Good

Priory Healthcare Group

Priory Hospital Lincolnshire

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-132325619	Priory Hospital Lincolnshire	Lancaster ward and Scampton ward	DN21 5UD

This report describes our judgement of the quality of care provided within this core service by Priory Hospital Lincolnshire . Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Priory Hospital Lincolnshire and these are brought together to inform our overall judgement of Priory Hospital Lincolnshire .

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

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

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

Summary of findings

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Summary of findings

Overall summary

We rated Priory Hospital Lincolnshire as good because:

- Patients had access to evidence based, high quality psychological therapy, with once or twice weekly one to one sessions, group therapy and drop in sessions to supplement the structured therapy program. The range of activities available to patients, was extensive, and of high quality. Staff designed activities to promote recovery.
- Leaders were strong, consistent, and well respected by the staff and patients we spoke with. We saw evidence that managers were implementing the information and action plans, that they had shared with us through the provider engagement meetings, into the culture and practice at the hospital. Staff commented positively about how the providers vision and values were embedded into practice at the hospital. The vision and values were based on promoting a culture of family, support for each other, belonging and ownership.
- There were robust systems in place for reporting and recording incidents. There were systems and procedures to ensure that wards were safe and clean. Managers were carrying out regular environmental audits and acting on the findings when needed. The provider had implemented a successful recruitment drive for permanent staff, and improved staff engagement had reduced the number of staff leavers. The service adhered to the requirements of the Mental Health Act and Mental Capacity Act.
- Staff undertook risk assessments of patients upon admission. Staff updated risk assessments during patient review meetings or following an incident. Staff completed comprehensive assessments of patients upon admission. Staff used the information gathered during the assessment to create holistic and personalised care plans. Patients were involved in, and took part in the planning of their care. We reviewed twelve patient care records which showed that staff discussed care plans with patients and recorded their views.
- The hospital was clean, well maintained and safe. All patients had their own en-suite bedrooms with patient call alarms. There was adequate space for a variety of activities to be happening at the same time. There were enough skilled staff to meet patients' needs and give all the necessary clinical and physical interventions needed. Clinics were clean tidy and well managed. Staff stored medication in locked cupboards within the clinic room. We checked 14 medication records for patients, staff had completed all records correctly.

However:

- The systems for recording and capturing supervision conversations were not clear or robust. Staff doubted the accuracy of the supervision data provided. Supervision records were not readily available and staff appeared to have lost some records. Although, prior to inspection, the registered manager had identified this as a problem and had started to put in place systems to ensure that staff recorded and stored supervision records appropriately.
- One patient who had complained of blurred vision, had been waiting several months for staff to arrange an optician's appointment for him. Staff explained the reasons for the delay and before the inspection finished, staff had made the patient an opticians appointment at the hospital.
- Lancaster wards' compliance with mandatory training was significantly lower than Scampton ward. We did not consider this a breach, because the providers overall training compliance was reasonable at 92%, however, the provider should address this discrepancy.
- Staff training in Mental Health Act and Mental Capacity Act was below the providers expected target.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Good

We rated safe as good because:

- Staff carried out regular risk assessments of the care environment. There was a complete and comprehensive ligature audit and assessment.
- All areas of the hospital were clean and tidy, furniture was maintained to high standard and cleaning records were up to date and showed that staff cleaned the ward regularly.
- The provider had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly. We reviewed 14 medication charts and found staff followed good practice in medicines management.
- The provider staffed wards safely. We checked duty rotas and the provider filled shifts with right numbers of staff.
- Staff used recognised risk assessments and completed comprehensive risk assessments on all patients at the time of admission.
- Data showed that 96% of staff had trained in safeguarding vulnerable adults and 96% of staff had trained in safeguarding children. The provider had a good track record for safety. Managers recorded and investigated all incidents fully and made changes based on the learning from those incidents.

However:

- We could not determine the providers compliance with, or quality of staff supervision. Supervision records were not readily available, staff appeared to have lost some records. Staff doubted the accuracy of the data provided, and told us they did have frequent, good quality supervision that allowed them to feel confident in their jobs. Although prior to inspection, the registered manager had identified this as a problem and had started to put in place systems to ensure staff recorded and stored supervision records correctly.

Are services effective?

Good

We rated effective as good because:

- We reviewed 12 care records, all care records showed that staff had completed comprehensive mental health assessments at the time of admission. Assessments included patients physical, emotional and mental health needs, and when necessary staff carried out other specialist assessments.

