an in-patient detoxification and addiction therapy programme, and an in-patient care and treatment for adults and children with eating disorders. Services are provided on the following wards:

• Upper Court provides an eating disorders services for up to 13 adult female patients.

• Priory Court is a mixed eating disorders service for up to 19 children and adolescents.

• East Wing provides care and treatment for up 12 female NHS patients.

• Garden Wing is a mixed adult ward for people experiencing acute mental illness. It provides services for up to 18 patients.

• West Wing is a private mixed acute psychiatric admission ward and a ward for people participating in the addictions therapy programme.

• Lower Court is a mixed ward and provides care and treatment for up to 12 children and adolescents up to 18 years old experiencing an acute episode of mental illness. (We did not inspect this service on this occasion)

The provider is registered to provide care for the following regulated activities:

• 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

There was a registered manager assigned to the hospital.

Our inspection team

The team that inspected the service comprised four CQC inspectors, an inspection manager, and two specialist advisors who were nurses with experience of working in acute and eating disorder services.

Why we carried out this inspection

We undertook this inspection to find out whether Priory Healthcare Limited had made improvements to their acute wards for adults of working age and specialist eating disorders services since our last comprehensive inspection, which took place from 23 February- 3 March 2016.

When we last inspected the hospital, we rated acute wards for adults of working age as **requires improvement** overall; we rated the core service as inadequate for safe, requires improvement for effective, good for caring, good for responsive and requires improvement for well-led.

We rated specialist eating disorder services as requires improvement overall. We rated the core service as requires improvement for safe, good for effective, good for caring, requires improvement for responsive and good for well-led.

We rated child and adolescent mental health wards as good overall. We rated this core service as good for safe,

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good for effective, good for caring, good for responsive and good for well-led. Since that inspection, we have received no information that would cause us to re-inspect this core service or change the rating.

After the inspection, we told the provider that it must take the following actions to improve acute wards for adults of working age and specialist eating disorder services.

- The provider must ensure that staff turnover is reduced and more permanent staff are employed to provide consistency of care
- The provider must progress work to improve the safety of the physical environment
- Care and treatment of service users must only be provided with the consent of the relevant person
- The provider must consider if patients with a high risk of self-harm should be admitted to an environment where it is hard for staff to observe patients
- The provider must ensure that staff record incidents correctly so the information can be used to monitor and improve the service.
- The provider must ensure that informal patients are able to leave the hospital in line with their legal status
- The provider must review staff engagement to ensure that staff working in the acute wards are able to raise concerns
- The provider must ensure that a suitable environment is available when patients require nutrition to be delivered through nasogastric tubes and that there is a suitable environment for the physical examination of patients on each ward
- The provider must ensure that personal log-in details of permanent staff are not shared with agency staff.

These related to the following regulations under the Health and Social Care Act (Regulated

Activities) Regulations 2014:

Regulation 11 Need for consent

Regulation 12 Safe care and treatment

Regulation 15 Premises and equipment

Regulation 17 Good governance

Regulation 18 Staffing

At the last inspection in March 2016, we rated child and adolescent mental health wards as good.

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- carried out an unannounced night visit to East, West and Garden Wings on 19 October 2016 during which we attended the handover between the day and night staff shifts, looked at the environment, spoke with staff and patients and met with the night shift co-ordinator and responsible medical officer
- carried out day visits to East, West and Garden Wings and the Eating Disorder Units (EDU) Priory and Upper Court on 20, 24 and 26 October 2016
- looked at the quality of each ward environment and observed how staff were caring for patients
- spoke with 15 patients who were using the EDU service and 14 patients and one relative on the acute wards
- spoke with the managers of each of the wards and two deputy ward managers
- spoke with seven other staff members on the EDU including doctors, nurses and social workers, and 21 other staff members on the acute wards including doctors, nurses, health care assistants, a therapist and a student nurse.
- attended the staff handover meetings and three ward rounds
- reviewed the admission records of seven new patients who had recently been admitted to the hospital

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- looked at eight care and treatment records of patients on the EDU and twelve patient records on the acute wards, and reviewed the statutory documents relating to the detention of ten patients detained under the Mental Health Act 1983 (MHA).
- carried out a specific check of the medication management on each ward and reviewed eight prescription charts on EDU and 15 on the acute wards.
- looked at a range of policies, procedures and other documents relating to the running of the service
- attended a 'flash' meeting (held daily) to monitor staffing and safety across the hospital
- spoke with the hospital director, two new clinical service leads, the governance and audit coordinator, the therapy services manager, and MHA administrator
- looked at seven staff recruitment records

What people who use the service say

We spoke with patients on each of the wards, including a group of 12 patients on Priory Court. Overall patients were satisfied the care and treatment provided, although they described feeling less satisfied when there were many new agency staff covering a shift.

Patients were generally very satisfied with the therapies provided to them, and the food provision and cleanliness in the hospital. Most were satisfied with the hospital environment. However, some noted areas that required refurbishment.

Most patients were happy with the support staff provided them with, and said they were able to see a doctor when needed. They attended ward rounds, and felt able to speak with the ward manager if they had any concerns.

Staff were described as kind, respectful and always doing their best. Some patients said there had been problems with high numbers of agency staff but the situation had improved.

On Priory Court patients said that they were concerned about their safety. They said that often there were not enough staff on duty, particularly when up to six staff had to deal with a specific incident. Patients said that there were always agency staff on duty. Some patients were concerned that the clinic room was next to the day area, which may compromise confidentiality if they were discussing problems. Patient felt the layout of the ward was unsuitable as restraints took place in the day area. Patients were also unhappy that staff locked their rooms between 8am and 8pm.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate 

We rated safe as inadequate because:

- At the previous inspection in February - March 2016, we identified that there were insufficient numbers of suitable staff deployed on the wards at all times to deliver the service safely. At the current inspection there remained high vacancy rates for nurses across the hospital and particularly on the eating disorder service, although this had been reduced since the previous inspection. This resulted in high use of bank and agency staff. Some bank and agency staff were unfamiliar with the ward. There were also a significant number of shifts with insufficient staff cover. There was a link between insufficient staffing and an increase in incidents on Priory Court when the required level of staffing was not met. Following the inspection the provider sent us revised figures indicating a higher level of staffing than indicated at the time of the inspection.
- There had been 95 incidents on Priory Court in the six months prior to the inspection. Staff and patients said that when incidents occurred there were sometime insufficient staff to supervise patients who were not involved in the incident.
- At the previous inspection in February - March 2016, we identified that the hospital environment was not sufficiently safe for patients. At the current inspection, the deadline for completion of all works to address this had not yet passed. At the time of the inspection, the hospital environment, particularly on the acute wards, remained unsafe, due to poor sight lines, ligature anchor points, and access to vacant, isolated corridors and staff offices.
- Risk assessments of the safety on the wards, did not include all areas of high risk found during the inspection.
- Staff carried out checks of emergency drugs and equipment sporadically on the eating disorder units, and there was no documentation to show that staff cleaned equipment in the clinic rooms regularly. The checklist for clinical equipment did not include space for staff to make comments. Comments in margins were difficult to understand.
- Essential equipment on the eating disorder unit had not been serviced or calibrated, meaning that staff could not be sure they were working correctly.
- Compliance with mandatory training was low.

Summary of this inspection

- Blanket restrictions were placed on patients on Priory Court, for example, most patients were not able to access their bedrooms during the day.
- Observations of patients' vital signs were not routinely carried out and recorded at regular intervals after staff administered rapid tranquilisation.

However:

- The hospital had introduced three-month contracts for agency staff. This helped to ensure they were familiar with the ward and participated in team meetings.
- At the previous inspection in February - March 2016, we identified that the hospital's admission procedures did not always keep people safe. At the current inspection, the provider had introduced pre-admission risk assessments to improve the handover of new patients' risks on admission.
- At the previous inspection in February - March 2016, we identified that staff needed to improve recording and learning from incidents. The hospital had introduced a new system to ensure that staff recorded serious incidents quickly and consistently. Managers held a 'learning and outcomes' group once a month to review all incidents that had taken place and identify areas for improvement.

Are services effective?

Good

We rated effective as **good** because:

- At the previous inspection in February - March 2016, we identified that informal patients were not always able to leave the hospital in line with their legal status. The provider had addressed this.
- Staff carried out assessments of patients' physical and mental health on admission. This including a handover system to ensure staff noted risks.
- Staff recorded regular physical examinations on a chart specifically designed to calculate the risks to patients with eating disorders.
- The wards provided a comprehensive range of psychological therapies, including dialectical behavioural therapy, mindfulness, and family therapy. Occupational therapists and dietitians facilitated activities and discussion groups.
- On the eating disorder wards, on admission, the dietitian used blood test results to prescribe a re-feeding programme for patients specifically designed to mitigate the risks of re-feeding syndrome.

Summary of this inspection

- Each ward used questionnaires to assess the progress and outcomes for patients. On the eating disorder wards, staff designed these questionnaires to meet the specific needs of patients with eating disorders.
- Managers carried out a comprehensive annual appraisal with each member of staff and staff spoke positively about their external clinical supervision.
- Staff had access to a wide range of training specific to eating disorder services. Training was provided through online courses and courses taught in classrooms. Training sessions took place within team meetings and staff learned new skills through working alongside experienced colleagues.
- The senior management team introduced a specific training programme to support the continuous professional development of nurses.
- There was a team of approximately 40 therapists for the hospital. Therapists provided debrief sessions for staff and patients as and when needed on the wards.

However:

- Risk assessments and care plans varied in consistency and detail, so that there was a risk of staff not meeting patients' needs.
- Staff had managerial supervision sporadically in recent months. Notes of these sessions were often brief and did not provide a clear indication of the employee's competence.

Are services caring?

Good

We rated caring as good because:

- We observed positive interactions between staff and patients and staff demonstrated a good understanding of patients' needs.
- Many patients said that staff were caring and supportive.
- Patients told us that they were involved in the development of care plans and nutrition plans.
- The eating disorders service provided a handbook with information for families and carers as well as facilitating a weekly family support group.
- Patients had the opportunity to be involved in the recruitment of new staff.

However:

- Patients on Priory Court said that they were upset by seeing staff restraining other patients on the ward, who were very distressed.

Summary of this inspection

- Staff did not always record patients' involvement in their care plans.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- At the previous inspection in February - March 2016, we identified that staff carried out naso-gastric feeding in an inappropriate environment. At the current inspection, on Upper Court, staff still carried out naso-gastric feeding in a therapy room (due to be addressed by 31 March 2017). There was no appropriate seating provided for the purpose.
- At the previous inspection in February - March 2016, we identified that physical examinations of patients were taking place in their bedrooms. At the current inspection, we observed that there were no clinical rooms on East Wing and Upper Court. This meant that staff frequently conducted physical examinations of patients in their bedrooms.
- Priory Court was noisy and chaotic. There were no quiet areas available and no privacy for patients who were distressed. Staff sometimes restrained patients in full view of other patients.
- Staff and patients from other wards walking through Garden Wing to access the canteen, affected the privacy and dignity of patients on Garden Wing.
- The small dining room on Upper Court showed signs of wear and needed updating to provide a positive therapeutic environment.

However:

- Patients had access to gardens and the grounds of the hospital. Food was prepared and cooked on site. Patients spoke positively about the quality of the food.
- There was a structured programme of activities throughout the week including a range of therapies, and access to a gym on site.
- There was a good range of information leaflets available to patients about healthy eating and lifestyles. Patients knew how to make a complaint. The provider thoroughly investigated complaints. Staff discussed investigation reports in team meetings.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- At the previous inspection in February - March 2016, we identified that there were insufficiently rigorous systems in

Summary of this inspection

place to ensure compliance. At the current inspection, we found that the governance systems had not been effective in bringing about significant improvement. Progress in bringing about improvements had been slow.

- At the previous inspection in February - March 2016, we identified that there were agency staff were using the log-in details of permanent staff on shift. At the current inspection, we found that some agency staff continued to use log-in details of permanent staff on shift.
- Staff compliance with mandatory training was low.
- Some staff felt demoralised by the high level of staff vacancies. Some staff were also frustrated that senior managers did not respond to requests for simple improvements to the ward environment.
- Staff on the wards were unaware of systems in place following an unexpected failure of the electronic patient record system.
- The provider had not displayed the current CQC inspection rating for each core service prominently as required.

