Florence Nightingale Hospitals Limited

# Nightingale Hospital

**Inspection report**

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

## Ratings

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

# Summary of findings

## Overall summary

We rated acute wards for adults of working age and specialist eating disorder wards as requires improvement overall. We rated the substance misuse ward as good overall.

We rated Nightingale Hospital as requires improvement because:

- Staff completed ligature risk assessments for wards, but these were missing important details, confusing and lacked clear plans in place to mitigate risks identified. Some staff we spoke with did not know how to find the risk assessment.
- Staff developed care plans but did not always reflect patient risks, needs and goals on the acute and eating disorder wards. We found that staff reviewed care plans on a regular basis but there was no evidence that these reviews were meaningful in terms of making appropriate changes in line with patients' current presentation. Care plans for day patients in eating disorder had not been reviewed after they were discharged from the ward, so were not an up to date reflection of their care.
- The service had systems and processes in place to provide assurance and deliver the organisation's services safely, but these were not always effective. We found areas for improvement in their governance processes. Although performance data was collected, there was limited evidence of improvements. For example, the quality of some essential patient records were still not adequate and could lead to unsafe care and treatment.
- The service had not documented a specific risk assessment for a patient under 18 years old admitted to an adult ward, including consideration of risk related to their age and vulnerability.
- Staff did not use a recognised risk assessment for patients in terms of their tissue viability (to monitor their risk of developing pressure ulcers) on the eating disorders ward and the ward did not have a safe and appropriate chair for patients who needed feeding by naso-gastric tubing.
- Patients in eating disorder ward described some variability in the way different staff treated them, with some staff not understanding their individual needs, and not treating them with compassion and kindness and respecting their privacy and dignity.
- Although records showed that staff checked emergency equipment weekly some of it had expired, removed from the emergency kit and not been replaced. A defibrillator was noted to have had a low battery since May 2022. It was not clear from the paperwork or from talking to staff how this identified issue had been actioned.
- Some prescription charts on the acute wards did not record the name of the patient or the name of the prescriber, which meant there was a risk of patients being given the incorrect medicines.
- Staff did not always document discharge plans or approximate dates of discharge for all the care records we reviewed on the acute, obsessive compulsive ward and eating disorder wards. It was difficult to ascertain whether these discussions had happened with the patients by looking at their records.
- The overall vacancy rate at the hospital for clinical staff was 29%. The hospital had used long term contracts with bank and agency staff to fill these roles. Staff vacancies had been filled with long term locum staff. This had the potential to affect continuity of patient care.
- The service was not smoke-free in line with best practice.
- The services used closed circuit television (CCTV) in all communal areas but did not have signs to make people aware of the use of CCTV. We raised this with the staff who promptly added the signs.
- Female patients on the substance misuse service mixed sex ward did not have access to a female only lounge.
- The provider had not developed staff competencies for key tasks specific to treating patients with eating disorders and autism.
- Clinic room temperatures in the substance misuse ward were above 25 degrees, which is above the recommended temperature for the storage of medicines.

# Summary of findings

However:

- Staff in substance misuse service, acute wards and obsessive compulsive disorder wards treated people with compassion and kindness and understood their individual needs.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team.
- The daily handover sheets were very informative and had key patient information that staff reported to be useful.
- Patients on acute and substance misuse wards felt that nurses were responsive, any issues raised are promptly addressed and patients enjoyed therapy groups.
- All records we reviewed in the substance misuse ward included a comprehensive assessment of patients' drug and/or alcohol dependence level, healthcare and other needs.
- The substance misuse ward met the needs of all patients – including those with a protected characteristic. The ward had recently held an LGBT+ event on the ward, where advice and information about services that support the LGBT+ community was shared.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Specialist eating disorder services** | Requires Improvement  | The eating disorder ward was located in a separate nine-bedded three-storey building. The eating disorder unit also accepted day patients. |
| **Acute wards for adults of working age and psychiatric intensive care units** | Requires Improvement  | The acute wards provided mixed sex accommodation, apart from two acute wards on the first and second floors, that are single sex. The ground floor ward was a mixed sex 11 bed acute ward for adults of working age. The first floor had two wards: a 14 bed male acute ward and a six-bed obsessive compulsive ward for adults of working age. The second floor was a 17 bed female only acute ward for adults of working age. |
| **Hospital inpatient-based substance misuse services** | Good  | The substance misuse service a 28-day treatment programme or a detoxification programme. The therapy programme followed the 12 step programme, a widely used and recognised psychosocial treatment programme for people with addictions. |

# Summary of findings

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# Summary of this inspection

## Background to Nightingale Hospital

Nightingale Hospital is an independent hospital that provides mental health care and treatment for people who may or may not be detained under the Mental Health Act 1983. The hospital offers general psychiatry, eating disorders, obsessive compulsive disorder and addiction treatment for adults as both inpatients and outpatients.

The service provides three acute wards for adults of working age, one obsessive compulsive disorder ward, a substance misuse and detoxification ward, and a specialist eating disorder service for adults. Wards provide mixed sex accommodation, apart from two acute wards on the first and second floors, that are single sex. The ground floor ward was a mixed sex 11 bed acute ward for adults of working age. The first floor had two wards: a 14 bed male acute ward and a six-bed obsessive compulsive ward for adults of working age. The second floor was a 17 bed female only acute ward for adults of working age. The eating disorder ward was located in a separate nine-bedded three-storey building. The eating disorder unit also accepted day patients.

The service has 73 beds across general mental health, addictions, and eating disorder treatment wards. At the time of our visit, there were 42 patients admitted to the hospital over six wards, with six patients on the eating disorder ward, three patients on the substance misuse ward and 34 patients on the general acute wards.

There are over 60 consultant psychiatrists who have been granted practising privileges at the Nightingale Hospital. This means that they can admit patients they see in the community to an inpatient bed and remain their consultant while the patients are on the ward.

The service is registered to provide the following regulated activities: treatment of disorder disease or injury; diagnostic and screening procedures; and assessment or medical treatment of person admitted under mental health act and nursing care. There was a registered manager in place at the time of the inspection.

We last inspected the Nightingale Hospital in March 2019. The overall rating was good. The hospital had made significant improvement after an inspection in January 2018 that had an overall rating of requires improvement. The acute wards for adults of working age and psychiatric intensive care units had requiring improvement rating in safe and good in effective, caring, responsive and well led. The specialist eating disorder ward and substance misuse ward was rated good overall, and good in safe, effective, caring, responsive and well led.

As this inspection took place during the Covid-19 pandemic we adapted our approach to minimise the risk of transmission to clients, staff and our inspection team. This meant that we limited the amount of time we spent in the service to prevent cross infection. Whilst on site we wore the appropriate personal protective equipment and followed local infection control procedures. We carried out some staff interviews via video, as well as analysis of evidence and documents. Our final video call interview was completed on 17 June 2022.

## 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?

# Summary of this inspection

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The team that inspected the Nightingale Hospital comprised 13 people. Six CQC inspectors, an inspection manager, a Mental Health Act reviewer, three specialist advisors who are senior nurses with expertise in management of eating disorder services, substance misuse and acute wards for adults of working age and two Experts by Experience. Experts by Experience are people who have recent personal experience of using or caring for someone who uses a similar service.

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

During the inspection visit, the inspection team:

• visited the service, looked at the quality of the environment and observed how staff were caring for clients

• spoke with 20 patients who were using the service and three relatives/carers of patients using the service by telephone

• spoke with the ward managers, compliance manager, director of nursing, medical director and a patient services manager

• spoke with 25 staff members including registered nurses, healthcare assistants, a student nurse, a dietitian, an occupational therapy assistant, a consultant psychiatrist, ward doctors

• looked at 26 care and treatment records of clients

• observed lunch supervision on the ward

• attended an occupational therapy session on the ward

• observed a multidisciplinary team meeting, an MDT senior management meeting and a therapy planning meeting.

• carried out a specific check of the medication management and looked at a range of policies, procedures and other documents relating to the running of the service.

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

how-we-do-our-job/what-we-do-inspection.

**What people who use the service say**

# Summary of this inspection

We spoke with 20 patients using the acute wards, substance misuse ward and eating disorder ward. Patients said that therapists explained every step in their therapy journey well and eased their anxiety. They described nurses in acute and substance misuse wards as responsive. Any issues raised were promptly addressed by staff and patients enjoyed the variety of groups offered.

Patients in the eating disorder ward said that staff were very good at meeting their physical health needs. The patients were very positive about the therapies provided, and therapy staff.

Feedback from patients in substance misuses ward was that the Fibroscan work, for detox patients, was positive.

## Outstanding practice

We did not identify any outstanding practice.

## Areas for improvement

**Action the provider MUST take to improve**

**Overall**

- The provider must ensure that eating disorder and acute wards have effective governance systems and processes in place to assess, monitor and drive improvements in the quality and safety of services provided, including addressing shortfalls in risk management, and discharge planning, and patients' concerns about variable staff treatment on the ward. Regulation 17(1)(2)(a)(b)(c).
- The provider must ensure that expired oxygen reservoir and tubing kits are replaced without delay. Regulation 12(2)(6)
- The provider must ensure that there is a specific risk assessment documented for patients who are under 18 years old admitted to an adult ward, including consideration of risk related to their age and whether one-to-one observations are needed. Regulation 12(2)(1).

**Specialist Eating Disorders Services**

- The provider must ensure that there is an appropriate and comfortable chair and space available for patients who require nasogastric feeding. Regulation 15(1)(3).
- The provider must ensure that staff use a recognised risk assessment for patients in terms of their tissue viability (to monitor their risk of developing pressure ulcers). Regulation 12(2)(1).
- The provider must ensure that day patients have their risk assessments and care plans updated from when they were inpatients on the ward, to reflect their current situations. Regulation 12(2)(1).
- The provider must address patients' experience of variability in staff compassion and empathy, and respect for their privacy and dignity. Regulation 10(1).

**Acute wards**

- The provider must ensure that ligature risk assessments for each ward and the risk mitigation in place is clear and consistent. Regulation 12(1)(2)(4)

# Summary of this inspection

- The provider must ensure that staff complete National Early Warning Scores charts in full to determine whether further action is needed and escalate as needed. Regulation 12 (1)(2)
- The provider must ensure that staff complete medication administration records in full. Regulation 12 (1)(2).
- The provider must ensure that care plans and risk assessments for all patients include sufficient details to address their needs. Regulation 9(1)(3)(b)
- The provider must ensure the robust discharge plans are documented in patient records. Regulation 9(1)(3)(b)

**Action the provider SHOULD take to improve**

**Overall**

- The provider should continue recruitment of staff for all wards, to ensure continuity of care for patients.
- The provider should ensure patients and visitors are aware that there is CCTV (closed-circuit television recording) in communal areas of the wards, including the use of signage to remind them.
- The provider should consider adopting a smoke-free policy on the premises in line with best practice.
- The provider should consider developing further staff competencies for staff in relation to treating patients with eating disorders and training in working with patients with autism.

**Specialist Eating Disorders Service**

- The provider should look at ways of quietening the bedroom doors when opening and closing to prevent patients using towels over the top of doors to do this (and compromising fire safety).
- The provider should ensure that the sharps disposal bin is signed and dated with the time of assembly, and that there is a handwashing poster in the clinic room as a reminder to staff.
- The provider should ensure that patients are aware of who their named nurse is, have regular one-to-one sessions with their named nurse, and that these sessions are recorded.
- The provider should ensure that patients are fully involved in discharge planning.
- The provider should ensure that they provide clear information to patients and visitors about the availability of meeting rooms to meet with family members on the ward.
- The provider should ensure that all staff knock and wait for a response before entering patients' bedrooms and are discreet and respectful when supporting them in communal areas.
- The provider should ensure that they take action to address patients' concerns about poor temperature control on the ward, particularly in their bedrooms.

**Substance Misuse Service**

- The provider should ensure access to a female lounge for women on the substance misuse service ward.
- The provider should ensure clinic room temperatures are within recommended room temperatures.
- The provider should ensure defibrillator batteries are replaced without delay when they are identified to be low.

# Our findings

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Specialist eating disorder services | Requires Improvement | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement |
| Acute wards for adults of working age and psychiatric intensive care units | Requires Improvement | Requires Improvement | Good | Requires Improvement | Requires Improvement | Requires Improvement |
| Hospital inpatient-based substance misuse services | Good | Good | Good | Good | Good | Good |
| Overall | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement | Requires Improvement |

Requires Improvement

# Specialist eating disorder services

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

## Are Specialist eating disorder services safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement.

**Safe and clean care environments**

**The ward was safe, clean, well equipped, well furnished, and well maintained. However, the room used for naso-gastric feeding was not fit for purpose, and there was some out of date emergency equipment.**

**Safety of the ward layout**

Staff completed and regularly updated risk assessments of all ward areas and removed or reduced any risks they identified. The ward was over three floors and its layout made it difficult for staff to observe all areas due to blind spots. These risks were mitigated by convex mirrors, and individual risk assessments and observations. Observations ranged between constant one-to-one observations and hourly observations.

The ward was in a separate building from the rest of the hospital with a separate entrance.

The service had not fully considered requirements of providing mixed sex accommodation and did not have a dedicated space for a female only and male only lounge, which may be needed depending on the patients who were admitted. All bedrooms had en-suite bathroom facilities and the second floor could be used as a male area but was not in use at the time of the inspection.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Ligature risks were mitigated by keeping rooms locked, environmental checks and hourly observations. A ligature risk assessment for the ward was undertaken annually, most recently in August 2021. It referenced photographs of individual ligature points. However, at the time of the inspection this was only available in an electronic format. Staff were able to tell us about ligature points on the ward and how they were being addressed. All bathroom doors and taps had been refitted to ensure they were anti-ligature.

Staff had easy access to alarms and patients had access to nurse call systems which were located in patient bedrooms in an accessible position.

Requires Improvement

# Specialist eating disorder services

At a previous inspection in January 2019, we observed that patients had placed towels over a number of bedroom doors to minimise disturbance during nightly observations, which compromised safety in the event of a fire. During the current inspection we found that two bedroom doors had towels placed over them to minimise the noise of opening and closing them at night. Staff said that they asked patients not to do this, but patients complained about the noise of opening and closing their doors for observations when they were sleeping.

**Maintenance, cleanliness and infection control**

**Ward areas were clean, well maintained, and well furnished, with the exception of the room used for nasogastric feeding, which was not fit for purpose.**

A small kitchen and a weighing scale chair were being used for nasogastric feeding (providing liquid food by tube) for a patient at the time of the inspection. This was not safe or comfortable for the patient.

Staff made sure cleaning records were up-to-date and the premises were clean. Patients were positive about the standard of cleanliness on the ward. During the inspection, the ward appeared clean and tidy, with the exception of rooms that were not in use, which were cluttered.

Staff followed infection control policy, including handwashing.

At the previous inspection in January 2019 patients requested an improvement in the furnishings in the communal areas, to make these more adult friendly (as the unit had previously been used as a ward for adolescents). This had been addressed by the time of the current inspection.

At the last inspection in January 2019, we noted that there were no audits available to show that patients' bed mattresses were being checked on a regular basis. During the current inspection we saw records of regular checking and cleaning of each mattress as appropriate.

Staff had access to the most recent infection control audit for the ward from May 2022 via the hospital intranet. The ward was undertaking Covid-19 precautions, including testing and isolation of newly admitted patients, and regular testing for staff members. Personal protective equipment including disposable masks, aprons, and gloves, and liquid hand gel were available on the ward as appropriate.

Staff completed weekly and daily environmental checks. We saw records of the checks, including highlighting any issues needing attention, such as changing lightbulbs. Once recorded staff ensured that these were addressed swiftly.

**Clinic room and equipment**

**The clinic room contained accessible resuscitation equipment and emergency drugs that staff checked regularly.**

The clinic room was locked and not accessible to patients. Medicines were stored in locked cupboards. Staff recorded the minimum and maximum temperature of the fridge and the clinic room, on a daily basis to ensure they remained in the appropriate range.

Staff checked, maintained, and cleaned equipment. There were records of weekly clinic room checks including regular calibration of the blood glucose machine.