Summary of findings

- Staff and patients developed joint care plans that met the identified needs of the patient. Care plans had been cross referenced to evidence based practice. Staff reviewed care plans with patients at regular intervals and patients could check their own progress using "My five green goals".
- Staff provided care and treatment in line with guidance recommended by the National Institute for Health Care Excellence. Activities were recovery focussed and available throughout the week and weekends. The range and quality of therapies and activities available to patients, was extensive and of high quality.
- Patients had access to high quality psychology, with once or twice weekly one to one sessions, group therapy and drop in sessions to supplement the structured therapy program available.
- The provider employed a full range of staff from different disciplines. Staff had the experience and qualifications to perform their roles and meet the needs of the patient group. The multidisciplinary team worked well together to provide cohesive treatment and care for patients. Managers ensured that staff had regular access to team meetings and reflective learning opportunities.
- The experienced Mental Health Act administrator ensured that the service maintained compliance with the Mental Health Act and Mental Capacity Act code of practice.

However:

- One patient who had complained of blurred vision, had been waiting about four months for staff to arrange an optician's appointment for him. Although staff explained the reasons for the delay, the inspection team felt this delay was not acceptable. Before the inspection finished the nurse in charge told us that they had found an optician and the patient had an optician's appointment.
- Lancaster wards compliance with mandatory training was significantly lower than Scampton ward, and we did not see enough evidence to show staff had addressed this effectively. We did not consider this a breach, because the providers overall training compliance was reasonable at 92%, however, the provider should address this discrepancy.
- Staff training in Mental Health Act and Mental Capacity Act was below the providers expected target. Though we did not see any impact of this on practice.

Are services caring?

We rated caring as good because:

Good

Summary of findings

- We saw how staff were kind and caring towards patients. Staff understood patients' needs and treated them with dignity and respect, engaging with patients in ways that were meaningful to them.
- Patients took part in the care planning process. We reviewed 12 patient records which showed that staff encouraged patients to take an active part in the care planning process. Staff supported patients to understand and manage their care, treatment or condition.
- Patients had access to advocacy. We spoke to an advocate and they informed us they helped patients to engage with meetings, care planning, safeguarding and the patient forum. Patients could give feedback on the service they received through the patient forum or during mealtimes, when staff sat with patients and they ate together.
- Both carers we spoke with felt involved in their relatives' care and were happy with the support and communication they received from staff and managers.
- Staff directed patients to other services when appropriate and, if needed, supported them to access those services.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patient discharges and transfers were well planned and supported.
- The provider had a range of rooms and equipment to support patient care and treatment. This included a fully equipped clinic room, therapy and group activity rooms, a gym, quiet rooms and private visitor's rooms. The hospital was in the grounds of an extensive woodland area that was accessible to patients.
- The provider offered patients paid real work opportunities at the hospital and supported patients to access voluntary work and education opportunities in the community.
- The provider had a range of accessible information about local organisations, patient rights, confidentiality and how to make a complaint.
- Patients told us the food was good and there was a good choice. Hot and cold drinks and snacks were available throughout the day. We saw evidence that the food options provided by kitchen staff, supported cultural and religious dietary requirements.

Summary of findings

- The provider had a robust complaints procedure. The manager investigated complaints and shared lessons learned with staff. Carers we spoke with felt that the provider dealt with complaints swiftly.

Are services well-led?

Good

We rated well-led as good because:

- Leaders had the skills, knowledge and experience to perform their roles effectively. Leaders had a good understanding of the services they managed and were visible on the wards and approachable for both staff and patients.
- Staff were aware of the organisation's visions and values. Staff told us how the values of the organisation, such as putting people first and being supportive of each other, underpinned the work they did. We saw staff behaviour reflecting the organisation's values. Managers had incorporated the vision and values into the new Care Certificate workbooks for all healthcare support staff.
- Staff felt respected, supported and valued. Managers had introduced staff wellbeing sessions, providing relaxation training, and complimentary therapies. The provider recognised staff success within the service through employee recognition events such as: employee of the month, team of the quarter, employee and team of the year. In addition to this, highly performing employees were nominated for the Priory's national staff awards.
- Staff had access to both a local and the organisational risk register. Staff concerns matched those on the risk register. Where cost improvements were taking place, they did not compromise patients care.
- Managers had access to the feedback from patients, carers and staff and used the feedback to make improvements. Managers had introduced a solution box, to encourage staff to identify problems areas and offer a solution. All staff whose solutions were implemented received a gift voucher as a thank you.
- Except for supervision processes, all other governance processes and systems were robust, and allowed managers to run an efficient and effective service. Managers had a formula for establishing staffing numbers based on patient's complexity and needs. There were robust systems in place for reporting and recording incidents.

However:

- Overarching governance and the systems for recording and capturing supervision conversations were not clear or robust.

Summary of findings

Although, we also noted that the hospital director had already, and prior to inspection, identified this as a problem and had started to put in place systems to address the issues we identified at the time of inspection.

Summary of findings

Information about the service

The Priory Healthcare Group own Priory Hospital Lincolnshire. It is a low secure, long stay rehabilitation hospital for adult males with complex mental health issues and personality disorders. Located in Gainsborough Lincolnshire it provides 28 beds to support those who are detained under the Mental Health Act.