However:

- At the previous inspection in February - March 2016, we identified that staff engagement was insufficient to ensure that staff felt able to speak up about concerns. At the current inspection, senior managers regularly visited the wards and there was a governance system in place to monitor the quality and safety of care provided. Senior managers had put in place systems to improve engagement with staff on the wards.
- There were daily meetings of senior managers to discuss incidents and immediate issues of concern.
- There were monthly clinical governance committee meetings to monitor the service, and a risk register was in place to highlight priority areas.
- Upper Court had achieved accreditation by the Quality Network for Eating disorders.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Use of the Mental Health Act was generally low across the hospital. The hospital systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Staff filled in detention paperwork correctly, up to date and stored it appropriately. On three records we found there had been delays in a second opinion appointed doctor authorising treatment for patients who lacked capacity or consent. This resulted in patients receiving treatment authorised by the responsible clinician under the provisions within the Mental Health Act for urgent treatment.

There was a Mental Health Act administrator based on site. Staff knew how to contact them for advice where necessary. Staff undertook training on the Mental Health Act and the Mental Capacity Act as part of their mandatory training. Staff explained patients' rights under the Mental Health Act to them routinely and had access to an independent mental health advocacy service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider delivered Mental Capacity Act 2005 (MCA) awareness training to all staff as part of the mandatory training programme, and the hospital had an identified member of staff who was the lead for Mental Capacity Act awareness.

There were no applications for authorisation to deprive patients of liberty under schedule A1 of the MCA at the time of the inspection, and there were no patients deprived of their liberty at the time of the inspection.

The hospital had a specific form to record the competency of patients under the age of 16.

Nurses on the wards told us that doctors considered mental capacity of patients at weekly ward rounds. They explained that if patients did not have capacity to consent to admission or treatment, and that inpatient treatment was necessary for the health or safety of the patient, they would make an application for detention under the Mental Health Act.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Specialist eating disorder services	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement

Detailed findings from this inspection

Notes

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

Requires improvement

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

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

Inadequate

Safe and clean environment

- At our previous inspection in February - March 2016, we identified that the hospital environment was unsafe for patients at risk of suicide or self-harm. An action plan was provided with some work still be completed by 31 December 2016. At the current inspection, we found that there remained ligature anchor points throughout the hospital and the wards. The provider had removed some ligature points since our last inspection. However, the ligature removal was not consistent on all of the wards. Three bedrooms on Garden Wing were designated 'observation' rooms for patients at higher risk of self-harm or suicide. The provider's action plan (updated 14 October 2016) indicated that the hospital's 'safer' or 'observation rooms' had been completed on 1 September 2016. These three bedrooms were close to the staff office on the ward but were set back behind another set of doors, off the main corridor. There were observation windows in the doors but the layout of the room meant that it was not possible for an observer to see most of the room including the majority of the bed. In the en suite bathroom, the provider had replaced the taps and there were no visible ligature anchor points. Curtain rails in the bedrooms were magnetic and collapsible. However, there was a large headboard and several pictures on the wall in the rooms that patients could use to secure a ligature. The deputy ward manager told us that the provider was due to refurbish the ward in the coming weeks but was not aware of the date.
- On West Wing, the layout of the ward meant that staff were unable to observe all parts of the ward. A newly refurbished ward office had been provided. Four bedrooms were in an area away from the main ward. Two bedrooms on the male corridor were down a short flight of stairs. Patients had unrestricted access to a staircase that led to a corridor of offices and therapy rooms. Staff left the door to this corridor open. Staff told us that they usually locked this door at around midnight. Staff left rooms along the corridor unlocked. Offices contained office equipment including a pair of scissors left on a desk. Patients could also access the staffroom from the staircase. Staff had not assessed the risks presented by patients' access to these areas.
- There were four assessment rooms on West Wing with reduced ligature risks including anti barricade doors, slanting wardrobe doors, and anti-ligature taps. However, these did include television cables, headboards, mirrors and pictures that presented a ligature anchor risk. The provider had covered windows in all the bedrooms on West Wing with a Perspex mesh to prevent patients tying ligatures. However, this did not apply to the windows in corridors and offices.
- On East Wing, the provider had removed all headboards and replaced them with a wooden headboard that sat flush against the wall so that patients could not tie a ligature. However, there were television cables or leads in the bedrooms. The furniture in the designated 'safer' rooms was new but had introduced further ligature risks into the rooms. The chairs had arms that were not

enclosed and around which patients could tie a ligature. In the regular bedrooms, there were taps in the sinks in the en-suite bathrooms. The main control measure identified in the ligature risk assessments dated 13 July 2016 was 'patients will be risk assessed and a risk management plan put in place. Patients' care plans must reflect the risk identified and a plan will be put in place to minimise the risk.' The ligature risk assessment identified that some furniture items were to be replaced and had been ordered but there was no delivery date stated. Ward staff confirmed that they had ordered replacement furniture as the current furniture was not safe. However, it remained in place in the rooms. The provider had covered the bedroom windows with Perspex mesh as on West Wing.

- On the second floor on East Wing, there was a small corridor including a staff room and a group/meeting room. At the end of the corridor, there was a connecting door through to another part of the hospital. The connecting door had a handle, which was a ligature risk. Staff had not identified this area of the ward on the ward ligature risk assessment dated 13 July 2016 and therefore not identified this ligature risk. This was an isolated part of the ward with unrestricted access. The East Wing blind spot audit, dated 31 August 2016, identified the blind spot on the staircase to the second floor and behind the archway but not the ligature risk. The blind spot audit stated the control measure to make it safer was to 'accept risk'.
- On each ward, staff carried out a ligature risk assessment every six months. The risk assessments identified the controls in place to manage the identified risks. These included the headboard, sign holders and room doors. However, staff had not identified the TV cables as a risk. Staff managed most risks by observing patients. Staff increased observation levels for patients assessed as being at risk of suicide and/or self-harm. Plans were in place to provide a further 17 'safer' rooms across the hospital.
- Ward layouts made it difficult for staff to observe patients clearly. There were many blind spots on all three wards. There were strategically placed convex mirrors on East Wing that helped staff to observe around corners and blind spots. These were not in place on Garden Wing, and only one such mirror was noted on West Wing. Staff carried out blind spot audits on the wards. On Garden Wing and West Wing, staff carried out the last blind spot audits on 4 October 2016. These identified the controls in place to mitigate the risks. Most controls stated 'accept risk' and the actions to take were usually 'robust observations' by staff. On East Wing, staff carried out the last blind spot audit on 31 August 2016. A steady stream of people passing through Garden Wing to access the dining area, made it difficult to monitor the safety of the environment. Since the previous inspection, fob doors had been introduced on Garden Wing and West Wing, resulting in a reduction in detained patients leaving without authorisation.
- Staff kept emergency equipment in the staff offices on each ward. This included a green grab bag and automated external defibrillator. There were several sets of ligature cutters on display including those specifically for cutting fabric and wire. Garden Wing kept an emergency medicines box that staff from all the wards could access out of hours if they needed to.
- Records showed that staff carried out regular checks on medicines and medical equipment to ensure that it remained fit for purpose. Locum staff were familiar with emergency procedures in the hospital. They knew who to contact in an emergency and where to evacuate to in the event of a fire.
- There was an alarm system on each ward and alarm call buttons in each bedroom. When staff sounded an alarm, the location was displayed on a screen in the ward office and on ward corridors so that staff could respond promptly. Staff checked alarms every week to ensure they were working properly.
- Staff completed records of patient observation checks they had carried out with patients. We reviewed some of those observations that were in progress at the time of our inspection and saw that staff recorded these contemporaneously.
- Garden and West Wing were mixed gender wards but all rooms had en suite bedrooms. Female and male patients had bedrooms in different areas, but Garden Wing did not have a separate female lounge. If female patients wanted to use a female only lounge, they could use the dedicated lounge upstairs on West Wing. East Wing was a female only ward.

Safe staffing

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

Requires improvement

- At our previous inspection in February - March 2016, we identified that there were insufficient staff employed and deployed at the hospital to ensure the safety and consistency of patient care. At the time of the current inspection, we found that on West Wing there had been 11 occasions in the last two months that the required level of staffing was not met during the day shift. This amounted to a shortfall of staff on 18% of day shifts, which affected patient care. For Garden Wing this figure was 16%. On West Wing 15% of night shifts had a shortfall of staff. This figure was 16% for Garden Wing. These figures of understaffed shifts were higher than those at the time of the previous inspection. Following the inspection, the provider sent us revised figures and analysis of the above data, indicating that some of these shifts had additional cover from other staff. However, we remained concerned that staffing was not being planned and reviewed to ensure that patients receives safe care and treatment at all times.
- Overall agency staff usage for the hospital had dropped within the last three months. West Wing used agency on 85% of day shifts in the last two months, Garden Wing used agency on 84% of day shifts, and East Wing used 74% respectively. For night shifts these figures were lower. Staff noted that high use of agency staff nurses meant that more weight fell on health care assistants, and this could be particularly difficult during admissions. They noted that sometimes staff did not share tasks equitably, with some staff undertaking observations for a whole shift, without any break. Observation of the rotas indicated that agency staff were often the most senior staff on shift.
- The hospital had recruited some agency staff on three-month contracts. These staff were described as being 'locum'. This meant they were familiar with the ward and participated in team meetings, training, incident reviews and group supervision. Agency staff did not receive management supervision but they did have access to one-to-one support if they requested this. There were induction records in place for new agency workers to learn about each ward. However, we noted that these were not explicit regarding highlighting ligature risks and blind spots.
- Shift co-ordination plans ensured that there was always a member of staff in the communal area of the wards. However, staff explained that this could be difficult when the ward was busy. They noted that they were able to request additional staff if needed, due to a particularly busy shift. However, this was often difficult to fill at short notice.
- A number of new staff had recently commenced work on all three wards, and we observed a significant number of newly recruited staff touring the hospital as part of their induction prior to commencing work on the wards. Following the most recent recruitment there remained vacancies for two nurses and one health care assistant post on West Wing, two nurse vacancies on Garden Wing, and one nurse and one senior health care assistant position on East Wing. Since April 2016, the provider scheduled an extra nurse to work each night on West Wing, providing cover for any ward in the hospital if needed.
- Ward staffing levels were set according to the number of patients admitted to a ward. The first one to one observation of a patient was included in the usual staffing number determined for the number of patients admitted. For any additional patients requiring one to one observations, managers added another member of staff to the rota. During the inspection, we saw that the wards were staffed according to these calculations. Some agency or locum staff worked at the hospital on a long-term basis. This helped maintain the continuity of care provided. The provider had reduced the overall number of staff vacancies since our last inspection in February. The number of nursing vacancies had halved. There were 12 vacancies for nurses at the time of the inspection. Management advised that pay enhancements had been helpful in filling nursing vacancies at the hospital.
- A nurse gave a locum nurse on the night shift on Garden Wing a tour of the ward and orientation. Locum staff received a hospital wide induction when they first started to work at the service. They received a local orientation on each ward they worked on. A locum nurse we spoke with told us they had worked about 10 shifts in the hospital in the last six weeks and this was the first occasion he had been the only qualified staff on the ward and therefore in charge. The locum nurse felt well supported whenever they worked in the hospital.
- Staff files showed that the provider had carried out pre-employment checks on the members of staff. These included a disclosure and barring service check and two

references from previous employers. There was a photographic identity document on file. The provider explored any gaps in staff members' work history as appropriate.

- A designated bleep holder on each ward responded to emergencies on other wards when required. Each ward had a junior doctor who provided medical cover to patients during the day. Outside office hours, a duty doctor based on the site was available on-call. There was a locum doctor provided by an agency on the hospital site out of hours in the evenings and at weekends. They worked from 5pm – 9am the next morning during weekdays and covered the hospital at the weekend. The out of hours doctors usually worked for a period of one week at a time. The locum out of hours doctor remained on site when on duty. There was a consultant psychiatrist on call out of hours.
- Locum doctors did not have log-ins to allow them to access the electronic records. Senior managers told us a system had been developed recently to allow locum staff to get a log-in quickly. However, this was not conveyed to staff on the wards and locum doctors. Locum staff, including doctors used the log-in of permanent staff to enter details into the patient electronic records.
- Across the hospital site, 73% of staff were up to date with mandatory training (69% including bank staff). For doctors this figure was only 43%. For the wards, mandatory training figures were 74% for West Wing, 76% for Garden Wing, and 74% for East Wing. Following the inspection, the provider sent us revised figures indicating higher compliance rates with training.
- Managers could monitor mandatory training completed by staff. Compliance with mandatory training for eligible staff was relatively low in particular areas, although there were improved training rates in suicide prevention and risk assessment. This was partly due to a significant turnover of staff within the hospital. On West Wing training in rapid tranquilisation was 57%. Figures for face-to-face training in prevention and management of violence and aggression (PMVA) and breakaway were 74%. Following the inspection, the provider sent us revised figures indicated higher compliance rates.
- On Garden Wing fire safety training was at 65% and safe handling of medicines was at 62%. PMVA training was completed by 60% and breakaway training by 55% of eligible staff. Following the inspection, the provider sent us revised figures indicating higher compliance in these areas.
- On East Wing training in infection control was completed by 48%. Only 36% of eligible staff were trained in rapid tranquilisation. Following the inspection, the provider sent us revised figures indicating higher compliance in this area.
- All staff had completed basic life support training, but staff had not yet had training in intermediate life support. The provider recognised this as a training requirement for all nurses. However, the training was only due to start the month after the inspection.