There were oxygen cylinders for use in an emergency. Records showed that staff checked emergency equipment every week. Checks had identified that the oxygen reservoir and tubing (adults) had expired at the end of April 2022 but had not yet been replaced. The manager advised that this had been ordered but not yet delivered by the time of the inspection. This might lead to delays in patients receiving oxygen in the event of an emergency. The ward had fast acting carbohydrate gels available on the ward for emergencies.

Staff had not recorded the date of assembly of the sharps bin in the clinic room for the safe disposal of used needles and other sharp items. There was no handwashing poster in the clinic room, which would have been good practice, as a reminder to staff.

The clinic room was not large enough to include a couch for examination of patients. Staff carried out procedures such as electrocardiograms (checking the heart's rhythm and electrical activity) in patients' bedrooms.

**Safe staffing**

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

**Nursing staff**

The service had vacancies for nursing staff, but used bank staff, and some agency nurses to keep patients safe when needed. Managers had calculated the number and grade of registered and non-registered nurses required. At the time of the inspection there were six inpatients and four day patients on the ward. Two registered nurses and two non-registered nurses worked each day. There were also two student nurses working on the ward during the inspection (however, they were new to the service). Staff could be supported with a third registered or non-registered nurse depending on the number of day patients on the ward.

The ward establishment was six registered nurses, and four non-registered nurses. There were vacancies for two registered nurses. There was a recruitment drive underway to address this. In addition to the ward manager there was a senior charge nurse, charge nurse, and senior staff nurse covering the ward. Staff noted that it had been particularly difficult to cover the ward over the winter period, not necessarily in terms of staffing numbers but in terms of staff expertise in working with patients with eating disorders. In the last year, one staff member was on long term sickness, another had relocated, and one staff member had retired. There was always a 'float' or extra staff member covering the hospital who could be called on to assist when needed. Staff and patients noted that it was particularly difficult to cover weekends with familiar staff. All staff and patients described difficulties caused by staff vacancies, leading to a lack of consistent staffing on the ward.

Managers limited their use of bank and agency staff as far as possible and requested staff familiar with the service. The ward manager ensured that there were always core staff on duty to work with agency staff. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. The agency staff we spoke with confirmed that they had an induction to the ward. Bank staff had access to the hospital mandatory training along with supervision. Agency staff were inducted using a checklist. However, patients told us that they frequently had staff working with them who were not familiar with eating disorders and may not have known they were coming to an eating disorder ward until they arrived. They said that this led to them sometimes saying inappropriate things (even if well meaning) which impacted on their experience on the ward.

Requires Improvement

# Specialist eating disorder services

We found that the ward manager often covered vacant nursing shifts on the ward with the aim to ensure a consistent staff group were available to patients. This meant they were not able to carry out their duties relating to the running of the ward. On both days of the inspection, the ward manager was included in the number of registered numbers on the ward due to other staff undertaking training that week.

Patients told us that they did not have regular one-to-one sessions with their named nurse, and there were no records of such sessions in patient records. Patients told us that they rarely had their escorted leave cancelled, even when the service was short staffed.

**Medical staff**

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There were three consultant psychiatrists who had practising privileges on the eating disorder ward. The hospital carried out a range of checks to ensure that each doctor was fit to carry out their role. These checks included General Medical Council registration, revalidation, appraisal, Section 12 approval, Disclosure and Barring Service, medical indemnity and the completion of a signed agreement with the hospital.

At the time of the inspection there were two consultant psychiatrists with patients on the ward. This included accepting referrals and screening admissions. One consultant was the lead psychiatrist for the ward and was easily contactable when not on the ward. Patients told us that they did not always have enough time to spend with the other consultant psychiatrist.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift. A junior doctor was also available on the ward.

**Mandatory training**

**Staff had completed and kept up-to-date with their mandatory training.**

The mandatory training programme was comprehensive and met the needs of patients and staff.

Managers monitored mandatory training and alerted staff when they needed to update their training.

The completion rate of mandatory training for all staff within the hospital overall was 95%. The training for nursing staff included adult and child safeguarding, basic life support, managing violence and aggression and nasogastric tube feeding training.

Bank staff were also able to access mandatory training. Managing violence and aggression and life support training were delivered face to face, with the rest of the mandatory training provided online. Staff were scheduled to undertake their mandatory training outside of time spent on the wards.

Human resources produced a quarterly mandatory training report for the ward each month to ensure that staff addressed any gaps.

**Assessing and managing risk to patients and staff**

Requires Improvement

# Specialist eating disorder services

**Staff did not complete risk assessments around the needs of patients under 18 years of age, or for patients' skin integrity**. Staff assessed and managed most risks to patients and themselves and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff rarely used restraint and only after attempts at de-escalation had failed.

**Assessment of patient risk**

Staff completed clinical risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident.

For inpatients, staff and the patients completed a daily risk assessment. Each completed different parts of the form and decided on a risk rating.

Day patients reviewed a risk assessment on a weekly basis with staff, but we saw that these risk assessments had not been updated since the patient moved from being an inpatient to a day patient. Staff had not updated the risk assessment to reflect the patient's current risks as a day patient.

The service did not have a policy on assessing and managing risk for patients who were under 18 years old and admitted to the ward. This had taken place twice in the 12 months before the inspection and at the time of the inspection there was one patient on the ward who was under 18 years old. Staff had not completed a risk assessment for this patient in terms of them being on an adult ward with adult patients. This meant there were no plans in place to manage and mitigate any risks.

Although staff were able to tell us how they protected patients with very low body weights from the risk of pressure ulcers, the service did not require staff to complete recognised risk assessment tools for tissue viability. This meant the staff were not able to monitor patient risks of developing pressure ulcers. Staff told us they protected patients with very low body weights from the risk of increased vulnerability to pressure ulcers by using pressure relieving mattresses.

**Management of patient risk**

Most staff knew about risks to each patient and acted to prevent or reduce risks. Staff completed risk assessments which informed risk management plans. Risk management plans included meal plans, body maps, and specific support to be provided in the event of a particular incident. We observed staff acting quickly to provide support for a patient experiencing difficulties, according to their wishes recorded in their care plan.

However, patients and relatives reported that some staff who did not work on the ward regularly, were not clear about patients' risks or needs, such as dietary requirements, and precautions to prevent self-harm. They gave examples of having to remind staff themselves or intervene in the cases of other patients.

Patients' level of observation was reviewed as needed when their risks increased or decreased. Rooms that were not in use, including the laundry room or activities room, were kept locked. If the top floor of the ward was in use, a staff member was stationed there, to ensure on patients' safety in this area.

Staff followed hospital policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. Informal patients could leave at will and told us that they knew this. The ward displayed signs explaining the rights of informal patients.

Requires Improvement

# Specialist eating disorder services

**Use of restrictive interventions**

**Levels of restrictive interventions were low. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe (for example to provide nasogastric feeding).**

Staff understood the Mental Capacity Act definition of restraint and worked within it. There had been no use of rapid tranquilisation within the last two years. There was no facility for seclusion on the ward.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. However, patients said that some staff did not always make them feel emotionally safe.**

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding adults and safeguarding children training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The hospital had a lead for adult and children's safeguarding. Staff said the lead was readily available for advice and support. At a weekend or during the night, staff could report a safeguarding alert directly online.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act such as providing care and treatment to transgender patients.

Managers took part in serious case reviews and made changes based on the outcomes.

**Staff access to essential information**

**Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.**

Although the service used a combination of electronic and paper records, staff made sure they were up-to-date and complete. Staff could easily access patient records.

All information needed to deliver patient care was available to relevant staff including agency staff when they needed it and was in an accessible form. This included when patients transferred to another ward.

Records were stored securely.

**Medicines management**

**The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.**

Requires Improvement

# Specialist eating disorder services

Staff followed systems and processes to prescribe and administer medicines safely. Staff followed good practice in medicines management in transport, storage, dispensing, administration, medicines reconciliation, recording, and disposal and did this in line with national guidance. Registered nurses administered medicines on the ward. There were no nurse prescribers on the ward, and staff did not give covert medicines.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Staff completed medicines records accurately and kept them up-to-date. The pharmacist completed medicines checks on the ward at least weekly and ensured medicines were stocked and in date. They also conducted monthly medicines audits for the hospital. Patients were able to meet with the pharmacist each week to discuss their medicines. Patients also had access to leaflets regarding their medicines.

Staff stored and managed all medicines and prescribing documents safely. Staff reviewed patients' medicines and discussed them with each patient in the ward round, including monitoring any impact on their physical health in line with national guidance for patients with an eating disorder. Nurses would also discuss medicines with patients during administration, and remind them why they were prescribed specific medicines, when needed.

Staff followed national good practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. They ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

**Track record on safety**

**The service had a good track record on safety.**

Over the last two years, the only serious incidents reported on the ward had been regarding minors admitted to this adult ward (aged over 17 years old). This was due to no other bed being available at other eating disorder services for young people. These incidents were notified to CQC as appropriate.

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with the provider's policy. Staff could give examples of incidents reported and learning from incidents. For example, staff told us about learning from an incident when a patient used an item to self-harm. Learning from the incident included restricting access to the item for this person and ensuring that there was a system to make sure the item was returned for safekeeping when the patient was not using it. This included a clear handover of information to night shift when a patient still needed to return this item after use.

Staff received monthly bulletins about lessons learned from incidents and complaints across the hospital. These included administering a controlled drug (prescribed medicines) at the wrong time of day, supporting a patient who had hypoglycaemia (low blood sugar), a wheelchair injury, and a fall.

Requires Improvement

# Specialist eating disorder services

Staff reported serious incidents clearly and in line with the provider's policy including admission of two patients under 18 years old within the last two years. The service had reported no 'never events'. Incidents were reported by nurses and doctors on a dedicated electronic form and sent to the compliance manager. These were also discussed in morning meetings with senior staff, and at daily ward handovers.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff had access to a duty of candour policy on the intranet, to ensure transparency about any errors in patients' treatment. Staff we spoke with were aware of their duties in this area. Staff confirmed that managers debriefed and supported them after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Staff received feedback from investigation of incidents, both internal and external to the service. The hospital compliance manager analysed the incidents and emailed these to the charge nurses on the ward. This would include learning from incidents including outcomes and areas for improvements. This report was discussed at the monthly quality performance management group.

Staff met to discuss the feedback and look at improvements to patient care. Recent incidents were routinely discussed at staff meetings.

## Are Specialist eating disorder services effective?

Requires Improvement

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

**Assessment of needs and planning of care**

**Staff assessed the physical and mental health of patients on admission to the ward. They developed individual care plans for inpatients, which were reviewed regularly through multidisciplinary discussion and updated as needed. However, they did not develop and review care plans for day patients on the ward, and there was limited patient input in discharge planning.**

For inpatients, we saw that staff completed a comprehensive mental health assessment on admission or soon after. Records showed staff developed a comprehensive care plan for each inpatient that met their identified needs. Staff regularly reviewed and updated inpatients' care plans when their needs changed.

For day patients, (who had previously been inpatients), staff did not update their care plans or information about their care since becoming a day patient. This was a recommendation at the previous inspection in January 2019. Not having an up-to-date plan for their care as a day patient meant their current needs had not been identified and there was no plan in place to support these.

Care plans were personalised. They included details of patients' views and wishes and how these were taken into account. Patients we spoke with confirmed that their care plans were individualised to their specific needs.

Requires Improvement

# Specialist eating disorder services

Patients told us that whilst most staff followed care plans well, there were times when this did not happen, and this had a negative impact on them. For example, patients not being certain if dietary requirements were being met, and patients being told their weight, despite a wish not to see their weight during weighing.

The care records we looked at did not include clear goals in working towards discharge. Patients said that there was a lack of consultation about their discharge plans, with them often just being asked to sign the plan, without contributing to the content. They did not feel that there was sufficient planning for the step down from inpatient to day patient.

Staff assessed and monitored physical health needs arising from patients' eating disorders, such as a fast heart rate, and urinary symptoms. They carried out blood tests and checked patients' vital signs on a regular basis. They also provided support with wider physical health needs such as diabetes.

Records showed that staff assessed patients for the risk of refeeding syndrome, which can include heart, lung and neurological symptoms. When required they carried out appropriate monitoring and treatment. For example, prescribing appropriate meal plans and thiamine, taking regular blood tests, and keeping the patient in a warm and restful environment.

The provider undertook regular audits of clinical notes, at least quarterly. We saw the results of care notes audits from November and December 2021 and February and May 2022. Areas for improvement included staff keeping care plans and therapy assessments up-to-date, and documenting whether or not a copy of their care plan was given to each patient.

Managers advised that they relayed any individual areas for improvement to the charge nurses, to ensure that they were addressed.

**Best practice in treatment and care**

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They participated in clinical audit.**

Staff provided a range of care and treatment suitable for the patients in the service in line with best practice and national guidance. They were aware of national guidance for the treatment of adults with an eating disorder. For example, the National Institute for Health and Care Excellence (NICE) recommended treatments, such as individual eating disorder focussed cognitive behavioural therapy and access to psychoeducation groups about a specific diagnosis. The service offered these, as well as a family forum, and a range of therapies including family therapy, art therapy, mentalisation, cognitive remediation therapy (becoming aware of how we think and changing this), and mindfulness.

Staff had access to NICE and other guidance such as the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) on the provider's intranet. The service was a member of the Royal College of Nursing specialist interest group in eating disorders and engaged in research with other services. The hospital had links with local universities and took nursing students for their placements. The lead consultant psychiatrist attended an annual conference on eating disorders.

Requires Improvement

# Specialist eating disorder services

Staff identified patients' physical health needs, recorded them in their care plans and made sure patients had access to physical health care, including specialists as required. For example, patients could be referred for an autism assessment or eye movement desensitisation reprogramming therapy for trauma.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service employed a clinical psychologist, occupational therapist and dietitian, and a range of psychotherapists, as part of the multidisciplinary team. Patients could access smoking cessation support if they wished.

The dietitian assessed patients' nutritional status, prescribed individualised eating plans, and supported behaviour changes around food. On admission, the dietitian met with the patient for an individual assessment which could include a family member if the patient wished. The service offered three stages of meal time support, which meant they could meet the needs of a range of patients. Intensive support involved one-to-one meal support in the ward dining room. The next stage was eating together in a small group in the ward dining room. The final stage was eating as a group in the main hospital restaurant. Patients eating in the restaurant would either have their meals portioned by staff, or could self-portion, depending on their care plan, which was reviewed in weekly ward rounds.

The occupational therapist offered group work and supported patients in eating out, creative groups and goal setting. There was a kitchen they could use with patients to support the preparation of meals, as part of treatment. Each patient was automatically referred to the occupational therapist during their admission. We attended an occupational therapy session in which the Kawa model was used (a model using the metaphor of a river with different contextual elements to represent human life).

Staff on the ward were having training in REDS (relative energy deficiency in sport) to support patients with physical exercise.

Nursing staff used documented guidelines written by the dietitian that outlined the exact portions of food to prepare at breakfast and snack times. This included details of how much food supplement should be provided if a patient was unable to finish elements of their meal.

There was a weekly timetable available to both day and inpatients which included individual and group therapy and psychoeducation groups. The therapy team met once a month to review the timetable and make any changes to meet the needs of the patient group at the time.

Oral refeeding was the preferred method on the ward. There was a policy in place for the use nasogastric feeding. At the time of the inspection one patient was being fed nasogastrically (by tube).

Records showed that staff completed outcome measures during patient admissions in order to capture data on severity of illness over time. Tools used included Beck's Depression Inventory, and the Eating Disorder Examination Questionnaire. Outcome measures for the ward did not include the outcome of patient evaluation (such an exit interview) or looking at progress after the admission (such as relapse rate). The consultant psychiatrist noted that they were looking at using an alternative outcome tool on the ward in future.

Staff took part in clinical audits, and managers used results from audits to make improvements. As recommended at the previous inspection, staff had access to the results of recent audits. These included monthly patient care audits,

including the patient treatment pathway, admission process, dignity and respect, collaborative care, and patient and family involvement. There was an annual audit plan for the hospital, including audits of emergency equipment, clinical rooms, medicines charts, infection control, care plans, discharge planning, patient consent, risk assessment, and observations.