The hospital has two wards:

Lancaster ward a 14-bedded ward for males who need stabilisation and support to decrease their levels of challenging behaviour.

Scampton ward a 14-bedded ward providing continuing care with a focus on rehabilitation, community reintegration and preparation for the person to move to further along the care pathway, or to community living. At the time of inspection Priory Hospital Lincolnshire had 20 patients, all detained under the Mental Health Act. The registered manager is Palmer Chinosengwa.

Priory Hospital Lincolnshire provides the following regulated activities:

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

We last inspected Priory Hospital Lincolnshire on 11 October 2016, at that time it was known as Meadow View, and we rated it as good overall.

Our inspection team

The team that inspected the service included three CQC inspectors three specialist advisors including a pharmacist, a nurse manager, a social worker, and an expert by experience. An expert by experience is a person with lived experience relevant to the service being inspected.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme, under the next phase methodology for independent healthcare providers. The inspection was unannounced meaning that the provider had not had time to prepare for our visit.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited both wards and all patient areas at the hospital, looked at the quality of the environment and saw how staff were caring for patients
- spoke with nine patients and two carers who were using the service

Summary of findings

- spoke with the registered manager, deputy manager and managers or acting managers for each of the wards
- spoke with 25 other staff members; including doctors, nurses, healthcare support workers, occupational therapist, psychologists, social worker, administration staff and facilities staff
- received feedback about the service from two care co-ordinators
- spoke with an independent advocate
- attended and saw one hand-over meeting and one multi-disciplinary meeting
- looked at 12 care and treatment records of patients and reviewed five sets of detention records
- reviewed 14 patient prescription charts and carried out a specific check of the medication management and prescribing practice on both wards
- reviewed 15 staff records, and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

- We spoke with nine patients and two carers. Patients told us that staff were kind and caring and supported them to meet their needs. Patients said they could give feedback and suggestions about things they were not happy with on the ward.
- Patients liked the food and felt there was a good choice, although two patients said they would like more healthier food choices. Patients felt there was a good range of activities and psychology was easy to access. One patient told us the real work opportunity he had been able to take up was a genuine paid job and had given him a lot of skills to help him get employment when he left the hospital.
- Carers told us staff treated their relatives with respect and staff had kept them involved in their family members progress. One carer told us staff had been very supportive of them when they were going through a difficult time with their family member. Another carer felt communication with the hospital was good. However, one carer told us that sometimes there could be a delay with returned telephone calls, particularly if the key worker was on leave or not back on shift for a few days.

Good practice

The range of therapies and activities available to patients, was extensive and of high quality. Of note was: -

- Access to psychological therapy, including dialectical behaviour therapy, cognitive behavioural therapy, Schema therapy, Motivation to change, and Mindfulness. Psychological therapy was available once or twice weekly in one to one or group sessions as well as drop in sessions to supplement the structured therapy program available.
- “Construction therapy”. This was an innovative, age appropriate, and therapeutic use of a popular brand of building bricks. Requiring participants to take on the roles of designer, supplier and builder, to create a 3-dimensional object. The therapy was designed to develop a range of intra- and interpersonal skills such as communication, co-operation, problem solving and creativity.
- Staff had cross referenced care plans and interventions with evidence based practice guidelines.

Summary of findings

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that overarching governance and systems for recording and capturing supervision conversations are robust, and allow for accurate data collection and quality monitoring.
- The provider should ensure that all patients physical needs can be assessed and addressed, regardless of where the assessment needs to take place.
- The provider should ensure that the mandatory training compliance rates on Lancaster ward meet the agreed targets for the organisation.
- The provider should ensure that all staff have completed Mental Health Act and Mental Capacity Act training.

Priory Healthcare Group

Priory Hospital Lincolnshire

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Lancaster and Scampton Wards	Priory Hospital Lincolnshire