Assessing and managing risk to patients and staff

- At our previous inspection in February - March 2016, we identified that the provider must consider if they should admit patients with a high risk of self-harm to an environment where it is hard for staff to observe patients. At this inspection, we found that the system for risk assessment of patients prior to admission to the hospital had improved, but there remained some inconsistency in assessments.
- Staff risk assessed all patients and assigned a risk rating – red, amber or green – and an observation level was set according to the level of risk identified. Records showed that staff carried out risk assessments on a standard form for all patients on admission. They updated these assessments frequently. These were linked to risk management plans that included the frequency of observation, and ways of addressing anxiety and challenging behaviours.
- Four levels of observation were available, ranging from constant observation (with a member of staff within eyesight of the patient at all times) to intermittent observations either twice or four times each hour, and general observations involving hourly checks. Nurses could increase the observation level but only a doctor could authorise a reduction. Restricted items, such as razors, were stored in the nurses' office.
- We reviewed the care records of the two newest patients on each ward. Staff had completed risk assessments and put risk management plans in place to address the risks. Overall, there was an improvement in the

recording of risk assessments for patients on admission and handover of risks from referrers. Mitigating actions included regular observations of the patients and removal of ligatures and sharp objects. However, staff did not always record details of risks on care notes (the electronic recording system) and address them in risk management plans. On East Wing, one patient had tested positive for illegal drugs. Staff recorded this as a risk but there was no particular risk management plan in place to address this.

- We found variable waiting times for nurse and doctor assessments following admission to the acute wards. Management advised that this should be within an hour or two hours of admission at the most. However, there was no system in place to monitor waiting times for an initial assessment. A system to stagger admission times using different time slots had been introduced, but this had not prevented patients coming in at times other than the slots arranged, leading to delays in assessments on the wards. There were plans to move the hospital's admission department closer to the main reception, and carry out joint assessments between doctors and nurses. We found inconsistent recording of doctors and nurses initial assessments of new patients, including a lack of evident input from patients, no psychiatric history recorded, lack of recording of significant bruising for one patient, and recording of a gambling addiction as a hobby.
- On Garden Wing, we found that the risk assessments for patients did not identify all the risks that were evident from their records. For example, staff had admitted one patient following a suicide attempt, but completed a risk assessment in their electronic record shortly after admission stating that the patient was not a suicide risk and their prior history was 'unknown'. For another patient staff completed a risk assessment that identified that they walked with a stick and had fallen at home. There was no further detail recorded about the risk. In an interview with the consultant, the patient said they had suffered a number of falls at home. There was no risk management or care plan in place to address the patient's risk of falling or reduced mobility. The patient told us that they had difficulty using the shower in their en suite bathroom but staff had not assessed or recorded this. The care records showed that the patient was diagnosed with a type of dementia. However, the risk assessment did not mention this or any risks associated with the condition. A patient, who had described three clear suicidal plans during a key working session, did not have their risk assessment changed as a result (indicating that they were at low risk). A patient who had Asperger's did not have any support plan in place to support them with this condition, other than to note that they found groups difficult. They were thus at risk of not having their needs met effectively.
- On West Wing, a patient spoke of delays in receiving medicines for back pain, as staff did not hand these over on admission, causing them discomfort for the first few days on the ward. Another patient's risk assessment did not include the risk of them bingeing and purging, although this was included in their history.
- We observed staff using handover meetings including the evening handover to share important information about patients with the on-coming shift. Staff completed handover sheets as a written record of the information handed over. Staff handed over the current risks affecting patients so that all staff were aware of them.
- Four patients on East and West Wings described near misses in terms of being given incorrect medicines or observing others in this situation. They attributed these incidents to agency staff unfamiliar with the ward.
- An external pharmacy audited the patients' medicine administration records at least weekly. They sent the results of the audits to ward managers. If errors were identified these were addressed with the individual staff concerned. For each medicine, there was a record of the start date, frequency, route and amount prescribed for the patient. Management assessed nurses each year in respect of their competence to administer medicines safely. Staff checked the stock medicines held on the wards every week. Staff checked medicine fridge temperatures on the acute wards daily and temperatures recorded were within appropriate limits. The wards kept records of medicines and healthcare products regulatory authority drug alerts and actions for staff to refer to.
- Personal alarms for staff members were only available on East Wing at the time of the inspection. However, management advised that they planned to roll these out on all units. Staff received training on preventing

violence and managing aggression and told us that they used restraint as a last resort. Staff found verbal de-escalation to be valuable in maintaining the relationships with the patients. This involved staff responding to patient's agitation by talking to them and understanding their concerns.

- A social worker at the hospital was the designated safeguarding lead. Staff said they had a good relationship with the local authority safeguarding team. The hospital safeguarding lead carried out a quarterly review of safeguarding activities. The report of this review provided details of themes that had developed and any lessons learned. Staff discussed this report in team meetings.

Track record on safety

- In the last twelve months, there had been 17 serious incidents on East Wing, two serious incidents on West Wing, and two on Garden Wing.
- Two hundred and thirty six restraints were carried out involving 52 different patients in the entire hospital in the last six months.
- In the last six months, 19 patients had gone absent without leave including four from Garden Wing.
- Patients reported a number of medicines errors and near misses on East wing in recent months, mostly attributed to the use of agency staff who did not know the ward well.

Reporting incidents and learning from when things go wrong

- At our previous inspection in February - March 2016, we identified that the provider must ensure that staff record incidents correctly and use the information to monitor and improve the service. We found appropriate reporting of incidents on the wards. Staff reported that they had learned lessons from serious incidents that had occurred in the hospital. They described changes and actions they took to improve the safety and care of patients. Staff had received additional training in risk assessment and conducting searches following the death of a patient at the service in 2015. Staff told us that they received a debrief and were supported after incidents. Night staff said that they were involved in discussion about incidents and included in de-briefings.
- Staff recorded incidents on an electronic record. They classified incidents as being serious if they involved a patient absconding, sustaining a significant injury, or if they needed to report the incident to the Care Quality Commission. For these incidents, staff completed a 'Situation, Background, Assessment, Recommendation' (SBAR) form. This system allowed staff to quickly organise the key information about an incident and present it in a consistent format. They sent all SBAR to the Priory Group head office.
- The governance and audit co-ordinator produced incident reports every month that pulled together all the incidents that had occurred in the hospital. They sent these reports to ward managers. A learning and outcomes group met every month to discuss incidents, themes and learning from incidents and actions to take to decrease the risk of further incidents. They highlighted all actions and risks rated at the beginning of learning and outcomes group meetings. Senior managers and ward managers attended these meetings
- Changes made as a result of recent learning and outcome group meetings included updated gym timetables, emergency phone packs for each ward, cutlery counting, a search policy for visitors, and training in monitoring medicines chart errors and the MHA. Following a serious incident, management placed a hold on admissions to one ward for three weeks.
- The minutes of learning and outcomes group meetings fed into monthly clinical governance meetings. Following the September 2016 learning and outcomes group meeting, seven key themes in incidents were identified relating to self-harm, ligatures, violence, governance breaches, security, absence without leave and staff accountability.
- The quality lead for the provider or by a senior manager in another Priory Healthcare service investigated serious incidents. Ward managers shared the outcome of investigations into serious incidents with other staff on the ward. They sent newsletters to staff and information about incidents was available on the provider's intranet. Staff reviewed incidents at team meetings on each ward once a month.

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

Requires improvement

- The management team had rolled out monthly emergency scenarios across the hospital, with learning taken forward after each event. An example of this was identifying a need for administrative staff to redo their basic life support training.

Duty of Candour

- Managers encouraged staff to be open about mistakes. The provider had a policy on implementing the duty of candour dated July 2016.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- An electronic patient record was used to store information about patients. This system was accessed by each member of staff having their own log-in details and password. Some information, such as records of physical health checks and paperwork relating to the Mental Health Act, were stored in locked filing cabinets.
- Staff carried out assessments of patients but these were inconsistent. On East Wing, staff admitted one patient on 9 October 2016. Staff started a nursing assessment on the day of admission but on 24 October 2016, it was still not complete and lacked detail. The reason for not completing the assessment at the time of admission was 'unable to respond'. However, there was no evidence that nursing staff had tried again to complete the assessment and care plan with the patient. The patient was fully able to communicate at the time we inspected the ward. The assessment of another patient was more detailed. Both patients had care plans in place that addressed most of the areas identified in the assessment of needs.
- On Garden Wing, staff completed a nursing assessment for one patient on admission. The assessment failed to identify needs recorded in other parts of the record. For example, although the reason for admission included a 'drug and alcohol problem' the patient's needs assessment in terms of substance misuse was left blank. Similarly, staff did not record a gambling addiction as a need; this was instead listed as the patient's 'hobby'. Staff did not record a physical health examination of the patient on admission. On 24 October, staff could not find a paper or electronic copy of a doctor's admission assessment. The ward doctor told us that they had just completed a physical assessment of the patient and were going to enter it on to their record. This was eight days after admitting the patient, following an incident in which they sustained an injury to their ribs. In the staff handover from day to night staff on 18 October 2016 the nurse in charge had explained to oncoming staff that the patient was prescribed pain medicine for the rib injury. Staff did not record this in their assessment of needs. The medical director later explained that an agency doctor had omitted to record a physical health assessment for four patients over a period of days when they admitted the patient.
- Similarly, for a second patient admitted to Garden Wing on 17 October 2016 there was no record that a doctor had completed a physical examination of the patient. There was no paper or electronic record on 24 October 2016 to show this had taken place.
- For a third patient on Garden Wing a care plan was in place to address their diagnosis of dementia. This stated that staff should support the patient with taking medication, orientate them to the ward and offer support when anxious. No other strategies were explored or in place to support the patient with their memory loss.
- A patient on West Wing who had mobility issues described difficulty using the en suite shower facilities provided. This had not been explored in their care plan, and no effort was made to provide them with a shower chair until an inspector raised this. We found that care plans we viewed were not detailed and did not show signs of patient involvement in the development of the care plans.
- Staff undertook a risk assessment and observation audit for the hospital on 24 October 2016. Actions identified including ensuring that all sections of the risk assessment were completed, including patients' past risk history, and that privacy and dignity issues should be detailed in care plans.

Best practice in treatment and care

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

Requires improvement

- In addition to prescribed medicines, the wards offered a comprehensive range of psychological therapies including dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT), life skills coaching and psychodynamic approaches. In the early stages of admission, patients tended to join creative groups and activities. When they were ready, they engaged with more complex therapeutic groups, such as DBT.
- Therapists provided debrief sessions for staff and patients as and when need on the wards.
- The wards recorded the Health of the Nation Outcome Scale (HoNOS) for each patient. Staff used patient health questionnaires and generalised anxiety disorder tools, but there was no formal monitoring of the effectiveness of therapies on the wards.
- The provider allocated link therapists to each consultant for consistency, and so that they could participate in ward rounds as needed.
- The provider arranged regular placements for university psychology students. Each service had its own monthly therapy team meeting, and all staff including students, had monthly individual and clinical supervision.
- The therapy services manager advised that they followed NICE guidance on positive psychology based therapies. He noted that the recent introduction of transactional analysis on the acute wards had been very successful, with patients continuing as day patients on discharge.
- The acute wards were introducing aspects of 'safewards'. Safewards is a model aimed at decreasing incidents of violence and aggression on wards using ten different interventions. The hospital wards had chosen three interventions each, which they were planning to implement. Staff on East Wing described recent implementation of a 'hope tree,' self-soothing boxes and providing dialectical behaviour therapy on the ward.
- Nursing staff told us they had been involved in audits of clinical practice in relation to physical health observations, risk assessments, consent to treatment and medication.
- A calendar of health care audits was in place for the hospital, including biannual ligature audits, and annual audits including reducing restrictive practice, information governance, restraints, infection control, schizophrenia and depression, safeguarding, risk assessments, care plans, preventing suicide, national patient safety agency and clinical supervision.
- Performance indicators were set across the provider organisation, including clinical effectiveness, physical health, and patient safety.
- Patients had the opportunity to be involved in the recruitment of new staff.