**Skilled staff to deliver care**

**The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. Managers provided an induction programme for new staff. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. However, this did not include competency training in all relevant areas of care, or training in working with patients with autism.**

The service had access to a full range of specialists to meet the needs of the patients on the ward. This included nurses, doctors with specialist knowledge of eating disorders, a pharmacist, an occupational therapist, clinical psychologist and a dietitian.

At the previous inspection in January 2019 we found that there was no formal core competency framework in place to ensure that staff had the necessary knowledge and skills to work with clients with an eating disorder. During this inspection, we found this had improved, but there were still key tasks that staff did not receive training for. We saw that staff involved in nasogastric feeding had been through a specific competency framework. However, staff had not received training in weighing patients, carrying out meal supervision and post meal reflective sessions. These are important elements in the care of someone with an eating disorder and have an impact on patient care and experience. Patients told us that some staff did not consistently adhere to individual care plans when carrying out these tasks.

All new hospital staff received an induction to the hospital from the human resources department. This included hospital policies, procedures, information on staff specific roles and responsibilities. A local induction then took place on the ward. For bank and agency staff this was an abbreviated induction. Patients told us that temporary staff did not always follow the specific details of their support plans in providing them with support around mealtimes and weighing.

Managers supported staff through regular supervision sessions and constructive appraisals of their work. Nursing staff confirmed that they received clinical and management supervision monthly and felt supported. This was confirmed by records of supervision sessions over the last six months. Of the 12 core staff on the ward, 10 had received an appraisal in 2022, and the other two were scheduled to take place in the next two months. We looked at two records of supervision for the ward, which indicated that a wide range of topics were routinely discussed including lessons learned from recent incidents or complaints. Student nurses confirmed that they received regular supervision and support.

Therapy staff received regular supervision from senior staff of the same discipline, in line with professional requirements. Junior doctors received supervision from a hospital consultant and worked closely with the ward consultant psychiatrist to gain expertise in eating disorders.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Although staff were generally up-to-date with mandatory training, opportunities for further specialist training had been limited during the Covid-19 pandemic. There were plans for some staff to undertake training in motivational interviewing. Staff had not undertaken any training in working with patients with autism, although patients with autism have a higher propensity to develop eating disorders.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff could attend these meetings either in person or by video conference. The meetings dealt with a range of issues relevant to the ward. However, topics did not include feedback on any recent complaints or incidents within the hospital.

**Multi-disciplinary and interagency team work**

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the hospital and with relevant services outside the organisation.**

Staff held regular multidisciplinary meetings where they discussed each patient, their care needs and recovery. The psychiatrist, therapy staff and nurses attended. Patients of the lead consultant were invited to weekly ward round meetings with the multidisciplinary team and were involved in making decisions about their care. Patients under the care of the other ward consultant were seen individually by the consultant. Staff had a clear understanding of the importance of the contribution from each different discipline to patient care. For example, the pharmacist was involved in the support plan of a patient with diabetes. The team worked together to look at the timetable for patients on the ward. Since the previous inspection, they had introduced post meal reflections once weekly for patients to share emotions, and thoughts or urges.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. Handover meetings took place twice a day between nursing shifts. Staff kept up-to-date and detailed records of patient needs and could refer to these notes throughout their shift. A monthly reflective practice session was provided for all staff on the ward. The ward had also introduced a debrief session for staff after meal supervision.

The full multidisciplinary team was involved in providing training for staff covering refeeding syndrome, dangers of eating disorders, bloods and monitoring, portion sizes, and family dynamics. Recent sessions included trauma in eating disorders, body image and managing distorted perceptions, comorbidities, and training on the function of the gut.

Ward teams had effective working relationships with other teams within the hospital. Staff did not routinely work with external agencies when providing care to patients but took and made referrals from other services.

Staff described the multi-disciplinary team as very welcoming, communicating well, and carrying out lots of collaborative work. However, they noted that there had been challenges due to staffing vacancies and absence within the last year. They noted that there had been shortages in therapists available during December 2021, and that that the nursing team could be very stressed, particularly at weekends.

The lead therapist for the ward had left after eight years in December 2021 and staff noted that this had been unsettling for therapy staff. However, a new lead therapist had been recruited and was due to start shortly after the inspection.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.**

At the time of the inspection there were patients on the ward detained under the Mental Health Act. Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice.

Requires Improvement

# Specialist eating disorder services

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrator was (available at the main hospital site) and when to ask them for support.

The service had clear, up-to-date policies and procedures that reflected the relevant legislation and the Mental Health Act Code of Practice. Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

**Good practice in applying the Mental Capacity Act**

**Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. Staff received mandatory training in the Mental Capacity Act.

There were no deprivations of liberty safeguards applications made in the last 12 months. There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. On admission, staff assessed patients' capacity to consent to treatment, either for the general care provided or for specific interventions, such as nasogastric feeding. Staff re-assessed capacity for new decisions or if there was a change in the patient's situation.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff audited the mental capacity assessment records as part of the care records audits for the hospital.

## Are Specialist eating disorder services caring?

Requires Improvement

# Specialist eating disorder services

Requires Improvement

Our rating of caring went down. We rated it as requires improvement.

**Kindness, privacy, dignity, respect, compassion and support**

**Most permanent staff treated patients with compassion and kindness. However, patients said that some staff, particularly agency staff, did not understand the care and support that they needed. Patients described times when their privacy and dignity had not been respected.**

Whilst understanding the need for clear rules and boundaries on an eating disorder unit, patients felt that staff did not always get the balance right. Patients said that they received compassionate care from some staff, but there were other staff who did not listen or understand their condition, and this led to setbacks in their progress on the ward. For example, patients described staff being defensive when they did something wrong, such as locking a patient's shower during a time period when they were allowed access to it. They also described mealtimes as sometimes being stressful and chaotic, with not enough support and a lack of empathy from some staff.

Patients told us that some staff entered their bedrooms without knocking, and were not always discreet when supporting them in communal areas. Patients gave examples of times when staff had made them feel ashamed in front of other patients, made them feel like children, and when they had ignored patients who were upset and needed support. Patients said they were not always asked whether student nurses could observe their meetings/support which could lead to them feeling like an 'exhibit'.

Patients said that some of the core staff members on the ward were very responsive and provided them with emotional support and advice when they needed it. However, they noted that other staff tended to act in a more punitive way, so different staff would respond differently to the same questions from patients. They noted that some agency staff did not have enough understanding of eating disorders and made inappropriate (even if well meaning) comments to them. For example, saying you should eat to make your family happy. Managers acknowledged that some agency staff arrived for shifts on the ward, without any prior notice that they would be working on an eating disorders unit. The ward manager and other permanent staff provided them with an induction to working on the ward at the start of their shift.

During the inspection we observed staff supporting patients patiently and sensitively, and permanent staff were able to tell us about the individual needs of patients. We observed appropriate meal support and supervision, staff ate with patients but there were no motivators, such as the use of meaningful messages or objects to support patients.

Patients were very positive about their relationships with therapy staff, who provided group sessions, but said that they did not have time to meet with them individually as much as they would like. We observed one group therapy session, which was very proactive and positive in approach, building on patients' resilience and strengths to set goals, and involving all the patients who attended. Patients were positive about the programme of groups and therapies, but noted that it could be very quiet at weekends (which was difficult for patients who did not have visitors). Patients who had been on the ward for longer periods of time, said that the sessions could become a bit repetitive.

Staff supported patients to understand and manage their own care treatment or condition through one-to-one support and group therapies. They directed patients to other services and supported them to access those services if they needed help. Each patient had a care and treatment plan indicating their support needs. However, patients said that

staff often treated their condition without understanding their individual needs, and therefore care and treatment was not always person-centred. Most patients were not aware of who their key nurse was, and we did not find records of regular one-to-one sessions with key nurses in patients' records. Several patients said that they received more support from other patients, than they received from staff on the ward.

Staff followed the provider's policy to keep patient information confidential. There was no patient information on display in the nursing offices or elsewhere on the ward. Staff had private spaces where they could discuss patient care without being overheard.

The service did not effectively inform patients that there was CCTV (closed-circuit television recording) in use in communal areas on the ward. Most patients we spoke with were not aware that this was in place. There were no signs informing patients or visitors that CCTV was in operation. Following the inspection, the provider advised that they had taken action to ensure that there were posters in relevant ward areas indicating that CCTV was in operation.

At the last inspection in January 2019 patients expressed concerns about the route they had to take in order to have meals in the main hospital restaurant. Although this route still involved crossing a small road, and passing near a smoking area, patients did not express any concerns at the current inspection.

**Involvement in care**

**There was some variation in staff involvement of patients in care planning and risk assessment. Patients and carers expressed concerns about having to meet outside the unit on a public street, and not being told when this policy had changed. Staff sought patient feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

**Involvement of patients**

Staff introduced patients to the ward and the services as part of their admission. On arrival at the ward, staff gave patients an information pack including what they should expect, introduction to the team, a timetable of groups, and how to complain. However, staff and patients said that the current ward brochure needed to be updated and did not contain all current relevant information. A new brochure was being produced.

Staff made sure patients understood their care and treatment. Staff involved patients and gave them access to their care planning and risk assessments. Patients said that staff worked with them to develop care plans and risk management plans. However, patients noted that the two consultant psychiatrists on the ward had different practices in involving patients. They said that one consultant spent more time meeting with them, and discussing their treatment plan than the other, where meetings were more rushed. They were able to discuss their medicines with nurses, doctors and the pharmacist.

Staff told patients what level of observation they were under and discussed how it was carried out and the review process for it. The patients we spoke with were aware of the level of observation they were on.

Group therapies offered patients education and information on the nature, course and treatment of eating disorders. Staff and patients could discuss information, harm minimisation and short and long-term risks associated with an eating disorder.

Patients spoke positively about the support provided to them by the dietitian, and their involvement in meal planning. They were able to substitute a certain number of disliked foods each week.

Staff involved patients in decisions about the service, when appropriate. There were weekly community meetings held on the ward. These meetings were recorded, and minutes showed that staff acted on feedback. However, patients told us that they did not think the community meetings were effective in bringing about changes in staff culture, despite this being raised. In recent meetings issues raised included 'staff to be less stressed,' consistency in staffing (with patients provided with information about how the provider was addressing vacancies), and the provision of non-dairy milk and newspapers in the dining room at breakfast time, which was agreed. There was also a request for the art room to be left open on one evening (dependent on staffing), and massage therapy to restart (all of which were agreed).

Patients could give feedback on the service and their treatment and staff supported them to do this through community meetings, and surveys.

Staff made sure patients could access advocacy services, and the contact details were posted in the lounge area on the ward. Patients were aware of the advocate's role and knew how to access them. The ward manager advised that there were plans for previous patients to come back and share their experiences with patients on the ward.

At the time of the inspection, no patients from the ward were acting as a patient representative for the hospital's patient and management forum to bring about improvements in the hospital. However, at recent meetings patients had raised issues including access to shorter charging cables for their telephones, lists of prohibited items being made available prior to admission, nurses (usually agency) not always knocking before coming into patient bedrooms, continuity of staff, and access to massage therapy. A response to each item raised was provided after the meeting. No patients were involved in the recruitment of new staff to the ward.

The provider collected patient feedback surveys across the whole hospital using an external electronic system and made results available to staff on the intranet. The hospital-wide results for overall satisfaction score were 4.63 out of 5 (93%) based on 410 surveys since June 2019, with similar scores for friendliness and cleanliness. However, these were not broken down by service type.

**Involvement of families and carers**

**Staff informed and involved families and carers appropriately.**

Staff supported, informed and involved families or carers appropriately and in line with patients' wishes. Records identified patients' main family/carers and contact details were recorded with the consent of patients. Each patient had the opportunity to consent for family members/carers to be involved in their care and treatment planning. Family members we spoke with were involved in attending ward rounds on a regular basis.

Patients told us and records confirmed that staff supported patients to maintain relationships outside of the hospital. For example, with family members, friends and partners. Patients could have their mobile phones on them to use anytime, except during meal times when they needed to be put aside. If patients did not have mobile phones, they could use the office phones to call family/friends.

Requires Improvement

# Specialist eating disorder services

Staff provided families and carers with support when needed. The service ran a carers support group that all family and carers could attend. This ran over eight sessions, and offered education and information on the nature, course and treatment of eating disorders. The content included practical skills for managing distress, dealing with challenging behaviours, and moving towards recovery. The sessions were well attended.

Since the Covid-19 pandemic, patients had usually only been able to meet with family members outside the unit. Family members told us that this usually meant sitting on the street outside or going for a walk. Detained patients had to use section 17 leave in order to meet family members outside of the unit. Despite reductions in restrictions, and staff noting that patients could now book a meeting room to see family members, no patients or carers/relatives that we spoke with were aware of this change indicating this had not been well communicated. Family members also told us that they were concerned that if patients tested positive for Covid-19 they could not attend therapy sessions by zoom link which patients found very demotivating.

Patients suggested that communication with their family members could be improved including information about carer support group meetings. One patient told us that their relatives did not receive replies to the messages they sent to the ward.

Family members/carers could give feedback on the service, and were invited to ward rounds with the patients' consent. We spoke with three family members who provided mixed feedback about the service. Some described improvements since previous admissions, and some described less support from previous services. On the whole they described experienced and knowledgeable core staff on the ward who were usually helpful and proportionate. They spoke very positively of the support provided by the ward manager. Family therapy was appreciated, although some said that there had been long waits for this. Some examples were given of incidents when they felt staff had been overly punitive in approach, lacking patience and empathy. Some relatives felt that the lack of many activities at weekends, could be very difficult for patients who were struggling, and this might lead to setbacks or even incidents on the ward. They noted that family members had to provide a huge amount of support to patients.

## Are Specialist eating disorder services responsive?

Good

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

**Access and discharge**

**Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit. Patients did not have to stay in hospital when they were well enough to leave. However patients wanted more involvement in discharge planning.**

**Bed management**

Patients were referred to the ward by clinicians from external services, GPs, or through self-referral. Patients were offered the opportunity to visit the ward before admission. The admissions pathway document stated that an admission had to be agreed by both the admitting doctor and the patient for it to take place. At the start of an admission, staff and

patients discussed the length of stay and therapeutic package to be delivered. This was usually influenced by funding arrangements and patients were made aware of any limitations. Bed occupancy did not usually go above 85% although the ward manager noted that there was an increase in demand for this service since the Covid-19 pandemic. The ward had capacity for nine inpatients, and at the time of the inspection there were six inpatients on the ward.

Patients could be admitted as inpatients or day patients, depending on their level of need. Day patients attended the service between 8am and 7pm each day and took part in all meals, therapeutic groups and sessions.

There were no written exclusion criteria for the ward recorded in policies or documents, but the lead psychiatrist said that they would carefully consider whether it was appropriate to admit patients with a chronic physical illness or psychiatric risk. The final decision to admit was the responsibility of one of the three admitting psychiatrists. Staff considered the needs of the patient at each referral. If it was clear a patient required more intensive care or long-term care than the ward could provide, the reason for not accepting the referral was explained to the patient and/or the referrer. When it became clear a patient required more intensive care during their stay, staff liaised with external services to arrange a transfer.

From the start of treatment, staff said there was a clear discussion and agreement with patients about their goals for treatment, including, when appropriate, any weight restoration.

Managers and staff worked to make sure they did not discharge patients before they were ready. When patients went on leave there was always a bed available when they returned. Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. Staff did not move or discharge patients at night or very early in the morning.

**Discharge and transfers of care**

**Patients did not have to stay in hospital when they were well enough to leave. When appropriate, patients were offered the option of day care as a step down from inpatient care prior to discharge.**

Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer. Where patients needed longer term care in another facility, staff liaised with external organisations, including NHS hospitals, to transfer patients.

Staff told us that they planned for patients' discharge, supporting patients to gain independence before leaving completely. This included going out for meals and snacks, and discussing how this went, prior to discharge. However, patients said that they were not consulted enough, or always well-informed, about their discharge, but instead asked to sign a completed document. This was particularly the case for the transition from inpatient to day patient.

Patient notes included brief information about discharge plans, but these did not focus on each patient's strengths, and there was a lack of detail about longer term plans for care after discharge.