Mental Health Act responsibilities

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

- At the time of inspection there were 20 patients detained under the Mental Health Act.
- While staff compliance with Mental Health Act training was 56% on Lancaster ward and 75% on Scampton ward, and the providers expected target was 90%, there was no impact on practice.
- We reviewed 12 patients' care records and five sets of detention paperwork, and saw that staff informed patients of their rights regularly in a way patients could understand. Staff recorded these conversations in the daily care notes.
- Staff completed Mental Health Act 1983 documentation appropriately including Section 17 leave forms. There was a Mental Health Act administrator who monitored and supported the hospitals Mental Health Act functions.
- Second opinion appointed doctors assessed patients' ability to consent to treatment where appropriate and completed the necessary documentation.
- The provider had accessible copies of original Mental Health Act paperwork. The Mental Health Act administrator carried out regular audits to ensure that legal documentation was correct. Staff accessed the Mental Health Act administrator for additional information and support as needed.
- The provider ensured photographs of patients were on their medicine administration records as required by the Mental Health Act Code of Practice.
- Patients had access to independent mental health advocates.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff compliance with Mental Capacity Act training was 56% on Lancaster ward and 86% on Scampton ward, and the providers expected target was 90%, there was no impact on practice.
- Staff completed Mental Capacity Act assessments. Staff completed these on a time and on a decision specific basis. When patients lacked capacity to make decisions for themselves, staff held best interest decision meetings. These included all relevant people involved in the patient's care.
- There were no patients subject to Deprivation of Liberty Safeguarding.
- Staff demonstrated reasonable knowledge on the Mental Capacity Act. Capacity was assumed unless staff had reason to think otherwise. We saw evidence in care records that doctors assessed patient's capacity, when necessary.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

- Staff carried out regular environmental risk assessments of the care environment, including a daily walk about. In addition, staff carried out monthly quality reviews of health and safety around the hospital with the organisations health and safety advisor. Staff escalated any issues found during the walkabouts or reviews to the hospital manager and they also reported them to the monthly security meeting, and clinical governance group.
- Staff completed a comprehensive ligature audit and assessment, and staff mitigated the risks identified. Ligature anchor points are places where patients could tie something to with the intention of strangling themselves. Staff carried out ligature audits once month. Staff placed patients on different levels of observations as needed and depending on the risk they presented, to mitigate the risks found in the assessments.
- The ward layout, and actions taken to mitigate blind spots, allowed staff to see all parts of the ward. Staff carried personal alarms at all times.
- All areas of the hospital were clean and tidy, furniture was maintained to high standard, cleaning records were up to date and housekeeping staff cleaned the hospital daily.
- We saw staff adhering to infection control practices, for example, hand washing between tasks.
- The hospital was male only and therefore complied with same sex guidance. All patients had their own en-suite bedroom, and all bedrooms had patient call alarms.
- The provider had a purpose-built seclusion room located on Lancaster ward to serve both wards. The seclusion room complied with CQC guidance and the Mental Health Act code of practice.
- The provider had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean. Clean stickers were in date and visible where needed.

Safe staffing

- The provider used an agreed staffing ladder to decide staffing levels needed. They had six whole time equivalent nurses and 18 whole time equivalent healthcare support workers. In addition to this each ward had a charge nurse, and various members of the multidisciplinary team working with patients on the wards at various times throughout the day.
- Current vacancies included two qualified nurses and four healthcare support workers. While managers recruited to all vacant posts, agency and locum staff filled the vacancies.
- Managers used known, regular bank and agency staff when needed. All agency staff were used from an agreed provider list and had completed an induction. For the period July 2018 to November 2018, bank staff had filled 168 shifts, and agency staff filled a further 243 shifts. For the same period 31 shifts had not been covered. Managers explained this had not been a problem as patient numbers had been lower than expected.
- The hospital operated two twelve-hour shifts per day, and a 9am-5pm shift every day, on each ward. On Lancaster ward there were two nurses and four healthcare support workers during day shifts and two nurses and three healthcare support workers on night shifts. While Scampton ward had one qualified nurse and four healthcare support workers during day shifts and one qualified nurse and three healthcare support workers on night shift. We checked the duty rotas and saw that the provider maintained safe staffing levels. There was always one qualified staff nurse on shift.
- The provider had a sickness rate of 6.5%, and the staff turnover rate for the previous year was 12%. The total number of leavers in the last 12 months was five.
- Managers could adjust staffing levels to meet the needs of the patients. Staff and patients told us there were enough staff to carry out physical interventions, and staff informed us that if observation levels increased, managers could make extra staff available. We saw evidence of this on staff rotas.
- Staff kept a presence in communal areas. Staff spent time engaging with patients and eating meals with them.

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

- The provider rarely cancelled escorted leave. Patients and carers confirmed that there always seemed to be enough staff and leave was not cancelled due to short staffing.
- There was appropriate medical cover during the day and out of hours. The provider had an on-call rota for doctors who covered this service and other locations. However, following the recommendations of a recent incident investigation, managers were arranging their own on call doctor rota.
- Data provided at the time of inspection showed overall mandatory training compliance was 92% across the hospital. However, Lancaster wards compliance with mandatory training was significantly lower than Scampton ward. Specifically, Fire safety was 41% compared to 93% on Scampton ward; Infection control 29% compared to 87% on Scampton ward; Mental Health Act 56% compared to 75% on Scampton ward and Mental Capacity Act training at 56% compared to 85% on Scampton ward. We did not consider this a breach, because the providers overall training compliance was reasonable at 92%, however, the provider should address this discrepancy.