Skilled staff to deliver care

- Staff received one to one managerial and clinical supervision. The night co-ordinator for the hospital supervised night nurses. They found these sessions to be positive. All staff had received an appraisal in the last twelve months.
- Staff had access to individual clinical supervision from an external supervisor. The external supervisor attended the hospital on two days every month. Staff, including locum agency staff, could book a supervision session. Staff described the supervisor as a source of unbiased support, however some staff said that they were unable to attend these sessions due to lack of time available.
- A trial of giving responsibility to ward managers and deputies to log and monitor clinical supervision over two months, had not been successful. Compliance in September 2016 was 40% and in October 34% a new outlier, as this had previously been 100%. The senior management team advised that they would be taking back responsibility for monitoring supervision from November 2016.
- There was a plan in place for staff training in life support, breakaway, safeguarding, mental capacity, conflict resolution, searching, and complaints. Managers supported health care assistants to take up nurse training.
- Managers addressed poor performance through the development of a performance plan that they monitored through supervision. The human resources department provided support to ward managers.
- The hospital's medical advisory committee reviewed the practising privileges of consultants who admitted patients to the hospital every year. They measured the performance of consultants primarily through their

appraisal and any incidents or complaints related to the care and treatment they provided. A report of their admissions, diagnosis of patients, length of stay, patient satisfaction survey results, and prescribing and Mental Health Act errors, was considered at their appraisal. The medical advisory committee met once a quarter. The medical director had a weekly lunch with consultants.

- A director of clinical services had started a professional development programme for all nurses in the hospital. The programme helped nurses develop both management and clinical skills. Newly qualified nurses had a preceptor on the ward and were supported to achieve the necessary competencies.
- We saw new staff undertaking an induction during the course of our inspection. New staff received a week-long induction to the hospital. This included training on risk management, supervision, health and safety, basic life support, safeguarding and managing violence aggression. This was followed by a further week-long induction that was specific to the ward.

Multi-disciplinary and inter-agency team work

- Wards had multi-disciplinary teams (MDT) that included nurses, health care assistants, psychologists, psychotherapists, occupational therapists, consultant psychiatrists and ward doctors. Fifteen consultant psychiatrists referred and covered patients on the wards.
- Handover meetings took place twice a day when the shifts changed. We attended the evening and morning handover meetings on each ward. Detailed information was provided on new patients and a specific list of tasks was agreed for the shift. Each member of staff was given a copy of the handover sheet that included details of the frequency of observations required for each patient.
- Patients saw a doctor at least once a week for a ward round including members of the multi-disciplinary team. There were weekly multi-disciplinary ward round meetings at which staff discussed each patient. Staff told us there were good relationships within the teams.
- East Wing and Garden Wing maintained good relationships with the referrers of their NHS patients, inviting them to care programme approach meetings to discuss discharge and future care. Staff informed referrers of any incidents the person they referred had been involved in.
- There was a team of approximately 40 therapists available for the hospital. There were two occupational therapists based on Garden and West Wings, and one was based on East Wing. There was a social worker in place for the hospital.
- Each ward had a programme of therapies available for patients including psychology, mindfulness, cognitive behavioural, psychoanalytic, eye movement desensitisation and reprocessing, family therapy, and bereavement counselling. The therapy services manager was also planning to introduce equine therapy sessions and new sessions of music and art therapy. West Wing acute patients had an activity programme on Saturdays but not Sundays. There were plans to employ an activity coordinator to provide activities on East Wing at weekends. Due to the short stays of many patients on this ward, most sessions focussed on psycho-education.

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

- At our previous inspection in February - March 2016, we identified that informal patients must be free to leave the hospital in line with their legal status. We did not find any patients who were not clear about their legal status during this inspection. Appropriate notices were provided on exit doors informing informal patients of their rights to leave.
- Staff completed online training on the Mental Health Act as part of the Priory Foundations for Growth training programme. Compliance rates were 67% on West Wing, 65% on Garden Wing and 70% on East Wing, indicating that this was an area requiring attention.
- Consent to treatment certificates or certificates signed by a second opinion appointed doctor (SOAD) were attached to medication charts when this was required.
- Records showed that staff gave patients information about their rights under the Mental Health Act when they were detained and that this was repeated during the period of their detention.
- Administrative support and legal advice was available from the Mental Health Act office based at the hospital. This office carried out regular audits of the use of the Mental Health Act.

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Requires improvement

- We reviewed the statutory documents relating to the detention of three patients on each ward. Staff completed these documents appropriately. The original documents were stored in the Mental Health Act office, with copies kept in a locked filing cabinet on the ward.
- Patients had access to an independent mental health advocacy service. Staff gave patients information about this service and it was displayed on notice boards. Dates were recorded of when referrals were made to this service.

Good practice in applying the Mental Capacity Act.

- Staff had assessed the capacity of patients to give consent. Staff discussed patients' mental capacity and consent to treatment at each ward round. Records of these meetings showed that staff considered the four components of mental capacity and patients had consented to treatment.
- Staff completed online training in the Mental Capacity Act as part of the Priory Foundations for Growth training programme. Compliance rates were 80% on West Wing, 67% on Garden Wing and 69% on East Wing indicating that this was an area requiring further attention. Following the inspection, the provider sent us revised figures indicating higher compliance rates in this area.
- There had been no applications for deprivation of liberty safeguards (DoLS).
- Nurses on the wards told us that doctors considered mental capacity of patients at weekly ward rounds. They explained that if patients did not have capacity to consent to admission or treatment, and that inpatient treatment is necessary for the health or safety of the patient, they would make an application for detention under the Mental Health Act.

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

Good

Kindness, dignity, respect and support

- We observed positive interactions between staff and patients across the wards. Staff were attentive and appeared to have formed good relationships with patients. Overall the atmosphere on each ward was calm and responsive. In handover meetings between shifts staff spoke about patients respectfully.
- We observed that night staff introduced themselves to each patient individually when the shift began. They asked the patient how they were feeling and if there was anything they needed. Patients were appreciative of this.
- In our interviews, staff showed a good understanding of patients' needs including their physical health, mental health and personal circumstances. We observed that staff were careful to protect patients' confidentiality by only opening out whiteboards with personal information when the office door was closed.
- Patients were generally positive about the way staff supported them, although some patients described problems with particular agency staff members including some abrupt responses. However, they noted that when they raised concerns with ward management, this was taken seriously.
- The layout of Garden Wing was not conducive to patient privacy and dignity. Staff used the ward corridor from across the hospital to access the staff dining room. Patients from West Wing came downstairs and through the ward in order to reach the patient dining room. There was a constant flow of people through the ward who were not necessarily connected to it. The patient lounge on the ward was open plan and on the corridor. Patients' bedrooms opened directly onto the main corridor.

The involvement of people in the care they receive

- Patients had access to an independent mental health advocate. Information about patient advocacy services were displayed on the wards. Some patients told us that they were familiar with these services.
- Some care plans showed evidence of patients' involvement, but this was not always the case. Patients told us they attended the ward round with their consultant each week and gave their views on care and treatment. There were records of one-to-one key working sessions documented in patients' notes.
- Patients were encouraged to complete feedback forms on the wards. Community meetings took place once a

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

Requires improvement

week, giving patients the opportunity to raise any concerns about their ward. We saw evidence that staff took as a result of these meetings, including contacting kitchen and information technology services to address concerns raised.

- Patients could be involved in interviews for new staff or submit questions they would like interviewers to ask applicants at interviews.

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

Requires improvement

Access and discharge

- The on-call manager reviewed all new referrals for admission. Referrers completed a risk assessment document prior to admission. The on-call manager called the referrer to clarify information when needed. Patients, whose records we checked, all had a completed pre-admission risk assessment. This was an improvement brought in following a serious incident in 2015.
- During the six months prior to this inspection, bed occupancy was 97% on East Wing, 87% on West Wing, and 92% on Garden Wing. There were no specific catchment areas for the wards. Most patients were from London and the South-East of England.
- Staff did not admit patients to beds allocated to patients who were on leave. Patients on leave would always return to the same bedroom.
- Staff planned discharges and they took place during the day. However, some admissions occurred at night.
- Staff responded to increased agitation by increasing levels of observation of patients. If patients required intensive care for their physical health, they were transferred to the local general hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- At our previous inspection in February - March 2016, we identified that there was not an appropriate environment for the physical examination of patients on each ward. At the current inspection, we noted that there was no clinical room available for examining patients on East Wing, and patient's bedrooms tended to be used instead.
- Patients had access to their own mobile telephone. Patients had a locked cupboard in their bedrooms in which they could store personal items.
- Patients had access to a gym onsite. East Wing had its own garden area. West and Garden Wing patients could access a garden near the therapies block. For patients detained under the Mental Health Act, access to outside space required the permission of their responsible clinician.
- Patients could meet with visitors on the ward either in their bedrooms or in lounges and therapy rooms. Patients could also use other rooms within the hospital to meet their visitors.
- Food was cooked and prepared on site. Patients spoke positively about the quality of the food, commenting that food was fresh and there was a good choice available.
- Each ward had a structured programme of activities and therapies throughout the week.
- Garden and West Wing were in need of redecoration, particularly to address some stained carpets, and worn furnishings. A programme of refurbishment was underway at the time of the inspection including redecorating and replacing furniture on West Wing and Garden Wing. This was due to be completed by the end of December 2016.

Meeting the needs of all people who use the service

- Information about where to obtain religious and spiritual support was displayed on ward noticeboards. A hospital chaplain was available to patients. Staff could support patients to attend places of worship of their choosing.
- The service could produce leaflets for people whose first language was not English. The service could provide interpreters although staff said this was not usually required.

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

Requires improvement

- Leaflets on health promotion were available to patients. Information was also provided on safeguarding, making a complaint, contacting the Care Quality Commission and accessing advocacy.
- Patients said the service was generally responsive, some described it as a "haven of peace," with enough activities available and food available to meet their individual and cultural needs. One patient noted that staff had ordered food for them from outside the hospital when they had been too late for canteen.
- On East Wing, staff provided groups which included crafts, recovery skills, creative writing, walks in the grounds, relaxation, cognitive behavioural therapy (CBT), cooking, health and wellbeing, gym, mindfulness, life skills, and music. Staff did not provide formal activities at the weekends.
- Garden and West Wings shared activities. The low intensity programme included problem solving, goal setting, creative expression, therapeutic reading, behaviour activation, a support group, gym, yoga, and relaxation sessions.
- The three week cognitive programme also included coping strategies, CBT for anxiety, art therapy, movement, CBT for obsessive compulsive disorder, CBT for depression, solution focussed therapy, assertiveness, a family programme, psycho-education, psychodynamic support, CBT formulation, transactional analysis, self-acceptance, gender support, bereavement, stress management, drama therapy, bipolar support, and self-esteem.
- The six-week cognitive programme also included anger management, dialectic behavioural therapy and social phobia therapy.

Listening to and learning from concerns and complaints

- Information on how to make a complaint was on display in the wards, and patients told us that they were aware of how to make a complaint if needed. Two patients said that they had raised issues with a ward manager, and were satisfied that these were taken seriously.
- The service timescale for acknowledging complaints was 48 hours, and complaints was 20 working days. If the provider could not provide a response within 20 days, they sent a letter of explanation to the complainant.
- There had been nine formal complaints to the service in the last three months. There were seven in August, two in September and none in October (up to 26 October 2016). We reviewed three individual complaint files from August and September. Complaint responses showed that the service had apologised to complainants. Letters included information about how a complainant could take the matter further if they were not satisfied with the outcome. The provider offered complainants meetings with their clinical team when this was relevant to their complaint.
- Recent complaints related to staff attitudes, the environment, discharge planning, safety on the wards, privacy, administration, communication, and medicines management. Senior staff and ward managers had received training in how to handle complaints more effectively. This training took place during the inspection period. Staff discussed the results of complaint investigations at team meetings, and circulated to all relevant members of staff in writing.

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

Requires improvement

Vision and values

- Staff were familiar with the organisational values, primarily that of putting patients first.
- The objectives for each ward reflected these values. These objectives were to provide a safe environment, to be caring and supportive towards patients, and to promote recovery.
- Staff knew the senior managers at the hospital. The provider had recently appointed two directors of clinical services. These directors had contact with the wards every day and, on occasion, provided practical support. Ward managers and directors met on a daily basis for a brief meeting to discuss any immediate concerns or incidents. These were known as 'flash' meetings. Senior staff also conducted regular 'quality walk arounds'. This enabled managers to regularly check the cleanliness or carry out random checks on the physical health monitoring of patients.