**Facilities that promote comfort, dignity and privacy**

**Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. However, patients complained about poor ventilation and temperature control in their bedrooms, and a lack of outside space available for the ward.**

Each patient had their own bedroom, which they could personalise and a secure place to store personal possessions. Patients could make phone calls in private. They kept their own mobile phones and could access wi-fi on the ward.

Staff used a full range of rooms and equipment to support treatment and care. Patients and staff could access a lounge, a quiet room, a kitchen and dining room and therapy rooms. Some of the furnishings were in need of replacement, but staff had ordered replacements, which were delayed due to shortages of materials impacting on the hospital's suppliers. In the last year the dining room table and chairs had been replaced. Redecoration of communal areas was planned for September 2022.

The service had quiet areas and staff had recently made a room available for patients to meet with visitors in private (following a relaxation in Covid-19 restrictions). However, this had not been communicated to current patients and relatives at the time of the inspection, and relatives were continuing to meet with patients on the pavement outside the ward.

The ward did not have an outside space that patients could access easily. Patients told us that they were able to go out either alone, or with a staff escort, when they wanted to, but during the Covid-19 pandemic the lack of an outdoor area was particularly difficult.

Patients told us that there was poor ventilation on the ward, with windows opening very little and no air conditioning. They were unable to control the temperature of the radiators on the ward other than by opening their windows and this meant it was often too hot.

Food and drink provided on the ward was carefully monitored in line with patients' care plans as part of their treatment. Food was prepared freshly on site at the main hospital restaurant and set meal plans ensured patients' personal nutritional and fluid intake needs were met, with vitamin supplements where necessary. Meals were varied and reflected individual cultural and religious needs.

The ward's weekly timetable was available for patients to see on the ward. This included daily mealtimes and a range of group therapies and educational sessions from Monday to Friday, and some weekend sessions. Groups included goal setting, social eating, decision making, dealing with uncertainty, distress tolerance, body image, creative writing, arts and crafts, and meal planning. Patients also had sessions in compassion-focussed therapy, dance and movement therapy, cognitive behavioural therapy, meditation, yoga, Tai Chi and gentle stretching. In addition, patients could use the art room, and access the hospital gym.

Staff told us that the size of the facilities on the ward limited the groups they could do. For example, the kitchen was too small to do a cooking group with all the patients.

**Patients' engagement with the wider community**

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

Staff made sure patients had access to opportunities for education and work, and supported patients. Day patients told us that they were able to continue with their university courses, and employment, with the support of the service.

Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the service and the wider community. Staff supported patients to maintain contact with their partners, families and carers.

The occupational therapist ran a social program for eligible patients using a graded approach. This started in the ward dining room, then moved to the main part of the hospital, and then to going out into the local community.

Once a week there was a shop and cook session, broken down into tasks from writing a shopping list, to cooking, portion control, followed by a reflective session.

**Meeting the needs of all people who use the service**

**The service met the needs of all patients, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The service was accessible for patients with mobility needs or those with very low weight who used a wheelchair. There was an assisted toilet next to the nursing office and a lift that staff and patients could use to reach all floors of the ward. If the service could not support a patient with a particular disability, they would explain to the referrer why this was the case. Air pump mattresses were available for patients at risk of pressure ulcers. Staff could access interpreters where necessary.

Staff members recorded and addressed patients using the name and title they preferred. Staff said they offered patients a staff member of the same gender or chaperone for physical examinations. Staff gave examples of supporting patients who were LGBT+ including patients who identified as transgender, in line with their identified gender.

Staff made sure patients could access information on treatment, local services, their rights and how to complain.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. The ward ran a weekly group for patients to confirm and clarify any questions about the following week's meal plans.

Patients had access to spiritual, religious and cultural support. Staff could support patients with religious needs, by facilitating access to places of worship and religious officials.

**Listening to and learning from concerns and complaints**

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them. Staff addressed and recorded verbal complaints raised by patients. If patients were unhappy with the response, staff encouraged them to make a formal complaint. The hospital aimed to acknowledge complaints within 48 hours and respond within 20 days.

Managers investigated complaints and identified themes. However, there had been no formal complaints about the ward within the last two years.

Staff said that they would protect patients who raised concerns or complaints from discrimination and harassment. They said that feedback from complaints across the hospital was shared with staff in lessons learned bulletins and at staff meetings. The service also used compliments to learn, celebrate success and improve the quality of care.

Requires Improvement

# Specialist eating disorder services

## Are Specialist eating disorder services well-led?

Requires Improvement

### Leadership

**The ward managers had the skills, knowledge and experience to perform their roles. The ward managers had a good understanding of the services they managed**.

Ward managers could explain clearly how the team was working to provide care. The ward managers were able to give a review of the wards' strengths and examples of improvements.

The ward managers discussed development opportunities that were available for staff in supervision. Staff were able to attend external training that they had requested. However, some staff felt that there were few development opportunities available for health care assistants.

Members of nursing staff, including the ward manager, were visible in the service and accessible to other staff and patients.

Sickness and absence rates were monitored, and managers offered support to staff who returned to work after a period of absence.

Staff spoke positively about the leadership provided by the hospital director, describing them as accessible and responsive. Although the hospital director had introduced the roles of staff and patient representatives for each ward, there was no allocated ward staff or patient representative at the time of the inspection.

The management team had forged good links with local universities, enabling links with research, and nursing students to have placements on the ward.

### Vision and strategy

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

The vision and strategy were focused on providing high quality care to all patients in a safe and nurturing environment, with a choice of appropriate experts to provide a range of care. The service had recently opened an OCD ward. The vision of the ward was to establish it as a centre for providing expert OCD care for patients for the United Kingdom.

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The provider displayed their values for staff and patients to see. These were compassion, respect, commitment, recognition, and one team. We saw evidence of the values being applied, for example, staff treating people with dignity and respect and compassion, and working together as a team.

Staff and patients had access to the minutes of staff and patient representatives' meetings, about the running of the hospital.

Requires Improvement

# Specialist eating disorder services

## Culture

**Staff felt respected, supported and valued and they could raise any concerns without fear. The ward staff reported a positive culture and valued the diversity of the senior leadership team.**

Staff told us they felt valued by the ward managers. When concerns were raised, they were taken seriously and where possible addressed.

Staff appraisals included conversations about career development and how it could be supported. However, health care assistants felt there were limited opportunities for career development.

Some staff expressed that would like to be involved in more projects to improve the quality of care in hospital and monitor more outcomes to promote improving services. However, they felt covering staff shortage was seen as more of a priority.

Some staff said that they did not always feel that their work was recognised by the hospital, for example by introducing a regular staff award for exceptional practice.

Senior leadership had introduced a perks box for staff, including a hamper delivered to them on their birthday. They had also provided long service awards for staff.

There were lots of opportunities for overtime at the time of the inspection, but management ensured that staff had sufficient days off. Senior staff dealt with poor staff performance when needed.

## Governance

**The service had systems and processes in place to provide assurance and deliver the organisation's services safely, but these were not always effective. We found areas of improvement in the governance processes were needed. Although performance data was collected, there where was little evidence of improvement, for example in the quality of records kept by staff.**

The service did not keep robust oversight over the quality and safety of care. For example, patient care plans and risk assessments were not reviewed when they became day patients, to reflect their different needs and risks. Staff we spoke with gave varying responses on who was responsible for the oversight of quality and action plans. Most staff thought that it was the responsibility of the compliance manager to have oversight of quality. The compliance manager considered they did not have sole oversight but felt this was an area that needed more clarity for staff to know who to contact if they had queries about quality.

The service had an audit planner for the year. It showed audits scheduled for different departments such as wards, therapy teams, mental health act and health and safety. Audits where completed in a timely manner by a charge nurse and the frequency of audits also discussed in team meetings. However, audits did not lead to an improvement in the quality of care records produced. For example, the risk assessment audit did not highlight that a daily risk assessment did not always inform risk management plans on most wards. We discussed this with the medical director, director of nursing and the managing director who agreed this was an area for improvement. They felt the service needed to clearly identify who was responsible for action plans from audits to ensure that action plans were implemented and followed up.

Staff had an annual planner and staff told us that learning from audits was shared in team meetings. We reviewed the ward team meeting minutes and ward manager team meeting minutes for the last three months and there was no recorded learning from audits. Ward team meetings discussed audit tools and audit plans but not audit outcomes or learning. Audit feedback was discussed in the care quality and performance management group with senior leadership only.

The service had a practising privileges policy. The medical director completed audits of practising privileges and consultant performance and these were shared in the steering groups with senior staff. The last audit was completed in April 2022 found that out 13 of 14 patients had been seen three times or more per week and one patient had been seen twice a week. We checked the information held by the hospital in relation to the practising privileges granted to four consultant psychiatrists. The information held on record was in line with the provider's current practising privileges policy and included documentary evidence of medical indemnity insurance, approval under Section 12 of the mental health act, a disclosure baring service check, an annual appraisal, a 5-yearly revalidation and hepatitis B vaccination or immunity. Practising privileges were reviewed every two years. The hospital director took the decision whether or not to grant practising privileges, in consultation with the medical director and medical advisory committee.

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Ward managers and the head of therapies met with the director of nursing on a monthly basis to discuss performance as well as incidents, complaints and audits. Information relating to quality and performance was reported up to the executive team in the care quality and performance management group which then reported to the provider's board. We reviewed a sample of local team meeting minutes from January 2021 to July 2021 and found that teams regularly discussed performance, incidents, audits, clinical outcomes, patient engagement, medicines management and complaints.

The hospital had a structure of committees to oversee the quality of care delivered. The quality performance management group was attended by the senior leadership team, lead consultants and sometimes by representatives from the French provider organisation. This provided an opportunity to discuss a range of relevant topics. Each month the senior clinical staff from the ward and senior hospital managers met at a steering group. This meeting was to discuss emerging trends on the ward, staff training requirements and feedback from carers and patients. Senior and operational managers met weekly. However, these structures were not sufficiently robust to identify gaps in risk management on the wards.

The hospital director had a structured estates plan for the hospital, providing clarity over funds available, so that the management team could make proactive plans for future improvements. Over the last year the dining room furniture in the eating disorder ward had been replaced, and redecoration of communal areas on the ward was planned in September 2022. There was also a quality improvement plan for the hospital, with current priorities including recruitment, extending CCTV in communal areas, moving to a paperless records system, and an alternative pharmacy system.

### Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care. However, ligature risk audit was of poor quality and not fit for purpose.**

Staff maintained and had access to the risk register. The risk register included subjects such as an awareness of ligatures, staffing, effects of COVID-19 and environmental risks. Risks were identified, and a plan made for each risk on the register. For example, for ligature risks it was identified that staff have ligature audit training.

Requires Improvement

# Specialist eating disorder services

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Ward managers, head of therapies, met with the director of nursing, on a monthly basis to discuss performance as well as incidents, complaints, risk register and audits. Information relating to quality and performance was reported up to the executive team in the Care Quality and Performance Management Group.

The provider had a system for monitoring consultant psychiatrists' practising privileges at the service. The system included detailed information of all required checks undertaken, and when they were due to be renewed.

Staff in the admissions office department produced a data sheet with trends to ensure that the service could meet demands and understand the market. For example, they noticed a peak in referrals for children and adolescents due to increased anxiety during the pandemic. Data also helped the service signpost referrals to other more suitable services.

There was a daily 'flash meeting' held at the hospital during which each ward lead met to check occupancy, staffing numbers, including additional staff available to assist across the hospital, and safety roles.

## Information management

**Teams had access to information related the provision of safe and effective care and were able to use the information to make some improvements, although there were gaps.**

The service collected reliable data and staff could find the data they needed, although some data collected did not seem to lead to improvements such as patient records. The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, some staff told us that it would be helpful to have more staff computers to use on the ward.

The team managers had access to information to support them with their management role. For example, supervision records, training data, admission and discharge information, staffing, complaints, incidents and accidents.

Information governance systems included protecting the confidentiality of patient records. However, the use of both paper and electronic patient records resulted in some unnecessary duplication, which impacted on the time staff had to spend with patients.

The provider recognised when incidents needed to be reported to external bodies, including the CQC.

## Engagement

**Managers engaged actively other local health and social care providers to ensure that an integrated health provided to meet the needs of the those that used the service.**

Patients and carers had opportunities to give feedback on the service they received. Carers were able to feedback directly to ward managers. The patient satisfaction survey for the past twelve months was overwhelmingly positive for all services. Out of 410 surveys, people's average score was four out of five, five being good. The hospital used a verified online satisfaction survey and the results were displayed on the hospital website. However, these were not broken down by service type. There was a comment box on the ward, although this was rarely used.

Requires Improvement

# Specialist eating disorder services

Patient management forum meetings were held in October and December 2021 and February and April 2022. Meetings were attended by the hospital's management team and a patient representative from different wards. Not all of these meetings included a representative from the eating disorder unit. Issues raised included radiator controls, continuity of staff, newspapers requested in the dining area, and access to massage therapy. There was an action plan to address each issue raised. Feedback in February 2022 forum showed that massage therapy would be re-introduced, newspapers were now provided in the dining room, radiators were in a future refurbishment plan and an update staff recruitment was given.

Managers engaged actively other local health and social care providers. For example, the compliance manager liaised with social care departments in different boroughs around the country to ensure social circumstances reports are completed in a timely manner.

The provider last carried out an employee opinion survey between 18 January 2020 and 3 February 2021. The survey had 61 responses consisting of 11 hospital administration staff, 30 nursing staff, 11 therapy staff, nine services staff and two from an unknown department. Respondents positive responses included feeling they could recommend a friend to work for the hospital, staff felt able to voice their opinions and felt listened to. Respondents were less positive in terms of the hospitals pay and benefits, felt there was poor internal communication and inflexible rules for therapy staff to access clinical supervision.

### Learning, continuous improvement and innovation

**Staff did not use quality improvement methods, there were no quality improvement projects taking place in the hospital.**

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

Requires Improvement

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

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

Requires Improvement

Our rating of safe stayed the same. We rated it as requires improvement.

### Safe and clean care environments

**Wards were clean, well-furnished and well maintained. However, clinic rooms were not always fully equipped, with in date, accessible resuscitation equipment. Ward ligature risk assessments did not always clearly identify risks and the mitigations in place to address them. The service did not have signs displaying information to make people aware of the use of CCTV in communal areas.**

#### Safety of the ward layout

The service provided three acute wards for adults of working age and one obsessive compulsive disorder (OCD) ward, four wards in total. The ground floor acute ward was a mixed sex 11 bed acute ward for adults of working age. The first floor had one 14 bed male acute ward and one six bed OCD ward for adults of working age. The second floor was a 17 bed female only acute ward for adults of working age.

Staff carried out regular environmental risk assessments on all wards and recorded these.

There were blinds spots on the wards, which were mitigated by concave mirrors and staff allocated at each shift specifically for the safety of the ward.

Staff completed ligature risk assessments for each ward. During the inspection we reviewed two of four ward risk assessments, for the ground floor and second floor. We found the ligature risk assessments, associated photographs and a ligature risk management document together, were inconsistent in the identification of patient bedrooms and ligature risks and were confusing. The photographs did not match the wards areas outlined in the ligature audit. The mitigation of risks lacked clarity. There was a risk that staff would not identify the actual risks in each area or room and would not implement appropriate mitigation to protect patients from preventable harm.

Staff had access to ligature heat maps that included the location of emergency equipment in folders on the ward and identified ‘high, medium and managed risk’ areas only but did not include details of how risks are to be managed. Some staff we spoke with did not know how to access the ligature audit or where to find it.

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

Requires Improvement

We shared our concerns about the poor quality of the ward ligature risk assessments with the leadership team who reviewed them during the inspection, carried out new assessments and updated staff on the new document for the second floor. This document was an improvement although some risk reduction actions raised with maintenance had not yet been completed.

Two wards had mixed sex accommodation. Each bedroom in the mixed sex wards had ensuite bathrooms. There was no separate female lounge on the mixed sex wards. Patients could access single sex lounges on other acute wards on other floors when needed. Over the 12-month period from 1 June 2021 and 1 June 2022, there were no mixed sex accommodation breaches within this service.

Staff had easy access to personal alarms and patients had easy access to nurse call systems in every room.