Assessing and managing risk to patients and staff

- We reviewed 12 patient risk assessments. Ten out of twelve risk assessments were fully complete. Two risk assessments were completed but the current risk section on the risk management plan had not been filled in. Staff had completed comprehensive and holistic risk assessments on all patients, on admission, and regularly updated these during patient review meetings or after an incident.
- Staff used recognised risk assessments including short term assessment of risk and treatability (START), historical clinical risk management 20 (HCR20), and risk management planning.
- While the risk of falls and pressure sores was low, staff were aware of the possibility and knew how to deal with any specific risk issues, if they occurred.
- The provider had policies and procedures for the use of observations. The provider used different levels of observations ranging from; general observations, intermittent observations and constant observations.
- The provider had a policy on searching patients. Staff had trained to use pat-down of patients after they came back from unescorted leave and staff searched patient's room if they had concerns.
- Restrictions on patients freedoms were only present where risk assessment indicated. Staff reviewed any restrictions placed on patients at regular MDT care planning meetings.
- Patients were encouraged to reduce or stop smoking and staff offered support and advice in the use of e-cigarettes and smoking substitutes.
- The provider had an in-date seclusion policy. For the period 01 February 2018 to 31 December 2018 there were three episodes of seclusion on Lancaster ward and five episodes on Scampton ward. Staff used seclusion appropriately and followed best practice when they did so. Staff kept records for seclusion in the correct manner.
- There was one episode of long term seclusion on Lancaster ward during this period, this was for three days. However, the provider admitted that during this episode of seclusion they had not been able to get an out of hours on call doctor to visit the patient within the correct timeframe. Staff had reported this as an incident, managers had investigated it and this had led to a proposed change in policy and practice in that Priory Hospital who now have their own on call doctor, rather than relying on the Priory groups shared on call doctor system.
- The provider had an in-date restraint policy and procedure. For the period 01 February 2018 to 31 December 2018 there had been five episodes of restraint on Lancaster ward and 3 for Scampton ward. Involving four different patients. There were no incidents of prone (face-down) restraint, and no incidents of rapid tranquilisation. Staff understood and worked within the Mental Capacity Act definition of restraint.
- Staff only restrained patients after de-escalation had failed. Staff received prevention and management of violence and aggression training and positive behaviour support training. through the providers training academy. Managers were involved in the providers reducing restrictive practice steering group, and had recently introduced the "safe wards" initiative as part of their prevention and management of violence and aggression training program. This emphasised the use of soft words, de-escalation and positive words to deal with challenging behaviour.
- Staff received safeguarding training. We reviewed the staff training records which showed staff compliance

Good

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

was 96% for safeguarding for vulnerable adults and 96% safeguarding children. Staff we spoke with knew how to raise a safeguarding concern, and to whom they should escalate the concern.

- There was a policy about children visiting the hospital and staff followed safe procedures when children visited.
- The provider used a secure electronic patient record system for their patient records. All information needed for patient care was available to all relevant staff, including agency staff when they needed it. This included when patients moved between wards or to other locations.
- Staff followed good practice in medicines management, and stored medication in locked cupboards within the clinic room.
- We reviewed 14 medication administration records and found staff completed these appropriately. We saw evidence to consent to treatment on all medication charts, all patients had any allergies recorded, and T2 and T3 matched the prescription charts including as and when medications.
- The provider used a local pharmacist for medication reconciliation. A pharmacist visited the ward once a month to check all medication and undertook audits of the medication.
- The provider had reported four medication errors between May 2018 and December 2018. Staff reported all incidents that should be reported, including near misses, and managers investigated them appropriately. Reports showed that managers had upheld their duty of candour to all affected parties where necessary.
- Staff discussed patient medication weekly in the multidisciplinary meetings. Staff also reviewed the effects of medication on patient's physical health regularly and in line with National Institute of Healthcare Excellence guidance, especially when doctors had prescribed patient's high doses of anti-psychotic medication.

Track record on safety

- The provider had reported ten serious incidents during the period 01 February 2018 and 31 December 2018. Two incidents related to medication errors. Four incidents related to patient assaults on staff resulting in injury. Four incidents related to safeguarding concerns. Staff recorded all incidents, and managers investigated them fully. There were clear recommendations following investigation.
- The provider made changes to the service based on learning from incidents. This included adopting the safe wards initiatives to improve patient and staff interaction, and enhancing staff training in de-escalation.