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

Requires improvement

Good governance

- At our previous inspection in February - March 2016, we identified that log-in details of permanent staff should not be shared with agency staff. At the current inspection, we found that this was still happening. Staff on the wards were still not clear about temporary log-in arrangements for agency staff including doctors and nurses, who did not have log ins provided unless they were block booked for an extended period. Temporary log ins were made available to the hospital director on a regular basis, however senior management acknowledged that the temporary log ins could be distributed to more staff in the hospital to ensure that they were used appropriately. We were also concerned that contingency plans to address unexpected downtime of the computerised records system were not known to staff on the wards. Senior management advised that a laptop was available, and couriers could deliver dongles if needed.
- Following a serious incident in 2015, the management team had committed to ensuring that a doctor or nurse assessed new patients within two hours of admission. However, at the time of our inspection, there was no system in place to monitor how long patients were waiting for assessments.
- The hospital had a governance system in place to assess and monitor the quality and safety of care and treatment provided to patients. A learning and outcomes group met monthly and discussed all incidents and complaints that had occurred or been received in the service. Weekly compliance meetings were also held. These meetings fed into the monthly clinical governance committee meetings.
- The clinical governance committee had an overview and monitored all safeguarding incidents, learning from serious case reviews and other incidents, infection control, health and safety, equipment, medicines, staffing, and staff training compliance. They also reviewed all complaints, and monitored use of restrictive practices, nutrition, policies and procedures, clinical records, health promotion, compliance with the Mental Capacity Act and Mental Health Act and staff supervision and appraisals. They looked at compliance with internal and external inspections, feedback from staff and patient meetings, and other audits. The provider maintained a risk register for the hospital, which the management team reviewed at compliance and senior management meetings. Staff could submit items to the hospital risk register through the clinical governance meeting.
- One issue on the risk register was that documentation on site was consistently scoring under the required level. Of particular concern was recording of physical health assessments on admission, patient involvement in care plans and evidence of multi-disciplinary decision making in risk assessments. Other issues on the risk register included potential for medication prescribing and administration errors that could affect patient safety. A risk register audit and research group met periodically.
- Managers carried out quality walk arounds on different wards. During the walk around they attended patient community meetings, spoke with two staff about their understanding of safeguarding and actions resulting from investigations of medicines audits. They also encouraged staff to raise any concerns they had. Physical health and environmental walk arounds also took place and included two wards every month. Staff conducting the environmental walk arounds checked that wards were visibly clean and tidy and identified whether repairs were needed.
- A 'flash' meeting took place in the hospital every morning on weekdays. We attended the 'flash' meeting held on Monday morning during our inspection. A manager or their representative represented each ward. The directors of clinical services were also present. Ward representatives reported back to the senior managers and other staff present on the number of incidents that had occurred on their respective wards over the weekend. They also reviewed staff numbers for that day and night. Where staffing shortfalls were identified plans were put in place to obtain more staff or staff were moved from other ward rotas if they had more than the required number of staff. Staffing reviews included whether staff were permanent staff or bank or agency staff on duty. Each ward had an overall risk rating based on the level of risk assessed for the patients on the ward. This helped senior managers maintain an overview of risks and concerns in the hospital and take action to mitigate the risks identified.
- There was no rating displayed for the service overall or for the core services that were inspected in February

2016. When we brought this to the attention of senior managers, they placed a copy of the overall rating for the hospital in the main reception area. They did not display the core service ratings.

- The senior management team governed the hospital. This included the hospital director, the medical director and the clinical services directors. Wards had a high proportion of vacancies for nursing posts. The hospital was taking steps to address this. Agency staff were employed on three-month locum contracts to ensure greater consistency in the staff working on the ward. However, there remained a significant proportion of shifts in which the wards had below the number of staff required. Some staff advised that morale on some of the wards was low due to staffing issues. Overall, over the hospital site there had been a 47% turnover of staff in the last year. At the time of the inspection there were approximately 25 vacancies, with 10-12 of these to be filled by staff recently recruited. However, there had been a significant decrease in nursing vacancies, reduced from 31 to 14 vacancies since March 2016.
- The ward managers told us they had sufficient authority to make decisions about staffing levels and felt supported by the clinical services directors.
- Staff were involved in clinical audits such as audits of ligatures, care plans, safeguarding and restraints. There were well established systems in place for the reporting of incidents and complaints and discussing lessons learned with the staff team. There were procedures in place for the use of the Mental Health Act, Mental Capacity Act and safeguarding.
- Key performance indicators included recruitment and retention, compliance with mandatory training and completion of outcome measures. Data on these indicators was provided to ward managers in a table that enabled them to monitor their performance.
- At the time of the inspection, staff told us that there was inconsistent evening and night cover from the agency doctor service. Doctors covered a period of a week at any one time. However, there had been recent problems ensuring consistent doctors who knew the service well and some performance issues.

Leadership, morale and staff engagement

- At our previous inspection in February - March 2016, we identified that the provider needed to review staff engagement to ensure that staff working in the acute wards were able to raise any concerns they might have. At the current inspection, we found that senior management had made efforts to improve engagement with staff on the wards.
- Every ward had a staff representative. Ward staff representatives met with staff from human resources every month at a staff forum. This enabled staff to raise any concerns that they or their colleagues had.
- Staff advised that team meetings were often cancelled on the wards due to insufficient staff available, but generally felt supported by ward management, although some felt that they did not feel listened to at a more senior management level. Nurse meetings took place on a monthly basis. The last team meeting on Garden Wing had taken place on 4 October 2016. The last meeting before that had taken place in July 2016.
- A facilitated staff support group was held on each ward every week. Health care assistants had access to group support in the therapies department every week.
- Staff told us they felt able to raise any concerns they had with their line manager. Staff were positive about the new senior management team in the hospital and said the directors of clinical services were driving change. They had an open door policy and staff were encouraged to speak up. Staff felt that there had been changes in the hospital since the last inspection. They said that there had been considerable investment in training and in the recruitment of new staff. Staff were offered bonuses when taking up a position in the hospital, and given further financial incentives to continue in their roles.
- The Priory Hospital had completed a staff survey in June 2016. Staff gave positive responses to questions about understanding how their works helps their team to achieve its aims, caring about the future of the service and enjoying work. There were negative responses to questions about having the necessary equipment and resources, believing that action will be taken as a result of the survey and workload being reasonable.
- 'Your say forums' were held periodically to encourage staff engagement in the running of the hospital. The

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

Requires improvement

most recent meeting was in August 2016. Informal staff catch up meetings with senior management were also arranged, including coffee sessions, ice cream and a barbeque arranged for staff in the summer.

- The average sickness rates for the whole hospital in the three months prior to the inspection was low at 2%.
- None of the staff raised concerns about bullying or harassment. Staff told us they knew how to use the whistleblowing procedure if they needed to.
- Overall, staff morale was good. Staff appeared very committed to their work and highly motivated to achieve positive outcomes for their patients. Some staff felt demoralised by the level of staff vacancies and high use of agency staff. These staff told us that they often felt very stretched. This was exacerbated by working with agency staff who lacked experience of working on the ward. Most health care assistants were psychology graduates and motivated to gain experience to enable them to pursue their careers. Some staff were frustrated that requests for redecorating areas of the wards appeared to have been ignored.
- There were some opportunities for leadership development. Some nurses had taken on responsibility for particular areas of practice such as the Mental Capacity Act and working with people with autistic spectrum disorders. The provider considered requests for continuing professional development training, with three approved in August, one in September and five approved in October 2016.
- Managers conducted appraisals on the majority of staff, with 165 completed as of 25 October 2016, and with four identified as overdue.
- Managers conducted a review of staff exit interviews, considering reasons for leaving, and held listening groups for staff on each ward. These had brought about some changes including providing more activity coordinator support on wards and out of hours programmes, recruitment of new ward clerks, and a review of how ward managers spent their time on wards.

Commitment to quality improvement and innovation

- A project to refurbish the hospital had commenced, although there were still adjustments to make to 'safer rooms' and considerable work needed in other areas.
- The hospital had installed a system known as 'care protect,' although this was not yet operational. This movement-activated system was to be piloted from November 2016 on West Wing and CAMHS, in order to provide extra protection for high risk areas in the environment, and assist with quality assurance.
- There were long term plans for CAMHS and Priory court to have all bedrooms with the specifications of 'safer rooms,' and a further eight 'safer rooms,' to be installed on the acute wards.
- Improvements to the environment completed in 2016 included redecoration of the therapy areas for West and Garden Wings, and controlling access to mitigate against detained patients absconding. The nurse call system had been upgraded, West Wing nurses office was refurbished, Upper Court communal areas and East Wing were redecorated, and new flooring was installed in communal areas. On West Wing 27 reduced ligature windows were installed.
- There were plans to relocate the admissions office to a site nearer the main reception by the end of January 2017.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

This service was not inspected on this occasion.

Are child and adolescent mental health wards effective?
(for example, treatment is effective)

Good

This service was not inspected on this occasion.

Are child and adolescent mental health wards caring?

Good

This service was not inspected on this occasion.

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

Good

This service was not inspected on this occasion.

Are child and adolescent mental health wards well-led?

Good

This service was not inspected on this occasion.

Requires improvement

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Inadequate

Safe and clean environment

- At our previous inspection in February - March 2016, we identified that the hospital environment was unsafe for patients at risk of suicide or self-harm. An action plan was provided with some actions still be completed by 31 December 2016. The provider's action plan (updated 14 October 2016) indicated that the hospital's 'safer' or 'observation rooms' had been completed on 1 September 2016. At the current inspection, we found that the provider had removed some ligature anchor points. However, this was not consistent, with ligature anchor points still present in the safer rooms. Upper Court was situated in an older part of the hospital. There were blind spots on corridor corners and on a staircase. A convex mirror had been installed to improve the visibility at one blind spot. Priory Court was a larger ward in a more modern building, set out over two floors. There were nine bedrooms on the lower floor and ten on the upper floor. Staff nursed patients on the lower floor on admission and moved to a bedroom upstairs when their level of risk had reduced. There was a small lounge on the upper floor, although patients only used this area if there were sufficient staff available to supervise. During our visit, patients did not have access to the upper floor during the day.
- Staff used a ligature point audit tool on both wards and updated them every six months. This included an audit of all the bedrooms. Both wards had bedrooms designated as observation rooms. These rooms were sited close to nurses' offices and were equipped with anti-ligature features, observation panels, Perspex window covers and anti-barricade doors. On Upper Court, standard bedrooms had large headboards, lamp chords and curtains, that could all be used as a ligature anchor. Staff being present mitigated the presence of ligature points in communal areas. However, this was more difficult in bedrooms without ongoing observation of patients in bedrooms.
- Upper Court only admitted female patients. Priory Court could admit male patients, although there were no male patients at the time of our visit. The last male patient was discharged in June 2016. If a male patient was admitted, a bathroom near their bedroom would be designated for them to use in compliance with Department of Health guidance.
- The clinic room on Upper Court was situated on an adjacent ward. Emergency drugs were stored in the clinical room with expiry dates displayed. Staff locked the box for these drugs as appropriate. The medicines cupboards were well organised with separate places for physical health medication and medication for mental health including anti-psychotic medicines. Oxygen and an emergency bag were stored in the nurses' office. Checks of the contents of emergency bags were sporadic. On Upper Court, these checks took place twice in July, once in August, twice in September and not at all during the first three weeks of October. On Priory Court, the checks were more frequent, but staff did not carry them out in a consistent routine. The lack of consistency of checks could compromise the effectiveness of the procedure to ensure emergency drugs and equipment were in order. This could present a risk of avoidable harm to patients, particularly as

patients frequently experienced poor physical health on admission. There was a small clinic room on Priory Court. There was a separate room with equipment for weighing and measuring patients, and for administering naso-gastric feeding.

- During our visit, the communal areas of Priory Court appeared untidy, but the ward was generally clean and well maintained. On Upper Court, the ward was clean. Furniture was in good condition and well maintained. The small dining room on Upper Court was in need of updating in order to provide a positive therapeutic environment. The floor showed signs of wear, which could have appeared dirty.
- There was no documentation to show that staff cleaned equipment in the clinic rooms regularly. This meant staff and patients were not assured that the equipment was clean for clinical use. Staff did not check the temperature of the fridge in the clinic room for Upper Court every day. On Priory Court the medicines fridge had not been working since 28 August 2016, although it was still being used to store medicines. Staff had not taken advice as to whether medicines stored in it were still safe to use.
- Each ward had a checklist recording system in place for general clinical equipment. There was insufficient space on this sheet for staff to add comments. As a result, staff wrote comments across the sheet and in margins. These comments were confusing and it was not always clear which piece of equipment they referred to. This would present difficulties for staff trying to monitor and rectify concerns. On Priory Court, the pulse oximeter and suction machine had both been serviced in June 2016. Equipment for taking patients' temperature had last been serviced in May 2015. The scales for weighing patients had not been serviced since February 2015. Staff confirmed that the equipment for measuring blood glucose had not been calibrated. This meant the staff could not be assured that the machine was working correctly.
- There were alarms buttons throughout the wards. The location of alarm activated was displayed on boards in the nurses' offices.