The service used closed circuit television (CCTV) in all communal areas. There were television screen monitors in the office that staff could view covering some communal areas. The manager used CCTV for reviewing incidents that occurred as part of their investigations. At time of the inspection there were no CCTV signs to make people aware of the use of CCTV. We raised this with the staff who promptly added the signs.

### Maintenance, cleanliness and infection control

**All wards were visibly clean and tidy. The furnishings were in good condition and appeared well maintained and fit for purpose.**

All wards kept up-to-date cleaning records that showed the ward areas were cleaned regularly.

Staff followed infection control guidelines, including handwashing guidance and wore appropriate personal protective equipment. Staff we spoke with knew the COVID-19 procedures for the service. There were arrangements in place for staff to undertake COVID-19 tests when required. Staff completed infection control audits. The last audit was completed in May 2022 with clear findings. For example, some staff were unable to answer correctly the five times handwashing should occur. The service planned a handwashing audit to be completed in August 2022.

### Clinic room and equipment

**Clinic rooms were not always fully equipped, with in date, accessible resuscitation equipment. Staff did not always carry out regular checks on equipment to ensure it was fit for purpose and record this.**

The wards had clean clinic rooms. Staff kept cleaning records for all clinic rooms and equipment. All wards had an electronic blood glucose monitor, pulse oximeter and defibrillator machine present in the clinic room.

However, staff did not always complete consistent, regular checks on equipment on all wards. One of three acute wards kept calibration records for blood glucose machines, but three wards did not. Staff we spoke to stated that some records had not been kept as they are awaiting booklets to record calibration readings. Staff did not have records of weighing scales being calibrated. We raised this with the provider during the inspection who made arrangements for weighing scales to be checked and calibrated in June 2022.

Clinic rooms were not always fully equipped, with accessible resuscitation equipment. We reviewed emergency kits on the four wards. Although records showed that staff checked and recorded contents of resuscitation equipment on a weekly basis, we found on the OCD ward that an oxygen reservoir and tubing for adults was missing from the emergency

kit. Staff told us that it had been removed as it had expired. This meant that staff did not have immediate access to oxygen reservoir and tubing for adults in the event of an emergency. Checks had identified that the oxygen reservoir and tubing (adults) had expired at the end of April 2022, two months before the inspection. This item had been removed from the bag, but it had not been replaced.

## Safe staffing

**The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm. However, there were a high number of nursing vacancies on the ward that were covered by locum staff.**

### Nursing staff

The overall vacancy rate at the hospital for registered nurses was 29%. There were 12 nursing vacancies in the acute wards. The ward managers told us that these vacancies were filled with bank and agency staff on long term contracts. The ward used regular bank staff who were familiar with the hospital and patients.

Managers had calculated the number and grade of registered and non-registered nurses required to keep patients safe. The managers ensured that there was a minimum of two registered nurses on each shift and two non-registered nurses for a minimum number of admissions. Staff had access to a staffing matrix that showed the number of staff needed for the number of patients admitted. The ward managers prioritised the safety of the patients and staff and booked additional staff as needed. Managers reviewed staffing every morning and when necessary. Managers deployed bank and agency nursing staff to maintain safe staffing levels. The ward used regular bank staff who were familiar with the patients. Staff produced a daily nursing 'flash' report at 10.00 am and 4.00 pm each day to enable managers to assist or support any staffing needs arising.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Induction for agency and new staff included topics such as care planning, the personal alarm system and how to report incidents.

Patients had regular one to one sessions with their named nurse.

Staff shared key information to keep patients safe when handing over their care to others. Handover discussions were documented in standardised handover sheets that included information such as factors leading to admission, level of observation, risk and physical health.

We reviewed the employment records of four staff. These showed that the provider had undertaken appropriate checks on staff before they started their employment. This included checks with the disclosure and barring service (DBS), qualifications, previous employment references, reasons for any gaps in employment and professional registration, where relevant.

The hospital carried out checks with the DBS every three years for each individual employee. The hospital monitored professional registration and revalidation for clinical staff.

### Medical staff

Wards had daily medical cover. A doctor was available to go to the wards quickly in an emergency. Staff could contact consultant psychiatrists who had practising privileges and were not based at the hospital, to update them about concerns. A duty doctor was on call at the hospital day and night, every day of the year. Staff knew how they could contact a doctor in the event of an emergency.

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

Requires Improvement

Admitting consultant psychiatrists saw their patients on the acute and OCD wards at least three times a week, one meeting of which could be remote. This included the option to have evening and weekend visits. To ensure that this was maintained the medical director conducted an audit of the number of times consultant psychiatrist saw their patients to ensure patients received standard reviews as per hospital practising privileges standards.

### Mandatory training

**Staff had completed and kept up-to-date with their mandatory training. Staff on the specialist OCD ward had received little specific training in the specialty.**

Staff compliance with mandatory and statutory training courses at June 2022 was 95%. The mandatory training programme was comprehensive and met the needs of patients and staff. It included subjects such as basic life support, information governance and infection control. The quality lead and managers monitored mandatory training and alerted staff when they needed to update their training as needed.

**Assessing and managing risk to patients and staff**

**Staff did not always assess and manage risks to patients well. Staff did not always document or update risk assessment and management plans in patient records. Patients' physical health risks were not always assessed and clearly recorded. There was a risk that a deteriorating patient would not be identified, and concerns escalated and acted upon promptly. However, staff followed safe policies and procedures for observing patients. Staff observed patients at unpredictable times.**

We reviewed the care records of 10 patients from across the four wards. Staff had completed daily risk assessments for patients in all 10 records we reviewed. However, risks identified in daily risk assessments did not always lead to documented follow up or a care plan to address the needs or risks identified. For example, a patient who had been identified as having an eating disorder regularly expressed, they were struggling with food in daily risk assessments. However, staff had not devised a care or risk management plan to address this. We shared this concern with the ward manager who responded promptly by devising a care plan with the patient during the inspection to address concerns identified.

In another example we found that staff had not updated patient risk assessments with risks identified in the daily risk assessment and in the handover records. For example, handover notes on one of the wards stated that staff should not give a patient paper with staples for safety reasons. However, this was not highlighted in the patient's risk assessment or care plan. We shared this concern with the ward manager at the time of the inspection.

Patients' physical as well as mental health risks were not always documented. This posed a risk that staff would not respond to any changes in risks to patients.

Staff did not always record vital signs on the National Early Warning Scores (NEWS) charts. Staff told us that they checked patients' vital signs every day, but this was not always recorded. Staff on all wards did not always total the NEWS scores to determine whether further action was needed and did not always take action in response to elevated NEWS scores in line with the escalation protocol. This meant that staff might not identify a deteriorating patient and take prompt action to address their needs.

Patient risk assessments on the three of the four wards were not always updated. For example, we saw patient notes that mentioned increased risk of harm to self for a patient but their risk assessments, that had been recently reviewed and updated did not identify any risks to self.

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

Requires Improvement

Staff followed good policies and procedures for observing patients. We reviewed records of observation during the inspection and staff had completed records of observations for all patients. Staff increased patients' levels of observation in response to risks and checks were carried out at random and unpredictable times in line with their care plan and good practice.

Informal patients could leave at will and knew that. There was information readily on the ward about leaving the ward as an informal patient if they were informal. Staff provided patients who were detained information on their rights under the Mental Health Act.

### Use of restrictive interventions

**Levels of restrictive interventions were minimal. Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.**

The service did not have a seclusion room. There had been no incidents of restraint in the past 12 months.

Staff made every attempt to avoid using restraint by using de-escalation techniques. We observed staff effectively intervening and de-escalating situations when patients started to become distressed or agitated on one ward.

## Safeguarding

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

There were comprehensive systems to keep people safe, which took account of current best practice. Patients were at the centre of safeguarding and protection from discrimination. Staff were trained in safeguarding, knew how to make a safeguarding alert, and did so when appropriate.

Staff followed safe procedures for children visiting the wards. All wards had access to visiting room for visitors with children available off the ward on the ground floor. Staff were available to facilitate any visits if needed.

Staff we spoke to were aware of how to identify adults and children at risk of suffering harm and knew how to refer on as necessary to the local authority safeguarding team. The hospital safeguarding lead was the registered manager who had level three safeguarding training. The safeguarding lead also shared concerns at regular local authority meetings.

## Staff access to essential information

**Some staff had easy access to clinical information, and it was easy for them to access clinical records. The service used paper-based and electronic records system. However, some staff reported delays in accessing electronic records.**

All information needed to deliver patient care was available to all relevant staff (including bank and agency staff) when they needed it and was in an accessible form. The managers made log in requests for electronic records for long term bank or agency staff so they could have access. However, some locum staff we spoke with reported that they had delays in accessing patient electronic record systems for up to four months, at times having to rely on other staff to access records.

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

Requires Improvement

## Medicines management

**Staff stored medicines safely, recorded patient allergies and administered medicines safely. However, the service did not always maintain accurate and fully completed medicine administration records.**

We reviewed eight medicine administration records for completeness, legibility and inclusion of relevant client details, including allergies**.** We found that staff did not always record patient names on medicine administration records. One medicine administration record did not have signature of the prescriber for the medicine that had been administered by staff. Staff could not identify who to contact about the prescription if necessary. We raised this issue with staff during the inspection who raised an incident report.

Medicines requiring refrigeration were monitored and temperatures recorded were within range.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines.

Staff were provided with additional training. For example, staff had additional training on medicine management when using medicines to deal with acute disturbance, the side effects of medications and clozapine.

## Track record on safety

The service had a good track record on safety. There had been two serious incidents in the past 12 months, between 1 June 2021 and 31 May 2022. These were in relation to medicine error and a death of a detained patient in general hospital.

## Reporting incidents and learning from when things go wrong

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately on most occasions. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff mostly recognised incidents and reported them appropriately, although we identified concerns with prescription records that had not been reported as incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service through meetings and supervision.

All staff we spoke with were aware of recent incidents and reported that lessons learned were shared in team meetings. For example, staff had learnt about ensuring there should enough staff to support any responses to self-harm incidents on each shift.

Staff understood the duty of candour. If or when things went wrong, staff apologised and gave patients honest information about what had happened and suitable support.

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

Requires Improvement

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

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

Requires Improvement

## Assessment of needs and planning of care

**Staff assessed the full range of clients' needs well. However, staff did not always document comprehensive care plans for each patient that reflected risks, needs and goals. Staff did not always update patients' care plans when their needs or care changed.**

We reviewed 10 care and treatment records, across the wards, during our inspection. Staff completed a comprehensive mental health assessment of each patient either on admission or soon after in all 10 records.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the wards. However, we found some handwritten medical notes made by senior medical staff on the OCD ward were illegible, which risked staff missing important information about patient care and treatment.

Staff developed care plans that did not always reflect patient risks, needs and goals on the acute wards. We found that staff reviewed care plans on a regular basis but there was no evidence of meaningful reviews that showed that changes in presentation of the patient had been taken into consideration. For example, we saw records identified that a patient was autistic but there had been no care plan to address the particular needs they had arising from this diagnosis. Staff completed regular care plan audits, but these did not identify the poor quality of the care plan reviews being undertaken nor did they lead to meaningful change.

Staff did not always update care plans when patients' needs changed. For example, when patient observation levels had changed or when new plans had been made in the multidisciplinary meetings.

## Best practice in treatment and care

**Staff provided a range of treatments and care for patients based on national guidance and best practice. They ensured that patients had access to physical healthcare. Staff participated in clinical audits such a care planning, risk assessments, emergency equipment and medication charts, but these did not always lead to improvements in quality. Staff did not always document referrals to other services.**

The ward used a range of outcome measures to monitor the performance of the service. Staff also completed Health of the Nation Outcome Scales (HoNoS) to measure the health and social functioning of patients on the wards. The hospital used a dashboard to display performance in areas such as recording of incidents. Staff also monitored the duration of admissions to the ward.

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). Staff were familiar with guidance issued by NICE. For example, psychological interventions recommended in psychosis and schizophrenia in adults.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration.

Staff facilitated groups and activities every day such as yoga, meditation, group therapy and drama therapy. The hospital website listed the variety of groups available for patients to access.

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

Requires Improvement

Staff participated in clinical audits such a care planning, risk assessments, emergency equipment and medication charts, but these did not always lead to improvements in quality. For example, the risk management plans audit for ward 1b in May 2022 identified that staff had not updated risk management plans to reflect their current risk status, risks were not reflected in care plans and no explanations were given when risks were medium or high risk, necessitating a management plan. We found that patient records had not improved since this audit had been completed.

Staff made sure patients had access to physical health care. However, we did not always find records of some recommendations for specialists' input. For example, a consultant psychiatrist had recommended dietitian input as part of the admission assessment plan. Staff we spoke to were unsure if the patient had been referred or seen by a dietitian and we could not find any record of this in the patient records. We raised this with the ward manager during inspection to follow up the recommendations.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, staff discussed reducing smoking in groups with patients. However, the hospital site was not smoke-free, which was not in line with best practice guidance.

### Skilled staff to deliver care

**The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided induction for new staff.**

The service had access to a full range of specialists to meet the needs of the patients on the ward. All wards were staffed with staff nurses, psychiatrists, therapists, occupational therapist, clinical psychologist, assistant psychologist and had input from a pharmacist.

Managers provided all staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. We reviewed supervision records and found that all staff had received monthly supervision. All staff had received an appraisal within the last year.

Ward managers reviewed any identified poor performance through supervision. Managers made plans with staff to improve performance. For example, staff had additional medicine management training as an identified need when poor practice in medicine management was identified.

Managers ensured that staff on OCD ward had received the necessary specialist training for their roles in addition to mandatory training.

### Multi-disciplinary and interagency team work

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The wards had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held multidisciplinary team meetings called ward rounds to ensure pertinent information was shared with the team. The meetings were attended by a ward manager, psychologist, ward nurse, student nurse, assistant therapist but no psychiatrists. Ward rounds had been recently introduced and had been in pilot for four weeks. During the inspection

we attended the ward round and observed discussions of four patients on the day of our visit. Although the ward rounds were helpful, they needed further development. For example, some staff felt that some consultant psychiatrists did not always respond to suggestions made about changes to patients' care in ward round meetings. Staff had plans to review this concern with senior leadership team and the medical director.

Staff shared information about patients at handover meetings within the teams, for example, from shift to shift. The ward handover happened for every shift and it included comprehensive handover notes that included risk history, physical health and updates from consultant psychiatrist weekly reviews.

The ward teams had effective working relationships with teams outside the organisation such as the local authority.

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

**Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.**

As of June 2022, 100% of the workforce in all the wards had received training in the Mental Health Act (MHA).

Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Consent to treatment and capacity requirements were adhered to. The initial assessment on the wards included consent to treatment. Patients were supported to make their own decisions wherever possible.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed. Paperwork relating to the detention of patients under the MHA was filled in correctly and was up to date. Original paper copies of MHA forms were held centrally by the MHA administrative team.

Patients had easy access to information about independent mental health advocacy. The ward offered information on local advocacy services and staff supported patients to contact advocacy services.

Informal patients were aware of their right to come and go from the wards as they wished. Staff displayed information on the rights of informal patients on the ward.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Information on section 17 leave easy read leaflets were displayed on the ward notice boards and were available for patients.

### Good practice in applying the Mental Capacity Act

**Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of the five principles. Staff training completion rate was 100 %.

There was a clear policy on Mental Capacity Act, which staff could describe and knew how to access.

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

Requires Improvement

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

Good

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

### Kindness, privacy, dignity, respect, compassion and support

**Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

There was a person-centred culture. Patient feedback about their care, treatment and support from staff was positive. Patients told us that staff were caring, respectful and supportive. Staff talked about valuing people, respecting their right to make decisions and being inclusive in their care.

Patients we spoke to felt that nurses were responsive, any issues raised were promptly addressed.

Patients said that therapists explained every step of therapy provided, which eased their anxiety. Patients said staff behaved kindly towards them and we observed caring interactions. Patients said they could contact a consultant psychiatrist when needed. Patients enjoyed the variety of groups offered.

The service displayed information for patients to refer to on all wards. This included information on how to ask the pharmacist about their treatment and leaflets on various mental health issues. Wards also displayed an up-to-date weekly therapy programme.

Staff provided patients with a comprehensive guide to admission so that they knew what to expect during their stay. This included COVID 19 safety precautions and a prohibited items and contraband list to refer to.