Reporting incidents and learning from when things go wrong

- Staff were aware of what an incident was and how to report them. The provider used an electronic recording system for incident reporting. Staff were open and transparent when reporting incidents.
- Staff received feedback from investigations of both internal and external incidents. The registered manager shared lessons learned in team meetings morning reviews and through a quarterly lesson learned newsletter. Managers made changes to practice and policy as needed, such as reviewing the seclusion room.
- Managers referred all serious incidents through the team incident review process. This process showed root causes and produced a report and action plan. Managers monitored action plans through the clinical governance group, until completion, and shared any learning with other hospitals in the Priory Hospitals organisation.
- Managers offered feedback and informal debriefs to staff after serious incidents. Both staff and managers told us communication involving incidents and the learning from them was good both up the line of communication and down. Staff informed us that managers also supported staff with incidents through supervision.
- The provider had a policy relating to duty of candour. Staff understood their responsibilities under the duty of candour, and the need to be open and honest with patients and their families. Duty of candour training was incorporated within safeguarding training and complaints and defensible documentation training. The organisation provided staff with training through their training academy.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

- We reviewed 12 care records. All records showed good practice in the areas reported below. Furthermore, staff had cross referenced all planned interventions with relevant evidence based practice and National Institute of Healthcare Excellence guidelines.
- Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Assessments included the patients physical emotional and mental health needs. Where indicated staff carried out specialist assessments such as the Wechsler Adult Intelligence Scale (WAIS); International Personality Disorder Examination (IPDE); and the Repeatable Battery for the Assessment of Neuropsychological Status, (RBANS).
- Staff carried out physical assessments of all patients on admission and updated these as needed. We saw evidence in care records of ongoing physical healthcare monitoring. However, one patient who had complained of blurred vision, had been waiting about four months for staff to arrange an optician's appointment for him. Although staff explained the reasons for the delay, the inspection team felt this delay was not acceptable. Before the inspection finished the nurse in charge told us that they had found an optician and the patient had an optician's appointment.
- Staff and patients developed evidence based care plans that met the needs found during assessment. This was achieved by using "My five green goals". A self-rated, positive behaviour support care plan, based on the following five objectives. Behaviours (green behaviours are no seclusions and no restraints; Therapies (attend and engage in all therapies); Medication (take all medication without prompting); Observations (maintain 60-minute observations); and Leave (use all my leave well). This ensured care plans were personalised, holistic and recovery-oriented.
- Staff updated care plans when necessary, and after every care plan review or incident.

Best practice in treatment and care

- Staff followed guidelines from the National Institute for Health and Care Excellence for prescribing medication.
- The provider offered psychological therapies recommended by the National Institute for Health and Care Excellence. Access to psychological therapy was readily available and the range of therapy offered was extensive and of high quality. Interventions included groups using a cognitive behavioural approach, and Mindfulness. One to one sessions including Schema therapy, Motivation to change, dialectical behaviour skills, and Life minus violence. Psychoeducational work and psychology drop in clinics.
- Occupational therapists provided a range of therapeutic and recovery focussed activities that were available during the week and at weekends. Of note was the "construction therapy". This was an innovative, age appropriate, and therapeutic use of a popular brand of building bricks. Requiring participants to take on the roles of designer, supplier and builder, to create a 3-dimensional object. The therapy was designed to develop a range of intra- and interpersonal skills such as communication, co-operation, problem solving and creativity.
- The provider offered patients paid "real work opportunities", such as groundsman assistants, janitors, ward ambassadors, and kitchen help. These were jobs provided within the hospital which patients applied for through an interview process. Other patients told us of volunteering opportunities that staff had supported them to take up in the community as part of their recovery and discharge planning.
- Staff supported patients to live healthier lives through smoking cessation programmes, physical health screening, and healthy eating advice. Through these programmes staff had recognised that some patients body mass index (BMI) had risen significantly in the previous twelve months. Following investigation, and in conjunction with the dietician, patients and staff had reviewed the daily menus and snacks to reduce saturated fats and unhealthy carbohydrates and introduce more fruit and vegetables. Staff offered patients healthy eating advice, weight management plans and encouraged patients to buy healthy snacks.
- The provider used a range of rating scales and outcome measures to monitor patient progress, including Health of the Nations Outcome Scales to monitor patients' progress.
- The provider was active in the Quality Network for Forensic Mental Health. The provider had just completed a health and safety peer review of their service. They had rated themselves as good overall and

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

found the following areas for improvement. Potholes in the driveway and car park needed repair. We saw that managers had made progress to address the issue and had arranged quotes for the work to be completed.

- Staff took part in clinical audits including: environmental risk assessment, medication and medical equipment audits, infection control and mattress audits, Mental Health Act safety audits, and peer review audits across the organisation. Staff monitored all action plans arising from audits through the providers monthly service development and clinical governance meetings.