Safe staffing

- At our previous inspection in February - March 2016, we identified that there were insufficient staff employed and deployed at the hospital to ensure the safety and consistency of patient care. At the current inspection, we found that on each ward, there had been six occasions in the two previous months that the required level of staffing had not been met during the day shift. This amounted to a shortfall of staff on 10% of day shifts. At night, the staffing requirement had not been met on Priory Court on 12 occasions, amounting to 20% of nightshifts. When the number of staff fell below the required level, the likelihood of an incident occurring increased considerably. There were seven occasions on which incidents occurred during the 49 night shifts that were fully staffing. There were incidents on all 12 of the shifts when Priory Court was not fully staffed. Following the inspection, the provider sent us revised figures and analysis of the above data, indicating that there was not a strong link between lower staffing numbers and incidents. This indicated that monitoring of these areas at the time of the inspection had not been rigorous.
- There was a 52% vacancy rate for nursing posts across both wards that resulted in bank and agency staff being used. On Upper Court four out of 10 nursing posts were vacant. On Priory Court, seven out of 11 permanent nursing posts were vacant. The overall vacancy rate for health care assistants was 13%. Priory Court had two vacancies for seniors HCAs and two vacancies for HCAs. There were 11 new staff appointed on Upper Court in the six months prior to the inspection. Overall progress had been made in recruitment across the hospital, with nursing vacancies falling from 31 to 14 since March 2016.
- The wards used a staffing ladder to adjust the number of staff on duty according to the number of patients on the ward at the time. On Upper Court there were two nurses on duty at all times. Managers adjusted the number of health care assistants (HCAs) to ensure there was one member of staff for every three patients, plus an additional member of staff. At night, this reduced to one member of staff for every four patients. Staffing levels on Priory Court were calculated on a similar basis. At the time of our visit, there were 16 patients on the ward, and a staffing allocation of six staff, including two nurses. This reduced to four staff at night. The number of staff on duty related to the number of patients actually on the ward. Therefore, there were often fewer staff at weekends when many patients had overnight leave with their families.
- On Priory Court, a pool of regular agency staff was used, although on some occasions an agency worker who had

not worked on the ward before would be allocated. Agency staff received an induction that included a tour of the ward, an introduction to the observation requirements, an introduction to emergency procedures and basic information on the safeguarding procedure. The hospital had recruited some agency staff on three-month contracts. These staff were described as being 'locum'. This meant they were familiar with the ward and participated in team meetings, training, incident reviews and group supervision. Agency staff did not receive management supervision but they did have access to one-to-one support if they requested this.

- On both wards, managers allocated additional staff for every patient on special duty nursing that involved one-to-one observations.
- On both wards, a member of staff was available to patients in the communal areas of the ward at all times.
- Patients said there were usually enough staff to facilitate leave and activities. However, on Priory Court there were frequent. On the Saturday night during the inspection there had been seven incidents. Two of these incidents involved a patient being restrained and a further two incidents involved patients harming themselves. When an incident occurred involving restraint, staff and patients told us that this often triggered self-harming in other patients on the ward. Staff from other wards could assist, but this was likely to leave other wards below the established level of staffing.
- Each ward had a junior doctor who provided medical cover to patients during the day. Outside office hours a locum duty doctor based on the site was available on-call.
- Compliance with mandatory staff training was low at 62% on Priory Court and 69% on Upper Court.

Assessing and managing risk to patients and staff

- On Priory Court there had been 95 incidents of restraint in the six months before the inspection. Staff carried out these restraints with 10 patients. On Upper Court, six patients had been restrained, on a total of 10 occasions.
- Records showed that staff carried out risk assessments on a standard form for all patients when on admission. They updated these assessments frequently. Patients typically presented risks of low weight, food restriction, deliberate self-harm and the physical risks associated with having a low body mass index (BMI). Risk assessments were accompanied by risk management plans that included the frequency of observation, diet plans for re-feeding, and ways of addressing anxiety. Some risk management plans stated that any of the patient's belongings that could be used as a ligature, must be stored in the nurses' office.
- There were some blanket restrictions in place. For example, on Upper Court patients were required to attend a support group after meals. Staff locked patients' bedrooms during this time. Also during this time, staff supervised access to the bathroom. Patients could not bring food and drinks onto the wards without informing staff, and the use of laxatives was prohibited. On Priory Court, staff locked patients' bedrooms throughout the day. Our visit took place during half-term when daytime activities were less structured than during the school term. We saw a number of patients spending time throughout the day sitting on the floor outside their bedroom door either reading or doing homework. If patients on Priory Court refused to go to the school, staff discussed this at a multidisciplinary team meeting.
- Care and treatment for informal patients could involve intrusive or restrictive practices such as enhanced observations, naso-gastric feeding and only being able to leave the ward with the permission of staff. Records showed that staff discussed these restrictions with patients and that patients were giving their informed consent. These records also included assessments of the patient's capacity to provide this consent. When it appeared that a patient may withhold their consent, or did not have the capacity to consent, staff considered detention under the Mental Health Act.
- The service provided four levels of observation. Constant observation required a member of staff to be in eyesight or arms reach of the patient at all times. Intermittent observations took place either twice or four times each hour. General observations required staff to check on each patient every hour. Nurses could increase the observation level. Only a doctor could authorise a reduction in this level. Staff searched all patients' belongings on admission. Restricted items, such as razors, were stored in the nurses' office. Property was also checked when patients returned from leave. Room searches took place at random. If a patient on Upper Court refused to give permission for their belongings to be searched staff would explain the reason for the search and encourage co-operation. If the patient still refused, they would be consider to be at a heightened level of risk and their observation level would be

reviewed. Staff could search patients on Priory Court without their consent if they presented a high risk. Staff would discuss this with the consultant and record the reasons on the patient's file. The hospital had introduced training on conducting searches. Four staff on Upper Court had completed this training.

- Staff received training on preventing violence and managing aggression. On both wards, staff told us that they used restraint as a last resort. Staff found verbal de-escalation to be valuable in maintaining the relationship with the patient. This involved staff responding to patients' agitation by talking to them and understanding their concerns. Staff could increase observation levels to manage a patient's distress. An occupational therapist on Priory Court was helping patients to create a 'self-soothing' box containing items the patient would find comforting and distract them from their distress.
- Staff on Upper Court said that they rarely used rapid tranquilisation. Records on Priory Court showed that staff used rapid tranquilisation by intra-muscular injection three times in the six weeks prior to the inspection. We did not find evidence of staff monitoring the patient's pulse, blood pressure, temperature or respiration immediately after administering the injection. On one record there was a single record of vital signs taken 3 ½ hours after the injection. On another record, staff were unable to find notes of physical observations. On the third record, staff had not recorded the time at which they checked vital signs and the injection was not recorded on the medicines administration record. Records showed that incidents of restraint involved four to six members of staff (sometimes because they elicited self-harming behaviour in other patients on the ward. National guidance (NICE NG10 - violence and aggression: short-term management in mental health, health and community settings May 2015 p218) states that after rapid tranquillisation, staff must "monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status."
- All staff received training in safeguarding as part of their mandatory training. This was an online training module, completed as part of the Priory Group's Foundations for Growth training. Nurses also completed a two-day course during their probation period. Staff told us they knew how to make a safeguarding alert. There had been three alerts on Upper Court in the three months before the inspection. A social worker at the hospital was the safeguarding lead. Staff said they had a good relationship with the local authority safeguarding team. The local safeguarding team informed the hospital of the outcome of their investigations. The hospital safeguarding lead carried out a quarterly review of safeguarding activities. The report of this review provided details of themes that had developed and lessons learned. Staff discussed this report in team meetings.
- Medicines management was provided by an external company. This service visited the hospital every Thursday to review the management of medicines. They provided feedback to managers. They had raised concerns about the expiry dates of medicines. One member of staff acknowledged that nurses did not always monitor this. We reviewed five medicine administration records. All prescriptions were in date and appropriately signed. For each medicine there was a record of the start date, frequency, route and amount. All charts included a list of allergies.
- If children were visiting patients, a room off the ward was booked for the visit.

Track record on safety

- In the previous year, one incident on Priory Court and five incidents on Upper Court were classified as serious. Over the weekend during the inspection there had been seven incidents on Priory Court in one night. These incidents were investigated to ensure that learning was taken forward to prevent a reoccurrence.

Reporting incidents and learning from when things go wrong

- At our previous inspection in February - March 2016, we identified that the provider must ensure that staff record incidents correctly so the information can be used to monitor and improve the service. At the current inspection, we found that incidents were recorded on an electronic record. Staff classified incidents as being serious if they involved a patient absconding, sustaining a significant injury or if the incident required notifying to the Care Quality Commission. For these incidents, staff completed a 'Situation, Background, Assessment, Recommendation' (SBAR) form. This system allowed

staff to quickly organise the key information about an incident and present it in a consistent format. Management sent all SBAR reports to the Priory Group head office for review.
- Senior managers held a 'Learning and Outcomes Group' once a month at which they discussed all incidents. They emailed the notes from these meetings to all staff. Staff reviewed the incidents at team meetings once a month.

Duty of Candour

- Managers encouraged staff to be open about mistakes. The provider had a policy on implementing the duty of candour dated July 2016.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Records showed that a doctor or nurse completed a comprehensive and timely assessment at the time of admission. Assessments covered the patient's physical health, mental health and any risk they may present.
- Staff carried out physical examinations, including blood tests, on admission and regularly updated them. Patients told us that staff carried out physical health checks up to four times each day. Staff recorded physical checks on a score sheet especially designed to calculate the physical health risks to patients with eating disorders.
- Care records were up-to-date and personalised. Records showed that patients usually attended ward rounds. Staff discussed patients' specific care needs and progress at these meetings. Nutrition and hydration plans included the patient's views. Records showed that staff considered each patient's physical and mental health throughout their treatment. Records included evidence of weekly key-working sessions.
- Staff used an electronic patient record to store information about patients. This system was accessed by each member of staff having their own log-in details and password. Some information, such as records of physical health checks and paperwork relating to the Mental Health Act, were stored in locked filing cabinets. On Priory Court, staff found it difficult to find information about physical health checks that was more than one month old due to the archiving system. This meant that it was difficult to track patient's health to ensure that treatments were effective.

Best practice in treatment and care

- Both wards offered a comprehensive range of psychological therapies including dialectical behavioural therapy (DBT), cognitive behavioural therapy (CBT), life skills coaching and psychodynamic approaches. In the early stages of admission patients tended to join creative groups and activities. Patients engaged in more complex therapeutic groups, such as DBT, once their physical health had stabilised. On Priory Court, staff offered each patient family therapy. This included arranging for family meals to take place in a small kitchen on the ward. The dietitian and occupational therapist facilitated groups on subjects such as "Food and me" and "Why carbs are important."
- The ward manager and a consultant reviewed all referrals to ensure that patients were physically able to cope with admission. Some patients required an admission to a physical health ward prior to admission to the specialist eating disorder service. Patients had good access to physical health care following admission. On admission, patients received a physical assessment by a doctor. This assessment included an electrocardiogram (ECG) and blood tests. Staff checked patients' blood pressure, pulse and respiration regularly. If patients' required more intensive physical health care they were transferred to the local general hospital.
- Maintaining patients' nutrition and hydration was a fundamental part of their treatment. On admission, many patients presented a high risk of re-feeding syndrome. This syndrome consists of metabolic disturbances that occur as a result of reinstituting nutrition to patients who are starved or severely malnourished. Staff showed a good understanding of this syndrome which could occur if the reintroduction of food was not managed correctly. Staff carried out a blood test and ECG on admission. Results of these tests were analysed by the dietitian who used this information to prescribe meals for patients that would address their specific nutritional needs. Patients who had had a very low calorific intake began with ¼

portions of meals along with additional milk. Staff provided naso-gastric feeding if patients were refusing to eat. They could carry out this procedure under restraint.