Staff ensured that patient voices had been recorded in care plans and in daily risk assessments on all wards.

### Involvement in care

**Staff involved patients in care planning and risk assessments and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.**

### Involvement of patients

Staff involved patients in care planning and risk assessment and patients said that staff sought their feedback on the quality of care provided.

Staff ensured that patients had easy access to independent advocates on a weekly basis or when needed. During the inspection we observed staff informing patients that the advocate was available to speak to.

Staff provided information about the ward to carers and patients on arrival. The ward issued a welcome pack to all patients and carers at the time of admission so that they knew what to expect from their time of the ward and what to expect from staff.

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

Requires Improvement

A patient forum was held two monthly to feedback on topics like hospital environment, staffing, meals and any other issues that patients wanted to raise. We saw displayed service feedback for patients in relation to a concern raised in a patient forum in February 2022. Patients felt that there should be more consistency from staff in removing restricted items across services. In response the director of nursing updated guidance on restricted items and shared the updates with staff to ensure consistency. Staff displayed feedback on patient forums on 'you said' and 'we did' posters on the wards.

Patients were able to give feedback through a quick response code anonymously. Feedback was displayed on the ward and on the service website. Feedback we reviewed included patients feeling their stay was transformative, with friendly staff.

Patients told us they were fully involved in the process of planning their treatment and recovery.

Staff followed policy to keep patient information confidential. The service had clear confidentiality policies in place that were understood and adhered to by staff.

### Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff held meetings for carers and families to attend. Carers and families participated in setting an agenda for the meetings. However, these had been suspended during the pandemic and not yet restarted.

Ward managers facilitated communication with carers and families through emails, telephone calls.

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

Requires Improvement

Our rating of responsive went down. We rated it as requires improvement.

### Access and discharge

**Staff managed beds well. A bed was available when a patient needed one. Patients were not moved between wards except for their benefit.**

### Bed management

The service's admissions office managed referrals to the hospital. Referrals were discussed in the morning meeting with ward managers and senior management. Patients could self-refer to the hospital and the admissions office department or be referred by a clinician. All patients admitted to the hospital had a consultant psychiatrist. Those that that did not have one were given an information pack that included profiles of consultant psychiatrists granted practising privileges by the hospital. Out of hours referrals were managed by clinical staff. The service had an admission risk exclusion criterion that included a risk history of violence to others.

There was always a bed available when patients returned from leave.

Patients were moved between wards only when it was best interest of the patient, such as when a patient identified a preference for mixed or single sex ward.

Managers regularly reviewed the length of stay of patients. The average length of stay was 23 days.

### Discharge and transfers of care

**Staff did not always document discharge plans or approximate dates of discharge in the 10 care records we reviewed. Staff we spoke to reported discharge planning typically started at admission.** However, there were no records of these conversations on any of the four wards we inspected. It was difficult to ascertain if these discussions had happened with the patients by looking at their records. We saw records of two patients that had reported to staff that they desired to be discharged. However, we could not find clear discharge plans recorded in the patient notes. We observed discussion of discharge planning in the multidisciplinary team meeting during the inspection, but we were told this was recent development.

The goals of the admission for patients on some wards were stated in ways that were vague and difficult to measure. For example, on the OCD ward, staff identified a patient 'learning to fight' and 'get control over OCD' as a goal. No measures of progress towards this goal were described or recorded.

Staff completed comprehensive discharge summaries for all patients. Discharge summaries were routinely discussed in team meetings as a reminder to staff to complete these in a timely manner.

Staff supported patients when they were referred or transferred between services. For example, transfer to an NHS hospital for further treatment.

## Facilities that promote comfort, dignity and privacy

**The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity.** Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Patients had their own bedrooms. Patients reported that they were aware that they could personalise bedrooms.

Patients had somewhere secure to store their possessions.

Patients had limited access to outside space due to the location of the building. The service had a courtyard that patients could access and used a designated smoking area.

Patients could make hot drinks and snacks 24 hours a day. Patients had support from staff to make a drink or snack. Staff offered patients drinks between mealtimes.

Patients were able to keep contact with carers and relatives. Patients could book the visitors room on the ground floor for visits.

Patients had access to the library that was located on female acute ward.

The service had an outside space that patients could access easily. There was a designated smoking area in one section of the courtyard. The hospital was not a smoke free.

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

Requires Improvement

## Patients' engagement with the wider community

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

Staff helped patients to stay in contact with families and carers though video calls as needed.

Patients had access to a range of activities such as movie night. Staff discussed activities that patients wanted to do for that day. For examples, visiting local hairdressers with the support of staff.

## Meeting the needs of all people who use the service

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients access advocacy.**

There were stairs and a lift between the floors. During the inspection the lift was out of service and had been reported for repairs. There was access to the service lift if needed. Patients with restricted mobility were admitted on the ground floor. The hospital provided a portable ramp to access the building.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to complain. The service had a magazine of local services that worked in partnership in the service that visitors and families could access in the hospital reception.

Staff could give examples of local services they could refer that offered support to those that had protected characteristic such as a disability, religion and sexual orientation.

Patients had a choice of meals to meet their dietary requirements, including religious requirements. Menus reflected patients' cultural and ethnic backgrounds.

Patients had easy access to information about independent mental health advocacy. The ward offered information on local advocacy services and staff supported patients to contact advocacy services.

## Listening to and learning from concerns and complaints

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

All the patients we spoke with told us they knew how to make a complaint if needed and approach the ward manager if they had concerns.

Between June 2021 and May 2022, the hospital received 79 complaints. Managers shared feedback from complaints with staff and learning was used to improve the service. Complaints were responded in a timely manner and response times reviewed by senior leadership.

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

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

Requires Improvement

Requires Improvement

Our rating of well-led went down. We rated it as requires improvement.

**Leadership**

**The ward managers had the skills, knowledge and experience to perform their roles. The ward managers had a good understanding of the services they managed**.

Ward managers could explain clearly how the team was working to provide care. The ward managers were able to give a review of the wards' strengths and examples of improvements. For example, improvements such as the need to include patient opinions in the multidisciplinary team pilot meetings. The senior leadership team was discussing with the medical director on how this could be implemented.

The ward managers discussed development opportunities that were available for staff in supervision. Staff were able to attend external training that they had requested.

Members of nursing staff, including the ward manager, were visible in the service and accessible to other staff and patients.

Sickness and absence rates were monitored, and managers offered support to staff who returned to work after a period of absence.

Staff spoke positively about the leadership provided by the hospital director, describing them as accessible and responsive. Although the hospital director had introduced the roles of staff and patient representatives for each ward, there was no allocated ward staff or patient representative at the time of the inspection.

The management team had forged good links with local universities, enabling links with research, and nursing students to have placements on the ward.

## Vision and strategy

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

The vision and strategy were focused on providing high quality care to all patients in a safe and nurturing environment, with a choice of appropriate experts to provide a range of care. The service had recently opened an OCD ward. The vision of the ward was to establish it as a centre for providing expert OCD care for patients for the United Kingdom.

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The provider displayed their values for staff and patients to see. These were compassion, respect, commitment, recognition, and one team. We saw evidence of the values being applied, for example, staff treating people with dignity and respect and compassion, and working together as a team.

Staff and patients had access to the minutes of staff and patient representatives' meetings, about the running of the hospital.

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

Requires Improvement

## Culture

**Staff felt respected, supported and valued and they could raise any concerns without fear. The ward staff reported a positive culture and valued the diversity of the senior leadership team.**

Staff told us they felt valued by managers. When concerns were raised, they were taken seriously and where possible addressed.

Staff appraisals included conversations about career development and how it could be supported. However, health care assistants felt there were limited opportunities for career development.

Some staff did not feel their input into patient care was valued by consultant psychiatrists. For example, some consultants visiting patients on wards did not always speak to staff for updates.

Some staff expressed that would like to be involved in more projects to improve the quality of care in hospital and monitor more outcomes to promote improving services. However, they felt covering staff shortage was seen as more of a priority.

Some staff said that they did not always feel that their work was recognised by the hospital, for example by introducing a regular staff award for exceptional practice.

Senior leadership had introduced a perks box for staff, including a hamper delivered to them on their birthday. They had also provided long service awards for staff.

There were lots of opportunities for overtime at the time of the inspection, but management ensured that staff had sufficient days off. Senior staff dealt with poor staff performance when needed.

## Governance

**The service had systems and processes in place to provide assurance and deliver the organisation's services safely, but these were not always effective. We found areas of improvement in the governance processes were needed. Although performance data was collected, there where was limited evidence of improvement, for example, in the quality of records kept by staff, in response to audits.**

The service did not keep robust oversight over the quality and safety of care. For example, on most wards patient care plans and risk assessments lacked detail and accuracy despite regular reviews by nurses and ward ligature risks assessments were of poor quality and not fit for purpose. Staff we spoke with gave varying responses about who was responsible for the oversight of quality and action plans. Most staff thought that it was the responsibility of the compliance manager to have oversight of quality. The compliance manager considered they did not have sole oversight but felt this was an area that needed more clarity for staff to know who to contact if they had queries about quality.

The service had an audit planner for the year. It showed audits scheduled for different departments such as wards, therapy teams, mental health act and health and safety. Audits were completed in a timely manner by a charge nurse and the frequency of audits also discussed in team meetings. However, audits did not always lead to improvements in the quality of care records. For example, the risk assessment audit did not highlight that a daily risk assessment did not always inform risk management plans on most wards. We discussed this with the medical director, director of nursing and the managing director who agreed this was an area for improvement. They felt the service needed to clearly identify who was responsible for action plans from audits to ensure that action plans were implemented and followed up.

Staff told us that learning from audits was shared in team meetings. However, when we reviewed the ward team meeting minutes and ward manager team meeting minutes for the last three months, there was no recorded learning from audits. Ward team meetings discussed audit tools and audit plans but not audit outcomes or learning. Audit feedback was discussed in the care quality and performance management group with senior leadership only.

The service had a practising privileges policy. The medical director completed audits of practising privileges and consultant performance and these were shared in the steering groups with senior staff. The last audit was completed in April 2022 found that out 13 of 14 patients had been seen three times or more per week and one patient had been seen twice a week. We checked the information held by the hospital in relation to the practising privileges granted to four consultant psychiatrists. The information held on record was in line with the provider's current practising privileges policy and included documentary evidence of medical indemnity insurance, approval under Section 12 of the Mental Health Act, a disclosure and barring service check, an annual appraisal, a 5-yearly revalidation and hepatitis B vaccination or immunity. Practising privileges were reviewed every two years. The hospital director took the decision whether or not to grant practising privileges, in consultation with the medical director and medical advisory committee.

Ward managers and the head of therapies met with the director of nursing on a monthly basis to discuss performance as well as incidents, complaints and audits. Information relating to quality and performance was reported up to the executive team in the care quality and performance management group which then reported to the provider's board. We reviewed a sample of local team meeting minutes from January 2021 to July 2021 and found that teams regularly discussed performance, incidents, audits, clinical outcomes, patient engagement, medicines management and complaints.

The hospital had a structure of committees to oversee the quality of care delivered. The quality performance management group was attended by the senior leadership team, lead consultants and sometimes by representatives from the French provider organisation. This provided an opportunity to discuss a range of relevant topics. Each month the senior clinical staff from the ward and senior hospital managers met at a steering group. This meeting was to discuss emerging trends on the ward, staff training requirements and feedback from carers and patients. Senior and operational managers met weekly. However, these structures were not sufficiently robust to identify gaps in risk management on the wards.

The hospital director had a structured estates plan for the hospital, providing clarity over funds available, so that the management team could make proactive plans for future improvements. Over the last year the dining room furniture in the eating disorder ward had been replaced, and redecoration of communal areas on the ward was planned in September 2022. There was also a quality improvement plan for the hospital, with current priorities including recruitment, extending CCTV in communal areas, moving to a paperless records system, and an alternative pharmacy system.

### Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care. However, ligature risk audits were of poor quality and not fit for purpose.**

Staff maintained and had access to the risk register. The risk register included subjects such as an awareness of ligatures, staffing, effects of COVID-19 and environmental risks. Risks were identified, and a plan made for each risk on the register. For example, for ligature risks it was identified that staff have ligature audit training. However, during the inspection we found that the ligature risk assessments were not fit for purpose, but this was not on the risk register. Neither were concerns about the quality of risk assessments and care plans.

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

Requires Improvement

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Ward managers and head of therapies met with the director of nursing, on a monthly basis to discuss performance, as well as incidents, complaints, risk register and audits. Information relating to quality and performance was reported up to the executive team in the Care Quality and Performance Management Group.

The provider had a system for monitoring consultant psychiatrists' practising privileges at the service. The system included detailed information of all required checks undertaken, and when they were due to be renewed.

Staff in the admissions office department produced a data sheet with trends to ensure that the service could meet demands and understand the market. For example, they noticed a peak in referrals for children and adolescents due to increased anxiety during the pandemic. Data also helped the service signpost referrals to other more suitable services.

There was a daily 'flash meeting' held at the hospital during which each ward lead met to check occupancy, staffing numbers, including additional staff available to assist across the hospital, and safety roles.

### Information management

**Teams had access to information related the provision of safe and effective care and were able to use the information to make some improvements, although there were gaps.**

The service collected reliable data and staff could find the data they needed, although some data collected did not seem to lead to improvements such as patient records. The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system worked well. However, some staff told us that it would be helpful to have more computers to use on the ward.

The team managers had access to information to support them with their management role. For example, supervision records, training data, admission and discharge information, staffing, complaints, incidents and accidents.

Information governance systems included protecting the confidentiality of patient records. However, the use of both paper and electronic patient records resulted in some unnecessary duplication, which impacted on the time staff had to spend with patients.

The provider recognised when incidents needed to be reported to external bodies, including the CQC.

### Engagement

**The hospital engaged with patients, carers and staff and tried to incorporate their views in the design and delivery of the services offered.**

Patients and carers had opportunities to give feedback on the service they received. Carers were able to feedback directly to ward managers. The patient satisfaction survey for the past twelve months was overwhelmingly positive for all services. Out of 410 surveys, people's average score was four out of five, five being good. The hospital used a verified online satisfaction survey and the results were displayed on the hospital website. However, these were not broken down by service type. There was a comment box on the wards, although this was rarely used.

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

Requires Improvement

Patient management forum meetings were held in October and December 2021 and February and April 2022. Meetings were attended by the hospital's management team and a patient representative from different wards. Not all of these meetings included a representative from the eating disorder unit. Issues raised included radiator controls, continuity of staff, newspapers requested in the dining area, and access to massage therapy. There was an action plan to address each issue raised. Feedback in the February 2022 forum showed that massage therapy would be re-introduced, newspapers were now provided in the dining room, radiators were in a future refurbishment plan and an update staff recruitment was given.

Managers engaged actively other local health and social care providers when needed. For example, the compliance manager liaised with social care departments in different boroughs around the country to ensure social circumstances reports were completed in a timely manner.

The provider last carried out an employee opinion survey between 18 January 2020 and 3 February 2021. The survey had 61 responses consisting of 11 hospital administration staff, 30 nursing staff, 11 therapy staff, nine services staff and two from an unknown department. Respondents positive responses included feeling they could recommend a friend to work for the hospital, staff felt able to voice their opinions and felt listened to. Respondents were less positive in terms of the hospitals pay and benefits, felt there was poor internal communication and inflexible rules for therapy staff to access clinical supervision.

### Learning, continuous improvement and innovation

**Staff did not use quality improvement methods, there were no quality improvement projects taking place in the hospital.**

Good

# Hospital inpatient-based substance misuse services

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

## Are Hospital inpatient-based substance misuse services safe?

Good

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

**Safe and clean care environments**

**All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.**

**Safety of the ward layout**

The inpatient addiction service was set across two floors, on the third and fourth floors. All bedrooms had en-suite facilities. The fourth floor was used as and when required, the fourth floor was not in use at the time of the inspection.

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. Fire safety checks were completed on a weekly basis. Staff also completed regular COVID-19 risk assessments.

The ward layout did not allow staff to observe all parts of the ward. There were blind spots on both floors, which staff mitigated by assessing patient risk, regular patient observations, and the use of convex mirrors

The ward complied with guidance on eliminating mixed-sex accommodation. All bedrooms had en-suite facilities. The ward did not have a female only lounge.