Skilled staff to deliver care

- The provider employed a full range of disciplines. These included; mental health nurses, healthcare support workers, recovery workers, a social worker, occupational therapists, registered general nurse, consultant psychiatrist, forensic psychologist, assistant psychologist, dietician, administrative and support services staff.
- Staff had the necessary experience and qualifications to perform their roles and meet the needs of the patient group. Staff including agency and locum staff received an induction prior to starting work on the wards. Induction included mandatory training for substantive staff. Where managers employed agency and locum staff their mandatory training was checked with the relevant agencies before starting work on the wards.
- Managers ensured staff had access to regular team meetings and daily handovers.
- We could not be sure of the providers compliance rate for supervision, or the quality of the staff supervision provided. Although, staff told us they had frequent, good quality supervision that allowed them to feel confident in their jobs.
- Supervision recording was not consistent and supervision records were not readily available. While the electronic monitoring record, submitted at the time of inspection, showed Lancaster ward had 74% compliance for supervision and Scampton ward 89%, with 97% compliance across the hospital for appraisal. Staff did not think the electronic data was correct. Staff believed their supervision compliance rates to be around 95%, and appraisal at 100%. However, prior to inspection, the registered manager had identified this as a problem and had started to put in place systems to ensure supervision records were recorded and stored appropriately.
- Managers identified staff training needs through the supervision process, and when identified staff received the necessary and specialist training for their role. Staff had undertaken RAID (reinforce appropriate, implode disruptive) behaviour management training and positive behaviour support training. The training informed staff of de-escalation techniques to support patients displaying challenging behaviour and reduce the use of restraint.
- We saw evidence of managers having addressed poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team worked well together to provide cohesive treatment and care for patients. Managers held regular multi-disciplinary meetings, including daily team meetings, and weekly care reviews. We attended a multidisciplinary care plan review meeting. Members of most disciplines attended this meeting and staff discussed patients, significant events and serious incidents. Staff also discussed patients leave, how patients wanted to use their leave, and how this would be facilitated.
- Staff conducted a handover at the end of each shift. Staff shared information gathered during handovers in the early morning review. Staff recorded and stored this information on the wards as a live document. This enabled staff who had not been able to be at the morning meeting, to check the information in context.
- Managers encouraged staff to attend monthly facilitated reflective practice groups. These sessions enabled staff to share their clinical experiences with each other to gain knowledge and insight and increase understanding and confidence to improve the quality of care for patients.
- The provider had effective working relationships both inside and outside of the organisation. The provider shared the minutes of meetings with necessary agencies and felt that they had good relationships with teams such as local businesses and the local safeguarding team.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

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

- At the time of inspection there were 20 patients detained under the Mental Health Act.
- Staff compliance with Mental Health Act training was 56% on Lancaster ward and 75% on Scampton ward the providers expected target was 90%.
- We reviewed 12 patients' care records and five sets of detention paperwork, and saw that staff informed patients of their rights regularly in a way patients could understand. Staff recorded these conversations in the daily care notes.
- Staff completed Mental Health Act 1983 documentation appropriately including Section 17 leave forms.
- Second opinion appointed doctors assessed patients' ability to consent to treatment where appropriate and completed the necessary documentation.
- The provider had accessible copies of original Mental Health Act paperwork. The Mental Health Act administrator carried out regular audits to ensure that legal documentation was correct. Staff accessed the Mental Health Act administrator for additional information and support as needed.
- The provider ensured photographs of patients were on their medicine administration records as required by the Mental Health Act Code of Practice.
- Patients had access to independent mental health advocates.

Good practice in applying the Mental Capacity Act

- Staff compliance with Mental Capacity Act training was 56% on Lancaster ward and 86% on Scampton ward. The providers expected target was 90%.
- Staff completed Mental Capacity Act assessments. Staff completed these on a time and on a decision specific basis. When patients lacked capacity to make decisions for themselves, staff held best interest decision meetings. These included all relevant people involved in the patient's care.
- There were no patients subject to Deprivation of Liberty Safeguards.
- Staff demonstrated reasonable knowledge on the Mental Capacity Act. Capacity was assumed unless staff had reason to think otherwise. Doctors normally assessed patient's capacity, when necessary.
- Staff made deprivation of liberty safeguards applications when needed and checked the progress of applications to supervisory bodies.
- The Mental Health Act administrator monitored the services adherence to the Mental Capacity Act code of practice, and was available to offer staff extra support and advice if needed.
- Staff regularly checked that the application of the Mental Capacity Act was correct for patients and acted on any learning that resulted from it.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- We spoke with nine patients and two carers. We saw staff to be kind and caring towards patients. Staff interacted with patients well particularly during group work and used appropriate communication tools, including diagrams to convey complicated and abstract ideas and coping strategies.
- Patients informed us that staff were kind, helpful and treated them well.
- Staff understood the individual needs of patients and supported patients with those needs.
- Staff supported patients to understand and manage their care, treatment or mental health condition. Staff directed patients to other services when appropriate and, if needed, supported them to access those services.
- Staff said they could raise concerns about disrespectful, discriminatory, or abusive behaviour or attitudes towards patients without fear of the consequences. Staff maintained the confidentiality of information about patients.