- On Upper Court, staff assessed patients on admission and discharge using the Eating Disorders Examination Questionnaire (EDQ). Staff collated a report of these scores every three months and submitted this to funders. The ward recorded the Health of the Nation Outcome Scale (HoNOS) for each patient. Priory Court also used EDQ along with the child and adolescent version of HoNOS, known as HoNOSCA. Staff used the Children's Global Assessment Scale to measure the mental health of children and young people.
- Nursing staff told us they had been involved in audits of clinical practice in relation to physical health observations, risk assessments, consent to treatment and medication.

Skilled staff to deliver care

- Both wards had multi-disciplinary teams (MDT) that included nurses, health care assistants, psychologists, psychotherapists, family therapists, occupational therapists, a dietitian, consultant psychiatrists and ward doctors. On Priory Court, teachers at the school attached to the ward were also part of the MDT.
- New staff received a week-long induction to the hospital. This included training on risk management, supervision, health and safety, basic life support, safeguarding and managing violence aggression. This was followed by a further week long induction that was specific to the eating disorders service. This included specific training on eating disorders, observation and meal management.
- Managers recorded supervision sessions on a standard form. Notes tended to be brief. The most recent supervision sessions on the five records we reviewed varied from between one month and four months prior to the inspection. Staff spoke positively about external clinical supervision they received. All staff had completed annual appraisals. The appraisal records were comprehensive providing details of the employee's development over the previous year. They included a summary by both the appraiser and appraisee and objectives for the year ahead. Team meetings took place once a week. Each week the focus of these meetings would be on either the business of the ward, complex patients, training or staff support. On Upper Court, staff used these meetings for training sessions, for example, on dialectical behavioural therapy or motivational interviewing. Staff on Priory Court said these meetings were well attended but often nurses and HCAs could not attend if they were supporting patients after meals. Similarly, staff said they were often unable to attend staff support groups if there was a high level of acuity on the ward.
- Senior staff provided training on the wards. For example, a family therapist had given training to HCAs on facilitating family meals. Nurses and HCAs had access to specific training in eating disorders accredited by the University of Brighton. On Priory Court, six staff had completed this training and a further three staff were undertaking the course. Nurses could complete an online leadership course as part of their continuing professional development. The hospital had also introduced continuing professional development training for nurses. The dietitian and ward manager on Upper Court provided training on naso-gastric feeding. Some nurses had completed training on inserting naso-gastric feeding tubes.
- The service specified that locum doctors should be competent in passing a naso-gastric tube as this was often required on the specialist eating disorder wards. We observed that arrangements were in place to supervise a doctor who was not confident in this task.
- Managers addressed poor staff performance through the development of a performance plan that was monitored through individual supervision. The human resources department provided support to ward managers.

Multi-disciplinary and inter-agency team work

- Each ward held multi-disciplinary team meetings to discuss each patient's progress twice a week. Patients attended these meetings and received notes to help them remember the discussion.
- Handover meetings took place twice a day when the shifts changed. The length of time for these meetings had increased from 15 to 30 minutes to ensure that staff discussed each patient. Staff told us there were good relationships within the teams.
- Both wards maintained relationships with the agencies that referred patients. Staff invited referrers to care programme approach meetings where arrangements for discharge and future care were discussed in depth. Referrers were also informed of any incidents that the

person they referred had been involved in. Staff said that a commissioner from a nearby local authority had visited the previous week to see all of the patients they had placed with the service.

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

- Staff completed online training on the Mental Health Act as part of the Priory Foundations for Growth training programme.
- Staff discussed patients' mental capacity and consent to treatment at each ward round. Records of these meetings showed that they had considered the four components of mental capacity. Staff attached consent to treatment certificates or certificates signed by a second opinion appointed doctor (SOAD) to medication charts when this was required. On three records we found there had been significant delays in a SOAD authorising treatment for patients who lacked capacity or consent. This resulted in patients receiving treatment authorised by the responsible clinician under the provisions within the Mental Health Act for urgent treatment.
- Records showed that staff gave patients information about their rights under the Mental Health Act when they were detained and that this was repeated during the period of their detention.
- Administrative support and legal advice was available from the Mental Health Act office based at the hospital. This office carried out regular audits of the use of the Mental Health Act.
- We reviewed the statutory documents relating to the detention of five patients. Staff completed these documents appropriately. The original documents were stored in the Mental Health Act office, with copies kept in a locked filing cabinet on the ward.
- Patients had access to an independent mental health advocacy service. Staff gave information about this service to patients and it was displayed on notice boards.

Good practice in applying the Mental Capacity Act.

- Staff completed online training in the Mental Capacity Act as part of the Priory Foundations for Growth training programme.
- There had been no applications for deprivation of liberty safeguards (DoLS).
- Nurses on the wards told us that doctors considered mental capacity of patients at weekly ward rounds. They explained that if patients did not have capacity to consent to admission or treatment, and that inpatient treatment is necessary for the health or safety of the patient, they would consider an application for detention under the Mental Health Act.
- The hospital had a specific form to record the competency of patients under the age of 16 to ensure that they checked for Gillick competence (whether a child of 16 years or younger is able to consent to their own medical treatment without parental permission).

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

- We observed positive interactions between staff and patients. Staff appeared attentive and compassionate towards patients. On Upper Court, the atmosphere was calm and responsive. Staff we spoke with were experienced in working with people with eating disorders and spoke caringly about their patients.
- Patients on Priory Court expressed concerns about safety. Patients felt there were often insufficient staff on duty, particularly when a number of staff had to deal with an incident. These patients highlighted that staff locked their rooms between 8am and 8pm, which meant they did not have anywhere to go if they wanted to be alone. Feedback from patients on Upper Court was positive. Patients commented that that permanent staff were caring and supportive. All the patients we spoke with on Upper Court expressed some concern about the high use of agency staff who they were unfamiliar with. One patient said they were alarmed that a male agency nurse she had never met walked into her room at night.
- Throughout our interviews, staff showed a good understanding of patients' needs in relation to their physical health, mental health and personal circumstances.

The involvement of people in the care they receive

Requires improvement

Specialist eating disorder services

- Staff planned admissions to the wards and sent patients information in advance of their admission. When patients arrived they were shown around the ward, and introduced to staff and other patients.
- Care plans and nutrition plans showed evidence of patients' involvement. Patients told us they attended the ward round with their consultant each week and gave their views on care and treatment. Staff documented one-to-one key working sessions in patients' notes.
- Information about patient advocacy services was displayed on both wards. Patients told us they were familiar with the services.
- Both wards provided family therapy. The service provided a handbook for families on understanding eating disorders. There were weekly family support meetings at the hospital. Staff invited families to attend ward rounds and to discuss discharge arrangements at care programme approach meetings. On Priory Court, the service facilitated family meals in a small kitchen as part of the therapeutic programme.
- On Priory Court patients were encouraged to complete a feedback form. Patients had completed twelve forms in the four months prior to the inspection. Most feedback was positive. Two forms were more negative. One patient commented that they did not like having seen other patients being distressed and they were upset by seeing blood on the walls where patients had harmed themselves. Two feedback forms stated that staff were friendly. Community meetings took place once a week, giving patients the opportunity to raise any concerns about the ward. The ward manager on Upper Court met with patients after their first 72 hours of admission to ask if they had any concerns.
- Patients could be involved in interviews for new staff or submit questions they would like interviewers to ask applicants at interviews. Sometimes it was difficult for patients to attend interviews if they took place at meal times.
- We found some evidence of patients being able to make advance decisions. On Upper Court, care plans could include details of how a patient preferred staff to restrain them if that was required.

Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- During the six months prior to this inspection, 98% of beds had been filled on Upper Court and 80% on Priory Court.
- Both wards accepted patients from across the country, although most patients tended to be from London and the South East.
- Staff did not admit patients to beds allocated to patients who were on leave. Patients on leave would always return to the same bedroom.
- Staff planned admissions and discharges and they took place during the day. Priory Court scheduled admissions between Mondays and Thursdays.
- No patients had been transferred to psychiatric intensive care units. Staff responded to increased agitation by increasing levels of observation. If patients required intensive care for their physical health they would be transferred to the local general hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- At our previous inspection in February - March 2016, we identified that staff should undertake naso-gastric feeding in an appropriate environment. We also identified that an appropriate environment for the physical examination of patients was needed. At the current inspection, we found that the provider had installed a new naso-gastric feeding room with an appropriate seating arrangement on Priory Court. However, on Upper Court staff were still carrying out naso-gastric feeding in a therapy room, not in a clinical area, and there was no appropriate seating in place. Staff fed patients sitting on a standard chair. This heightened the risk of injury if staff had to restrain a patient. Staff told us that there were plans in place to address this. There were no facilities on either ward for patients to receive a full medical examination. Staff used an examination couch on another ward.
- On the day of the visit, Priory Court was very noisy. The main lounge was chaotic. Doors slammed very loudly. Staff locked patients out of their bedrooms. This meant that many of the young people were sitting outside their

rooms doing their school work. There were no quiet areas available and no privacy for patients who were distressed. Restraint of patients took place in full view of other patients. We saw many patients looking bewildered at witnessing restraints taking place. During this time, the lounge on the upper floor was not in use.

- Patients could meet with visitors on the ward either in their bedrooms or in lounges and therapy rooms. Patients could use other rooms within the hospital to meet their visitors.
- Patients had access to their own mobile telephone. On Priory Court this was limited to certain times of the day. Patients on Priory Court had to hand their mobile telephones to staff at night. Priory Court also had a cordless telephone that patients could use to make calls in private.
- Patients had access to the garden and the well maintained grounds of the Priory Hospital. For patients detained under the Mental Health Act, access to outside space required the permission of their responsible clinician. On Upper Court, 15 minute walks in the grounds were facilitated by staff twice a day. For some patients, exercise was restricted due to a low body mass index.
- Food was cooked and prepared on site. Staff on Upper Court said they had a good relationship with the catering team. Staff from the ward supported the catering staff to understand the needs of patients. The dietitian planned meals to meet the specific needs of each patient. These meals were provided in ¼, ½, and ¾ portions to accommodate patient's re-feeding needs. Patients spoke positively about the quality of the food, commenting that food was fresh and there was a good choice available.
- Staff managed patients' access to hot drinks and snacks as part of their care plan.
- Young people on Priory Court could personalise their bedrooms. Staff told us that patients on Upper Court could also personalise their bedrooms although, in the bedrooms we looked at, no one had chosen to do so.
- There were facilities on both wards for patients to store their belongings securely.
- Both wards had a structured programme of activities and therapies throughout the week. A timetable for activities was displayed on both wards. Patients on Priory Court were required to complete 24 hours of structured activity each week. Activities included snack cookery, swimming, team meetings, dance & movement, outings, post meal support, and information sessions. Other group programmes included dialectical behavioural therapy, self-awareness, yoga, games therapy, drama therapy, mindfulness, creative writing, tai chi, and relaxation.

Meeting the needs of all people who use the service

- Upper Court was unable to admit patients with high mobility needs. Patients on Upper Court had a personal evacuation plan if they were likely to require assistance in an emergency. Patients could access Priory Court by a lift from the ground floor to the lower and upper levels of the ward.
- The service could produce leaflets for people whose first language was not English.
- Leaflets on health promotion were available to patients. The wards also provided information on safeguarding, making a complaint, contacting the Care Quality Commission and accessing advocacy.
- The service could provide interpreters although staff said this was not usually required.
- The dietitian planned meals and accommodated the dietary requirements of religious and ethnic groups. Halal food was available. Upper Court had recently begun to develop meals for patients requesting vegan food.
- A hospital chaplain was available to patients. Staff could support patients to attend places of worship.

Listening to and learning from concerns and complaints

- On Upper Court there had been three complaints in the previous 12 months. One was retracted, one was partly upheld, and one was not upheld. On Priory Court there had also been three complaints. All these complaints had been made by patients' parents. None had been upheld.
- Patients told us they knew how to make a complaint. Information about making complaints was displayed on notice boards.
- We reviewed the reports of five investigations of complaints. Investigations were thorough with evidence collated through interviews and reviews of documents. Complainants received a written response with the findings of the investigation.

Requires improvement

Specialist eating disorder services

- The service timescale for acknowledging complaints was 48 hours and the provider responded to complaints within 20 working days. If they could not provide a response within 20 days, the provider sent a letter of explanation to the complainant.
- Staff discussed the outcomes of complaint investigations at team meetings.

Are specialist eating disorder services well-led?