Staff had easy access to ligature cutters at the nursing station.

Staff had easy access to alarms and patients had easy access to nurse call systems. An alarm system for patients was in place and all staff carried a personal alarm.

**Maintenance, cleanliness and infection control**

Good

# Hospital inpatient-based substance misuse services

**The ward was visibly clean, had good furnishings and was well-maintained. The ward had a cleaner who cleaned the ward seven days a week. Cleaning records were maintained to demonstrate that the ward areas were cleaned regularly.**

Staff followed infection control guidelines, including handwashing. At the time of inspection all staff were observed to be wearing appropriate personal protective equipment (PPE). PPE was readily available in the reception area for patients and staff to access. Hand sanitizer stations were located throughout the building. Staff maintained specific changes designed to minimise COVID-19 transmission. Cleaning requirements had increased since the pandemic.

**Clinic room and equipment**

**The clinic room was fully equipped with accessible emergency drugs that staff checked regularly. Naloxone was available to be used for opiate overdose.**

At the time of the inspection the clinic room temperature was above 25 degrees, which is above the recommended temperature for the storage of medicines. If medicines are not stored properly, they may not work in the way they were intended, and so pose a potential risk to the health and wellbeing of the person receiving the medicine. It was not clear from staff about how this issue had been escalated.

Staff checked the medicine fridge temperatures daily. All temperatures recorded were within normal range.

Staff maintained most of the equipment well and kept it clean. An electronic blood glucose monitor, pulse oximeter and defibrillator machine were all present in the clinic room. The defibrillator was checked daily and had been noted to have a low battery since May. It was not clear from the paperwork or from talking to staff how this identified issue had been actioned. There was a risk that the defibrillator may not work properly when used in an emergency. Once the service was informed of this the batteries were replaced immediately.

**Safe staffing**

**The service had enough nursing and medical staff, who knew the patients and received appropriate training to keep people safe from avoidable harm. However, there were significant nursing vacancies on the ward.**

The ward establishment for registered nurses was seven whole time equivalents (WTE), and two WTE non-registered nurses. At the time of the inspection four out five staff nurse posts were vacant. The ward manager told us that the posts were covered by bank staff and by locum staff. Locum staff were agency staff members who had a block contract with the service and were employed on the ward for several months. The impact of the staff vacancies was that the permanent staff felt under pressure. The ward manager told us that they would always be able to cover the shifts however it could be challenging to find staff. At the time of the inspection, only three out of the ten beds on the ward were occupied. Staff felt that due to the low headcount on the ward, their workload was manageable. However, staff were concerned that the pressure on them would increase if the headcount on the ward increased. Patients also told us that the staff on the ward were always changing. Student nurses also worked on the ward.

There were four therapists allocated to the ward. The therapists were responsible for running the daily therapy programme. Staff felt that four therapy staff was appropriate to meet the demand on the ward.

There were set staffing levels depending on bed occupancy. These were the same during the day and at night. At the time of the inspection, there were two registered nurses and a non-registered nurse to meet the needs of the three patients admitted to the third floor.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Staff were able to attend the addictions training workshop which was offered to all staff. The workshop covered topics such as detoxification and medicines used to support detoxification. Patients told us that some of the agency staff appeared to be unsure of the rules on the ward.

Managers supported staff who needed time off for ill health. Managers made arrangements to cover staff sickness and absence through the use of agency staff or bank staff. Managers requested staff familiar with the service.

Patients had regular one to one sessions with nurses on the ward. Patients told us that members of staff were always available on the ward.

The ward had a dedicated addictions specialist consultant who admitted patients to the ward. A duty doctor was on call at the hospital day and night each day of the year. Staff knew how they could contact the doctor in the event of an emergency.

**Mandatory training**

Staff had completed and kept up-to-date with their mandatory training. Training data was only available for the whole hospital. At the time of the inspection, 95% of staff had completed all aspects of their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff. Mandatory training for staff included, conflict resolution, fire safety, infection prevention and control and safeguarding. Nursing staff also had role specific mandatory training modules such as medicines management.

The ward manager monitored mandatory training and alerted staff when they needed to update their training. Managers would discuss staff training compliance during managerial supervision.

**Assessing and managing risk to patients and staff**

**Staff assessed and managed risks to patients and themselves well.**

**Assessment of patient risk**

We reviewed six care records during our inspection. In all of the records we reviewed, a nurse and doctor had completed comprehensive assessments of the person's drug and/or alcohol dependence level, healthcare and other needs, in a timely manner, before treatment had started. This included the alcohol use disorders identification test (AUDIT), which assessed alcohol consumption, drinking behaviours and alcohol-related problems. The clinical opiate withdrawal scale (COWS) was used to rate common signs and symptoms of opiate withdrawal. Staff also completed a comprehensive physical health examination on admission, this included an ECG and blood test. This ensured staff were able to recognise and respond to warning signs and deterioration in patients' health. Patients also provided a specimen for drug testing. Staff assessed patients' mental health, specifically concerning any potential risks of the patient harming themselves.

Staff updated risk assessments daily, based on a discussion between the nurse and the patient about how the patient was feeling that day. Staff and patients completed a daily risk assessment document. Patients self-assessed their current risks and a discussion with the nurse then followed.

**Management of patient risk**

The ward had access to a medical doctor 24-hours, seven days a week. This meant there was medically directed evaluation, care and treatment of substance misuse disorders on the ward. Staff on the ward managed risks associated with withdrawal from alcohol and/or opiates by using appropriate detoxification tools, such as COWS for opiates, and the clinical institute withdrawal assessment for alcohol scale assessment (CIWA) for alcohol.

Staff provided patients who wanted to leave prior to their detoxification treatment finishing with advice. This information concerned the increased risks to patients if they consumed alcohol or drugs. The ward manager checked that staff provided patients with this information. The service had a discharge against medical advice policy. A copy of the discharge summary would be provided to the patient's GP where consent to share information had been obtained. When patients had reservations about sharing information with the GP, the doctor explained the importance of information sharing and would consider if an admission was safe to carry out without information sharing consent.

Staff searched patients when they were admitted to the ward for alcohol or drug detoxification treatment. Staff took items that could cause harm, such as phone chargers that were longer than five inches. These phone chargers were not permitted in patients' bed space and communal areas. The chargers were stored in a charging tower on the ward where patients could charge their electronic devices.

Staff identified and responded to any changes in risks to, or posed by, patients. Patient risk assessments were updated on a daily basis.

Staff followed hospital policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. One patient told us that they felt the process of searching patients on return from leave could be tightened up. The patient told us there had been several occasions where they had not been searched for contraband on return from leave. Concerns around the monitoring of restricted items was also raised at the February patient forum. Following the forum, the director of nursing was asked to investigate the issue of consistency of approach to restricted items.

Patients were aware of their rights as informal patients. Patients were asked to complete an addictions unit patient agreement. This agreement laid out guidelines for all patients to follow. For example, all patients agreed to not leave the hospital grounds for the first three days after admission. This was to allow some time for the patient settle in and to allow staff to facilitate appropriate assessments.

**Safeguarding**

**Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.**

Ninety-five per cent of staff across the hospital had completed safeguarding children and adults training at the time of the inspection.

Staff members knew how to identify potential risks to vulnerable adults and children. This included indirect risks, such as domestic violence. Safeguarding concerns were assessed at admission. Staff had previously raised concerns to the local authority due to children being present while their parents were intoxicated. Safeguarding issues were routinely discussed at handover meetings and ward rounds.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff told us they would inform the safeguarding lead at the hospital if they were concerned. Ongoing safeguarding concerns were reviewed during the monthly ward managers meeting.

Staff followed safe procedures for children visiting the ward. Children who were aged under 12 were not allowed to visit the ward. Staff booked separate spaces away from the ward for family visits.

**Staff access to essential information**

**Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.**

Staff kept comprehensive and detailed records of patients' care and treatment. Staff accessed patient care records by an electronic care record system and paper files. Staff knew how each type of information was recorded and what information was available electronically or on paper.

All information needed to deliver patient care was available to all relevant staff. Bank and agency staff could access and document patient information.

**Medicines management**

**The service used systems and processes to safely prescribe, administer and record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health. However, at the time of inspection some medicines were not stored at an appropriate temperature.**

Staff had medicines management training and followed effective medicines procedures. Medicine administration records included any patient allergies and clearly recorded medicines prescribed for the patient.

Staff checked the medicine fridge temperatures daily. All temperatures recorded were within normal range. However, at the time of the inspection the clinic room was above the recommended temperature of 25 degrees. There was a risk that the medicines stored outside of the fridge may not be as effective.

New staff and bank and agency staff were provided with training regarding naloxone. Naloxone is used for the emergency treatment of known or suspected opioid overdose.

The hospital had an in-house pharmacist who was responsible for medicines reconciliation, supplying and stocking of medicines on the ward, and the disposal and transportation of medicines. The pharmacist visited the ward weekly.

The drugs cupboard was secure and the controlled drugs register was clear and up-to-date.

Good

# Hospital inpatient-based substance misuse services

Staff reviewed the effects of medicines on patients' physical health regularly and in line with the National Institute for Health and Care Excellence (NICE). For example, they monitored blood pressure, pulse and respiratory rate when patients were prescribed pharmacological treatments to enable detoxification.

**Track record on safety**

**The service had a good track record on safety.**

**Reporting incidents and learning from when things go wrong**

**The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.**

Staff were confident in knowing what incidents to report and understood how to raise an incident via the electronic incident reporting system. Staff reported a wide range of incidents and these was done in a timely manner and followed up where necessary.

Incidents and learning outcomes were regularly discussed on the ward. Staff told us that incidents were discussed at team meetings. Meeting minutes demonstrated that feedback from incidents was an agenda item and staff discussed the learning from incidents.

Staff reported serious incidents clearly and in line with the provider's policy. All staff that we spoke to were aware of how to report a serious incident. Staff told us that there was an incident form to complete on the intranet.

The service had not had any 'never events' on any wards. Never events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. For example, a patient was due to have a urine drug screen (UDS) but the nurse on the ward was not familiar with addictions and provided the wrong test. The patient raised this with the ward manager. The ward manager apologised to the patient involved and provided further training to all staff working on the ward.

Staff received feedback from investigations of incidents, both internal and external to the ward. Learning from incidents was discussed at team meetings and learning from incidents was available for staff to read on the provider's intranet.

There was evidence that changes had been made as a result of feedback. For example, there had previously been issues with contraband on the ward. Following these incidents further training on searching patients had been provided to staff. Food deliveries were now searched by staff members as a result of contraband items being delivered to the ward.

Managers debriefed and supported staff after any serious incident. Immediate debriefs took place following serious incidents.

Good

# Hospital inpatient-based substance misuse services

## Are Hospital inpatient-based substance misuse services effective?

Good

Our rating of effective stayed the same. We rated it as good.

**Assessment of needs and planning of care**

**Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.**

As part of the inspection we reviewed six patients' care and treatment records, three records that we looked at were for patients that had been recently discharged.. Patients had a comprehensive assessment when they were admitted for alcohol or opiate detoxification. This included a full substance misuse history and assessment, mental state assessment and an assessment of their physical health. The physical health assessment included a physical examination, blood testing and an electrocardiogram (ECG). Blood testing was to identify any liver abnormalities and the ECG was to identify any heart abnormalities which could affect treatment.

Care plans were personalised, holistic and recovery-orientated. They were up to date, thorough and completed in a timely manner. They were detailed and included the view of the patient. All patients that we spoke to were aware of their care plan and their goals for recovery.

**Best practice in treatment and care**

**Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.**

The service had a comprehensive alcohol and drug detoxification policy in place, which had recently been updated and was in line with national guidance. The hospital provided all staff on the ward with specific substance misuse training to ensure staff were aware of the NICE guidance when monitoring the physical status of people undergoing detoxification or withdrawal.

Staff identified patients' physical health needs and recorded them in their care plans. All patients had their vitals taken daily such as blood pressure, pulse and temperature. All patients received an ECG and full physical assessment on admission to the ward and all patients were also offered a fibroscan during their time at the hospital. A technician visited monthly to conduct patient fibroscans. A fibroscan is a type of ultrasound which measures how much scarring there is in the liver due to liver disease.

The service had a clear policy in place to ensure all patients undergoing alcohol detoxification received pabrinex. Pabrinex is used for correcting severe depletion or malabsorption of vitamins B and C, particularly in alcoholism, where a severe depletion of thiamine can lead to a brain condition called Wernicke's encephalopathy.

Patients attended a 28-day treatment programme or a detoxification programme which was normally ten days. The therapy programme followed the 12 step programme, a widely used and recognised psychosocial treatment programme for people with addictions. The programme involved several therapy groups per day with individual activities for patients to complete outside of groups. Patient groups included relapse prevention, anger management and maintaining relationships group.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients had access to a gym onsite which they could regularly attend. The site was not smoke-free which was not in line with best practice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff had recently started measuring patient outcomes once they had been discharged. Staff asked patients to complete the GAD-7, CORE and PHQ-9 outcome measures before discharge, these assessed a patient's mental health at discharge compared to admission. A questionnaire was sent to patients one month, three months, six months and one year after discharge. The questionnaire covered patients' current mental health and substance misuse. Staff planned to use the results to adapt their programme.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. An audit schedule was in place for the ward. Each audit was conducted twice a year, these audits included, reviewing care plan and risk assessments quality and consent to treatment audits.

**Skilled staff to deliver care**

**The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.**

The team had access to the full range of specialists required to meet the needs of patients on the addictions ward. This included addiction specialist consultant psychiatrists, an addiction specialist ward doctor, registered, and non-registered nurses, student nurses, a pharmacist, and specialist addiction therapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Staff received specialist in-house training for their role on an inpatient detoxification ward. For example, staff received training in administering intra-muscular Pabrinex. A member of staff explained, they observed staff carry out the injections on multiple occassions and then had the opportunity to administer the Parbinex under the observation by a senior member of staff. The student nurses that we spoke to felt the ward staff were helpful in allowing them to progress and to enhance their skills as nurses.

The therapy team had a range of specialisms, staff specialised in dual diagnosis, addiction and family therapy.

Managers gave each new member of staff a full induction to the service before they started work. The hospital provided new staff with an overall induction to the hospital, and the addictions team offered new staff a specific induction to working on the addiction ward. For example, a student nurse told us that they had been given a detailed introductory run through of health and safety issues and emergency contacts when starting on the ward.

The ward manager supported staff to develop through yearly, constructive appraisals of their work. All staff had received an appraisal within the last year.

Managers supported through regular, constructive supervision of their work. At the time of inspection, all staff had received regular monthly supervision apart from staff members who were on leave or were away due to sickness.

**Multi-disciplinary and interagency team work**

**Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.**

Staff held weekly multidisciplinary ward rounds to discuss patients' progress with care and treatment. The meeting followed an agenda, which included essential items suchas reviewing risk levels, medicines, physical and psychological progress and discharge planning.

Staff shared information about patients at effective handover meetings, twice per day. Flash meetings took place daily. These meetings reviewed staffing and patient risks during detoxification

All staff that we spoke to felt respected and valued within the team. Staff told us that all members of the team worked effectively and communicated openly.

Staff shared information with organisations outside of the hospital. For example, patients were asked for their permission to share information with the GP. We saw letters that had been sent to patients GPs to lower the risk of double prescribing.

**Good practice in applying the Mental Capacity Act**

**Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.**

The hospital had a policy on the Mental Capacity Act (MCA). Staff knew where to get advice from within the hospital regarding the MCA. Staff had received training in the MCA.

Patients on the ward had given their consent to treatment and had been given sufficient information about treatment options and risks and had the capacity to make an informed decision. Staff gave patients verbal and written information regarding their care and treatment on admission, and the nurse and doctor completed an assessment of each patient's capacity to consent to admission and treatment. Staff said that the service occasionally admitted patients with impaired capacity due to alcohol intoxication. In these situations, staff would monitor the patient to ensure their safety and wait for the patient to regain capacity once the effects of alcohol had worn off.