Requires improvement

Vision and values

- Staff were familiar with the organisational values, primarily that of putting patients first.
- The objectives for both wards reflected the values. These objectives were to provide a safe environment, to be caring and supportive towards patients, and to promote recovery. Both wards were working towards greater involvement of families and carers. Priory Court had specific objectives to address the number of vacancies for nursing staff.
- Staff knew the senior managers at the hospital. The provider had recently appointed two directors of clinical services. These directors had contact with the wards every day and, on occasion, provided practical support. Ward managers and directors met on a daily basis for a brief meeting to discuss any immediate concerns or incidents. These were known as 'flash' meetings. Senior staff also conducted regular 'quality walk arounds'. This enabled managers to regularly check the cleanliness or carry out random checks on the physical health monitoring of patients

Good governance

- At our previous inspection in February - March 2016, we identified that log-in details of permanent staff should not be shared with agency staff. At the current inspection we found that this was still happening. Staff on the wards were still not clear about temporary log-in arrangements for agency staff including doctors and nurses, who did not have log ins provided, unless they were block booked to work at the hospital for an extended period. Temporary log-ins were made available to the hospital director on a regular basis. However, senior management acknowledged that they needed to distribute temporary log-ins to more staff in the hospital to ensure that they were used appropriately. We were also concerned that staff on the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. Senior management advised that a laptop was available, and couriers could deliver dongles if needed.
- The senior management team governed the hospital. This included the hospital director, the medical director and the clinical services directors. The hospital provided staff with mandatory training**.** Compliance with mandatory training was 62% on Priory Court and 69% on Upper Court. Staff received regular supervision. An appraisal of all staff took place once a year. Some staff received supervision specific to their role from specialist practitioners.
- Both wards had a high proportion of vacancies for nursing posts. The hospital was taking steps to address this. The hospital employed agency staff on three-month locum contracts to ensure greater consistency in the staff working on the wards. Staff told us they spent as much time as they could on direct care activities, although this varied according to the needs of the patients. When there was a high level of need across the ward, staff spent more time directly working with patients. Staff took part in clinical audits such as audits of ligatures, care plans, safeguarding and restraints. There were well established systems in place for the reporting of incidents and complaints and discussing lessons learned with the staff team. There were procedures in place for the use of the Mental Health Act, Mental Capacity Act and safeguarding.
- Key performance indicators included recruitment and retention, compliance with mandatory training and completion of outcome measures. Data on these indicators was provided to ward managers in a table that enabled them to monitor their performance.
- The ward managers had sufficient authority to make decisions about staffing levels. Both ward managers felt supported by the clinical services directors. Both wards employed an administrator.
- The clinical governance committee had an overview and monitored all safeguarding incidents, learning from serious case reviews and other incidents, infection control, health and safety, equipment, medicines, staffing, and staff training compliance. They also

reviewed all complaints, and monitored use of restrictive practices, nutrition, policies and procedures, clinical records, health promotion, compliance with the Mental Capacity Act and Mental Health Act and staff supervision and appraisals. They looked at compliance with internal and external inspections, feedback from staff and patient meetings, and other audits. The provider maintained a risk register for the hospital, which management reviewed at compliance and senior management meetings. Staff could submit items to the hospital risk register through the clinical governance meeting.

- One issue on the risk register was that documentation on site was consistently scoring under the required level, of particular concern was recording of physical health assessments on admission, patient involvement in care plans and evidence of multi-disciplinary decision making in risk assessments. Other issues on the risk register included potential for medication prescribing and administration errors that could affect patient safety. A risk register audit and research group met periodically.
- A 'flash' meeting took place in the hospital every morning on weekdays. We attended the 'flash' meeting held on Monday morning during our inspection. A manager or their representative represented each ward. The directors of clinical services were also present. Ward representatives reported back to the senior managers and other staff present on the number of incidents that had occurred on their respective wards over the weekend. They also reviewed staff numbers for that day and night. Where management identified staffing shortfalls, plans were put in place to obtain more staff or staff moved from other ward rotas if they had more than the required number of staff. Staffing reviews included whether staff were permanent staff or bank or agency staff on duty. Manager gave each ward an overall risk rating based on the level of risk assessed for the patients on the ward. This helped senior managers maintain an overview of risks and concerns in the hospital and take action to mitigate the risks identified.
- There was no rating displayed for the service overall or for the core services we inspected in February 2016. When we brought this to the attention of senior managers, they placed a copy of the overall rating for the hospital in the main reception area. They did not display the core service ratings.

Leadership, morale and staff engagement

- At our previous inspection in February - March 2016, we identified that the provider needed to review staff engagement to ensure that staff working in the acute wards were able to raise any concerns they might have. At the current inspection we found that senior management had made efforts to improve engagement with staff on the wards.
- Every ward had a staff representative. Ward staff representatives met with staff from human resources every month at a staff forum. This enabled staff to raise any concerns that they or their colleagues had.
- Staff told us they felt able to raise any concerns they had with their line manager. Staff were positive about the new senior management team in the hospital and said the directors of clinical services were driving change. They had an open door policy and staff were encouraged to speak up. Staff felt that there had been changes in the hospital since the last inspection. They said that there had been considerable investment in training and in the recruitment of new staff. Management offered staff bonuses when taking up a position in the hospital and further financial incentives to continue in their roles.
- The Priory Hospital had completed a staff survey in June 2016. Staff gave positive responses to questions about understanding how their works helps their team to achieve its aims, caring about the future of the service and enjoying work. There were negative responses to questions about having the necessary equipment and resources, believing that action will be taken as a result of the survey and workload being reasonable.
- The average sickness rates for the whole hospital in the three months prior to the inspection was 2%. This was one of lowest levels of sickness across 12 Priory Hospital sites. On Upper Court, there were four members of staff on long-term sick leave.
- None of the staff raised concerns about bullying or harassment. Staff told us they knew how to use the whistleblowing procedure if they needed to.
- Overall, staff morale was good. Staff appeared very committed to their work and highly motivated to achieve positive outcomes for their patients. Some staff felt demoralised by the level of staff vacancies and high use of agency staff. These staff told us that they often felt very stretched. This was exacerbated by working

with agency staff who lacked experience of working on the ward. Most health care assistants were psychology graduates and motivated to gain experience to enable them to pursue their careers. Some staff were frustrated that senior managers appeared to have ignored requests for redecorating areas of the wards. The nurses' office on Priory Court was particularly hot and staff were frustrated that senior management had not responded to requests for air conditioning.

- There were some opportunities for leadership development. Some nurses had taken on responsibility for particular areas of practice such as the Mental Capacity Act and working with people with autistic spectrum disorders. The provider considered requests for continuing professional development training, with three approved in August, one in September and five approved in October 2016.
- The majority of staff had appraisals, with 165 completed as of 25 October 2016, and with four identified as overdue.
- The provider undertook a review of staff exit interviews, considering reasons for leaving, and held listening groups for staff on each ward. These had brought about some changes including providing more activity coordinator support on wards and out of hours programmes, recruitment of new ward clerks, and a review of how ward managers spent their time on wards.
- Staff spoke positively about their work with colleagues and commitment to team work.

Commitment to quality improvement and innovation

- A project to refurbish the hospital had commenced, although there were still adjustments to make to 'safer rooms' and considerable work still to be carried out in other areas.
- There were long term plans for Priory Court to have all bedrooms with the specifications of 'safer rooms.'
- On Upper Court, information was provided on how the ward had made improvements as a result of complaints in a 'You said, We did' format.
- Upper Court had achieved accreditation by the Quality Network for Eating disorders.
- There were plans to relocate the admissions office to a site nearer the main reception by the end of January 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there are sufficient staff to provide safe and consistent care to patients on each shift.
- The provider must ensure that the hospital environment is safe for patients at high risk of self-harm or suicide.
- The provider must ensure that a suitable environment including seating, is available when patients require nutrition to be delivered through nasogastric tubes on Upper Court and that there is a suitable environment for the physical examination of patients on each ward.
- The provider must ensure that consistently rigorous risk assessments and care plans to address identified risks are put in place for patients on acute wards, and address gaps in physical health assessments, and monitoring of patients after rapid tranquilisation.
- The provider must ensure that the layout of the ward does not impact on the dignity of patients who are being restrained on Priory Court. Blanket restrictions on this ward must be reviewed. The thoroughfare of staff and patients from other wards walking through Garden Wing to the dining area, must be addressed as this impacts on patients' privacy and dignity, and increases security risks.
- The provider must ensure that gaps in staff mandatory training are addressed, including intermediate life support training for nursing staff.
- The provider must ensure that there is a system in place to monitor the time new patients wait for an assessment on admission to the acute wards.
- The provider must ensure that emergency medicines and equipment is checked, maintained and calibrated regularly on the eating disorder wards, to ensure the safe and effective treatment of patients.
- The provider must ensure that personal log-in details of permanent staff are not shared with agency staff.
- The provider must ensure that contingency plans in the event of unexpected computer system outage are made clear to staff on the wards.
- The provider must ensure that the current CQC inspection rating for all core services is displayed prominently at the hospital.

Action the provider SHOULD take to improve

- The provider should ensure that records of care plans show evidence of patient involvement in the process, and that they are person centred.
- The provider should review procedures on Priory Court that may provide blanket restrictions on patients.
- The provider should address some gaps in management supervision for staff in recent months.
- The provider should continue to engage with staff who are feeling demoralised regarding staff vacancies and a lack of response from senior management to requests made on the wards.
- The provider should ensure that the small dining room on Upper Court is refurbished, to provide a positive therapeutic environment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients on Priory Court and Garden Wing did not have access to private areas and, the management of incidents, including restraint, compromised patients' dignity. On Priory Court patients there were some blanket restrictions regarding patients access to their bedrooms and other quiet spaces. On Garden Wing a regular flow of staff and patients from other wards accessing the dining area through the ward, impacted negatively on the privacy and dignity of patients. This was a breach of Reg 10(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. No suitable seating arrangement was available to ensure the safety of patients and staff during nasogastric feeding on Upper Court. The refrigerator on Priory Court was out of order but still in use. This placed patients at risk of receiving unsafe medicines.

This section is primarily information for the provider

Requirement notices

On Priory and Upper Courts, sporadic checks were undertaken on emergency medicines and equipment, and there were a lack of cleaning records for clinical areas.

There was a lack of consistency and detail in risk assessments on admission, and risk management plans and care plans put in place for patients across the hospital. There were also gaps in physical health assessments, and monitoring of patients vital signs following rapid tranquilisation.

There were gaps in staff training in mandatory areas, and no training had yet provided in intermediate life support.

This was a breach of regulation 12(1)(2)(a)(b)(c)(e)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The premises were not always suitable for the purposes for which they are being used. Nasogastric feeding was not undertaken in an appropriate location. A suitable environment was not provided for the physical examination of patients on Upper Court and East Wing. 'Safer rooms' for high risk patients included a number of ligature anchor point risks. Risk assessments did not include all ligature anchor points and other risks to patients on the wards, including areas out of site and access to staff offices. These risks had not been adequately mitigated against to ensure the safety of patients on each ward.

This section is primarily information for the provider

Requirement notices

Not all equipment was properly maintained and appropriately located for the purpose for which it is being used.

Nasogastric feeding was still taking place in an unsuitable environment on Upper Court. On East Wing patients had physical examinations in their bedroom because no clinical room was available, which was inappropriate.

On Priory and Upper Courts patient weighing scales had not been checked and calibrated as appropriate to ensure their accuracy for patients on these eating disorder units.

This was a breach of regulation 15 (1)(b)(c)(f)

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 Systems or processes to assess, monitor and mitigate risks to the health, safety and welfare, were not operated effectively to ensure compliance. There was no system in place to monitor waiting times for new patients to be assessed by nursing and medical staff from their time of arrival on the ward. New agency staff were still sometimes using permanent staff log ins to record on the electronic patient record keeping system. Staff on the wards were not clear about the action to take in the event of unplanned downtime of the electronic patient record keeping system.

This section is primarily information for the provider

Requirement notices

This was a breach of Reg 17(1)(2)(a)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20A HSCA (RA) Regulations 2014 Requirement as to display of performance assessments The CQC inspection ratings were not displayed in a prominent place at the service. The inspection rating was not displayed during the inspection, until we raised this with the senior management team. Following this, the provider summary was displayed, but not the ratings for each core service as required. This was a breach of regulation 20A

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 18 HSCA (RA) Regulations 2014 Staffing There were not always sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed on the wards at all times to deliver the service safely. High staff turnover and vacancies remained an issue. There were significant numbers of shifts which were understaffed according to the provider's own staffing specifications, particularly on West and Garden Wings, Upper and Priory Court. On Priory Court there were not always sufficient staff to support all patients in the event of an incident occurring on the ward. We served a warning notice in respect of Regulation 18(1) on 29 November 2016