Good

# Hospital inpatient-based substance misuse services

## Are Hospital inpatient-based substance misuse services caring?

Good

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

**Kindness, privacy, dignity, respect, compassion and support**

**Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.**

Patients we spoke with were very happy with the support they received from staff. They described staff as respectful, compassionate and caring. However, patients said that the nursing staff changed frequently, and that agency staff were not always aware of the ward rules. For example, one patient told us that agency staff did not breathalyse them when returning from leave on several occasions.

Staff gave patients help, emotional support and advice when they needed it. Patients told us that there was always a staff member available if they required advice or support.

Staff directed patients to other services and supported them to access those services if they needed help. Patients told us that staff had directed them to support groups following discharge from the service such as alcoholics anonymous.

All staff that we spoke to said they felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff protected patients' confidentiality and understood the importance of this. They gave examples of how they maintained patient confidentiality. For example, not discussing patients' treatment in front of other patients.

**Involvement in care**

**Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided.**

**Involvement of patients**

Staff used the admission process to orient patients to the ward and to the service. On admission patients were shown around and were provided with an induction pack. This contained information in relation to what to expect, introduction to staff members on the ward and timetables for various groups and activities.

Staff involved patients in their care planning and risk assessments. For example, patients would complete a daily risk assessment with a member of staff.

Staff made sure patients understood their care and treatment. Patients attended a weekly ward round meeting with the multi-disciplinary team (MDT). Patients told us that they felt listened to during these ward rounds.

Good

# Hospital inpatient-based substance misuse services

Staff involved patients in decisions about the service, when appropriate. Patients and staff told us there was a longer community meeting once a week where any concerns or problems could be discussed. A patient forum was also held bi-monthly, patients from across the hospital could attend this meeting. This provided an opportunity for patients to meet the hospital management team. Issues arising from the most recent patient forum were in relation to the environment looking tired and a lack of continuity in staffing. The patient forum was not always well attended, only one patient attended the April meeting and three attended in February.

Patients could give feedback on the service and their treatment and staff supported them to do this. There was a daily meeting for patients with staff where any issues could be discussed. The therapy team provided a discharge survey to staff that were leaving the ward. Staff had reduced the length of the therapy groups as a result of patient feedback.

**Involvement of families and carers**

**Staff informed and involved families and carers appropriately.**

Staff informed and involved families and carers appropriately and provided them with support where needed. Patients told us that they were supported to visit or be visited by family and friends during their stay on the ward. Families and carers were welcome to visit the ward during visiting hours, if patients wanted them to do so. They could meet on the ward or in visiting rooms away from the ward.

Family therapy was offered to patients and their families. The ward held a family day once a month where family therapy could be provided.

## Are Hospital inpatient-based substance misuse services responsive?

Good

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

**Access and discharge**

**Staff managed beds well. A bed was available when a patient needed one.**

**Bed management**

The addictions unit was for 24-hour, medically directed evaluation, care and treatment of substance misuse disorders. The ward accepted patients from across the United Kingdom and from other countries.

Patients usually self-referred or were referred by their GP to the ward. The hospital had an admissions team who would assess the referral and decide whether it was appropriate. The service had alternative care pathways and referral systems in place for people whose needs could not be met by the service.

The addictions unit had exclusion criteria for the service. Patients with extremely aggressive behaviour, significant forensic history or patients with significant physical health issues were not accepted to the unit.

Good

# Hospital inpatient-based substance misuse services

**Discharge and transfers of care**

Patient discharge was planned during treatment. Staff developed a discharge plan for patients, and this was reviewed weekly at the patient's ward round. Staff ensured that discharge summaries were sent to professionals in the community with the patient's consent, such as their GP.

Aftercare was provided for all patients that had been discharged. Online weekly therapy sessions were offered to all patients.

**Facilities that promote comfort, dignity and privacy**

**The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.**

Patients had their own bedrooms, which were en-suite. They could personalise their bedrooms if they wished.

There were facilitates for patients to store their belongings securely.

Patients had access to the full range of rooms and equipment to support treatment and care. Therapy groups took place each day in the therapy department off the ward. Patients had their meals in the restaurant shared by all the patients at the hospital.

The service had quiet areas and a room where patients could meet with visitors in private. Patients could make phone calls in private.

The service had an outside space that patients could access easily. There was a designated smoking area in one section of the courtyard. The smoking area limited the outside space that was available to non-smokers.

Patients could make hot drinks and snacks at any time. The ward kitchen was stocked with tea and coffee and a water cooler**.**

**Patients' engagement with the wider community**

**Staff supported patients with activities outside the service, such as work, education and family relationships.**

Staff provided information about local places of worship to patients.

Patients were supported to maintain contact with those that mattered to them, such as family members or friends.

Patients had access to local alcoholics anonymous, narcotics anonymous, cannabis anonymous and gambling anonymous groups and were encouraged to attend these groups, following treatment.

**Meeting the needs of all people who use the service**

Good

# Hospital inpatient-based substance misuse services

**The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.**

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. The ward could be accessed via an elevator, however the elevator was not working during the inspection. The ward manager told us that the elevator was due for repair shortly. The ward had recently held an LGBT+ event on the ward, where advice and information about services that support the LGBT+ community was shared.

Staff ensured that patients could obtain information on treatments, local services, patients' rights and how to complain. Patients received this information in their welcome packs, this information was also displayed on notice boards in the communal area of the ward.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. All food was prepared and cooked onsite and could be made according to specific needs and preferences. The chef at the hospital could cater for a range of dietary needs. Staff told us that the chef would create a range of Kosher food when requested.

Staff could make information leaflets available in languages spoken by patients in response to patients' specific needs.

**Listening to and learning from concerns and complaints**

**The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.**

In the 12 months before the inspection there had been eight complaints in relation to the substance misuse service. Following investigations, five were partially upheld and three were not upheld.

Patients, relatives and carers knew how to complain or raise concerns. All patients that we spoke to told us they were aware of how to complain.

The service clearly displayed information about how to raise a concern/complaint in patient areas.

Staff knew how to deal with complaints and there was an established system for ensuring complaints were responded to. This included informing the person who had complained of the timescale when they would receive a response. For example, following a complaint about a staff member's communication the ward manager met with patient. The patient did not wish to take complaint any further but wanted the staff member to receive feedback. The patient was offered a mediation meeting but they declined. Feedback was given to the staff member also who appreciated the feedback and acknowledged they would be more aware of their communications and dynamics of the ward.

Managers investigated complaints and identified themes. The most common theme of complaints in the last 12 months was staff communication and complaints about the care and treatment patients had received.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint. All patients that we spoke to said they felt able to raise concerns with staff.

Good

# Hospital inpatient-based substance misuse services

Managers shared feedback from complaints with staff and learning was used to improve the service. Learning from complaints was shared in team meetings and during supervision.

The service used compliments to learn, celebrate success and improve the quality of care. 'Thank you' cards were displayed in the nursing office.

## Are Hospital inpatient-based substance misuse services well-led?

Good

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

**Leadership**

**The ward managers had the skills, knowledge and experience to perform their roles. The ward managers had a good understanding of the services they managed**.

The Ward manager could explain clearly how the team was working to provide care. They were able to give a review of the wards' strengths and examples of improvements.

The ward manager discussed development opportunities that were available for staff in supervision. Staff were able to attend external training that they had requested.

The ward manager was visible in the service and accessible to other staff and patients.

Sickness and absence rates were monitored and support offered to staff who returned to work after a period of absence.

Staff spoke positively about the leadership provided by the hospital director, describing them as accessible and responsive.

The senior management team had forged good links with local universities, enabling links with research, and nursing students to have placements on the ward.

### Vision and strategy

**Staff knew and understood the provider's vision and values and how they applied to the work of their team.**

The vision and strategy were focused on providing high quality care to all patients in a safe and nurturing environment, with a choice of appropriate experts to provide a range of care.

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

The provider displayed their values for staff and patients to see. These were compassion, respect, commitment, recognition, and one team. We saw evidence of the values being applied, for example, staff treating people with dignity and respect and compassion, and working together as a team.

Staff and patients had access to the minutes of staff and patient representatives' meetings, about the running of the hospital.

### Culture

**Staff felt respected, supported and valued and they could raise any concerns without fear. The ward staff reported a positive culture and valued the diversity of the senior leadership team.**

Staff told us they felt valued. When concerns were raised, they were taken seriously and where possible addressed.

Staff appraisals included conversations about career development and how it could be supported.

Some staff expressed that they would like to be involved in more projects to improve the quality of care in hospital and monitor more outcomes to promote improving services.

Senior leadership had introduced a perks box for staff, including a hamper delivered to them on their birthday. They had also provided long service awards for staff.

There were lots of opportunities for overtime at the time of the inspection, but management ensured that staff had sufficient days off. Senior staff dealt with poor staff performance when needed.

### Governance

**The service had systems and processes in place to provide assurance and deliver the organisation's services safely, although these were effective in the substance misuse services they were not in other areas.**

The hospital had an audit planner for the year. It showed audits scheduled for different departments such as wards, therapy teams, Mental Health Act and health and safety.

Staff had an annual planner and staff told us that learning from audits was shared in team meetings.

The service had a practising privileges policy. The medical director completed audits of practising privileges and consultant performance and these were shared in the steering groups with senior staff. The last audit was completed in April 2022 found that out 13 of 14 patients had been seen three times or more per week and one patient had been seen twice a week. We checked the information held by the hospital in relation to the practising privileges granted to four consultant psychiatrists. The information held on record was in line with the provider's current practising privileges policy and included documentary evidence of medical indemnity insurance, approval under Section 12 of the mental health act, a disclosure baring service check, an annual appraisal, a 5-yearly revalidation and hepatitis B vaccination or immunity. Practising privileges were reviewed every two years. The hospital director took the decision whether or not to grant practising privileges, in consultation with the medical director and medical advisory committee.

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Ward managers and the head of therapies met with the director of nursing on a monthly basis to discuss performance as well as incidents, complaints and audits. Information relating to quality and performance was reported up to the executive team in the care quality and performance management group which then reported to the provider's board. We reviewed a sample of local team meeting minutes from January 2021 to July 2021 and found that teams regularly discussed performance, incidents, audits, clinical outcomes, patient engagement, medicines management and complaints.

Good

# Hospital inpatient-based substance misuse services

The hospital had a structure of committees to oversee the quality of care delivered. The quality performance management group was attended by the senior leadership team, lead consultants and sometimes by representatives from the French provider organisation. This provided an opportunity to discuss a range of relevant topics. Each month the senior clinical staff from the ward and senior hospital managers met at a steering group. This meeting was to discuss emerging trends on the ward, staff training requirements and feedback from carers and patients. Senior and operational managers met weekly.

The hospital director had a structured estates plan for the hospital, providing clarity over funds available, so that the management team could make proactive plans for future improvements.

## Management of risk, issues and performance

**Teams had access to the information they needed to provide safe and effective care.**

Staff maintained and had access to the risk register. The risk register included subjects such as an awareness of ligatures, staffing, effects of COVID-19 and environmental risks. Risks were identified, and a plan made for each risk on the register.

Senior staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. Ward managers, head of therapies, met with the director of nursing, on a monthly basis to discuss performance as well as incidents, complaints, risk register and audits. Information relating to quality and performance was reported up to the executive team in the Care Quality and Performance Management Group.

The provider had a system for monitoring consultant psychiatrists' practising privileges at the service. The system included detailed information of all required checks undertaken, and when they were due to be renewed.

Staff in the admissions office department produced a data sheet with trends to ensure that the service could meet demands and understand the market. For example, they noticed a peak in referrals for children and adolescents due to increased anxiety during the pandemic. Data also helped the service signpost referrals to other more suitable services.

There was a daily 'flash meeting' held at the hospital during which each ward lead met to check occupancy, staffing numbers, including additional staff available to assist across the hospital, and safety roles.

## Information management

**Teams had access to information related the provision of safe and effective care and were able to use the information to make some improvements.**

The service collected reliable data and staff could find the data they needed.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. However, some staff told us that it would be helpful to have more staff computers to use on the ward.

The team managers had access to information to support them with their management role. For example, supervision records, training data, admission and discharge information, staffing, complaints, incidents and accidents.

Information governance systems included protecting the confidentiality of patient records. However, the use of both paper and electronic patient records resulted in some unnecessary duplication, which impacted on the time staff had to spend with patients.

The provider recognised when incidents needed to be reported to external bodies, including the CQC.

### Engagement

**Managers engaged actively with patients, carers and staff to meet the needs of the those that used the service.**

Patients and carers had opportunities to give feedback on the service they received. Carers were able to feedback directly to ward managers. The patient satisfaction survey for the past twelve months was overwhelmingly positive for all services. Out of 410 surveys, people's average score was four out of five, five being good. The hospital used a verified online satisfaction survey and the results were displayed on the hospital website. However, these were not broken down by service type. There was a comment box on the ward, although this was rarely used.

Patient management forum meetings were held in October and December 2021 and February and April 2022. Meetings were attended by the hospital's management team and a patient representative from different wards. Not all of these meetings included a representative from the eating disorder unit. Issues raised included radiator controls, continuity of staff, newspapers requested in the dining area, and access to massage therapy. There was an action plan to address each issue raised. Feedback in February 2022 forum showed that massage therapy would be re-introduced, newspapers were now provided in the dining room, radiators were in a future refurbishment plan and an update staff recruitment was given.

Managers engaged actively other local health and social care providers. For example, the compliance manager liaised with social care departments in different boroughs around the country to ensure social circumstances reports are completed in a timely manner.

The provider last carried out an employee opinion survey between 18 January 2020 and 3 February 2021. The survey had 61 responses consisting of 11 hospital administration staff, 30 nursing staff, 11 therapy staff, nine services staff and two from an unknown department. Respondents positive responses included feeling they could recommend a friend to work for the hospital, staff felt able to voice their opinions and felt listened to. Respondents were less positive in terms of the hospitals pay and benefits, felt there was poor internal communication and inflexible rules for therapy staff to access clinical supervision.

### Learning, continuous improvement and innovation

**Staff did not use quality improvement methods, there were no quality improvement projects taking place in the hospital**

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 |
|---|---|
| Treatment of disease, disorder or injury<br>Diagnostic and screening procedures<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect<br>• The provider must address patients' experience of variability in staff compassion and empathy, and respect for their privacy and dignity. Regulation 10(1). |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Diagnostic and screening procedures<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>• The provider must ensure that care plans and risk assessments for all patients include sufficient details to address their needs. Regulation 9(1)(3)(b).<br>• The provider must ensure the robust discharge plans are documented in patient records. Regulation 9(1)(3)(b). |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Diagnostic and screening procedures<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>• The provider must ensure that expired oxygen reservoir and tubing kits are replaced without delay. Regulation 12(2)(6)<br>• The provider must ensure that there is a specific risk assessment documented for patients who are under 18 years old admitted to an adult ward, including consideration of risk related to their age and whether one-to-one observations are needed. Regulation 12(2)(1). |

This section is primarily information for the provider

# Requirement notices

- The provider must ensure that staff use a recognised risk assessment for patients in terms of their tissue viability (to monitor their risk of developing pressure ulcers). Regulation 12(2)(1).
- The provider must ensure that day patients have their risk assessments and care plans updated from when they were inpatients on the ward, to reflect their current situations. Regulation 12(2)(1).
- The provider must ensure that ligature risk assessments for each ward and the risk mitigation in place is clear and consistent. Regulation 12(1)(2)(4)
- The provider must ensure that staff complete National Early Warning Scores charts in full to determine whether further action is needed and escalate as needed. Regulation 12 (1)(2)
- The provider must ensure that staff complete medication administration records in full. Regulation 12 (1)(2).

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Diagnostic and screening procedures<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>• The provider must ensure that eating disorder and acute wards have effective governance systems and processes in place to assess, monitor and drive improvements in the quality and safety of services provided, including addressing shortfalls in risk management, and discharge planning, and patients' concerns about variable staff treatment on the ward. Regulation 17(1)(2)(a)(b)(c). |

| Regulated activity | Regulation |
|---|---|
| Treatment of disease, disorder or injury<br>Diagnostic and screening procedures<br>Assessment or medical treatment for persons detained under the Mental Health Act 1983 | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>• The provider must ensure that there is an appropriate and comfortable chair and space available for patients who require nasogastric feeding. Regulation 15(1)(3). |