The involvement of people in the care that they receive

- Staff orientated patients to the ward when they first arrived. Patients we spoke to were familiar with the ward, the staff and the daily routines.
- Patients were involved in the planning of their care. We reviewed 12 care records. Staff ensured care plans were personalised, holistic and included patient views and included the patient voice. Patients regularly attended care review meetings and staff gave them copies of their care plan if they wanted one.
- Patients had access to advocacy, both independent mental health advocates and independent mental capacity advocates. We spoke to the advocate during our inspection. The advocate informed us that they supported clients with understanding their rights, attending meetings, debriefs and expressing their concerns or raising complaints. The advocate spoke highly of the care and treatment they had seen.
- Patients could give feedback on the service they received through the patient forum or during mealtimes, when staff sat with them to eat together.
- We spoke with two carers. Both carers felt involved in their relatives' care and were happy with the support and communication they received from staff and managers.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Our findings

Access and discharge

- The provider had a bed occupancy rate of 60% between 1 February 2018 and 31 July 2018. The provider admitted patients nationally so there were no out of area placements.
- Staff did not admit to patient's beds whilst they were away on leave. Staff did not move patients from one ward to the other unless on clinical grounds and only when it was in the best interest of the patient.
- Staff planned patient discharges, so they happened during the daytime. Staff involved patients, relatives, carers, advocates and future care providers in discharge planning.
- The provider informed us that there were two delayed discharges both due to there not being an appropriate step-down facility available.
- Staff supported patients when discharged including good liaison with care managers and care co-ordinators.

The facilities promote recovery, comfort, dignity and confidentiality

- Staff and patients had a range of rooms and equipment to support care and treatment. These included; a clinic room with an examination couch, activity rooms, lounges, a gym and quiet rooms to meet visitors in private.
- Patients had access to the extensive woodland grounds surrounding the hospital. Patients could use mobile phones and had access to the portable office phone if they needed to make calls in private.
- Kitchen staff provided freshly cooked meals and could cater for patients with religious, cultural and special dietary requirements. Patients informed us the food was good and they had plenty of choice.
- Patients had access to drinks and snacks throughout the day. Snacks and water were readily available on the wards. Patients could use the kitchen servery for hot drinks.
- Patients had their own bedrooms and lockable cupboards in their rooms, they could also give valuable items to staff for safe keeping. Patients could personalise their rooms.
- Patients had access to a wide range of activities designed to promote recovery. The occupational therapy team provided activities five days a week. The nursing team provided weekend activities.
- Patients had access to paid real work opportunities within the hospital and grounds and subject to risk assessment and leave entitlement patients could access voluntary work placements in the local area.
- When leave arrangements allowed, staff encouraged patients to use the community facilities nearby. Although the surrounding area was rural there was a bus stop at the end of the road with buses to nearby towns. The hospital also had its own unmarked 7 seat people carrier that staff used to take patients to places where public transport was not available or leave was time limited.
- Staff supported patients to keep contact with their family and friends. Staff encouraged patients to develop and keep new relationships both within the hospital and the wider community.

Meeting the needs of all people who use the service

- The service had made adjustments for patients who had disabilities, by ensuring disabled people's access to the building, visiting areas and ward areas were on the ground floor, and wheelchair accessible. Staff informed us they could access sign language and other language interpreters if needed.
- We saw information in the communal ward areas relating to treatments, local services, patients' rights, how to make a complaint and how to access advocacy.
- Although we did not see any information leaflets in other languages, staff informed us all information leaflets were available in other languages using their digital software. We saw care plans and daily activity schedules in large print, easy read and picture formats.
- Patients had personal evacuation plans for emergencies. Staff we spoke with knew what the evacuation plans were for the areas they were working in.

Listening to and learning from concerns and complaints

- The provider reported nine complaints in the 12 months leading up to inspection, involving five separate complainants, while none of these complaints were fully upheld, several of the complaints had multiple

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elements. For example, one complaint included 29 elements, and of these 21 elements were not upheld, four were partially upheld and four were found not applicable to this service. We saw evidence that managers had investigated all complaints and sent letters to the complainants explaining the rationale for their decisions.

- Evidence in the complaints folder showed that where managers had identified lessons learned from complaints they had produced dated action plans to make improvements to their service. None of the complaints had been referred to the Parliamentary and Health Service Ombudsman.
- Patients and carers knew how to make complaints. The provider displayed improvements on the ward under the 'you said, we did programme'. One carer we spoke with also mentioned that the provider had dealt with concerns raised by a patient quickly.
- Staff knew how to handle complaints appropriately and detailed that they would escalate this to their line managers.
- Staff received feedback on the outcome of complaints and worked to improve on any issues found. Staff discussed complaints during morning review and team meetings. Managers shared lessons learned through their clinical governance meetings.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

- The providers vision was based on: Putting people first; Being a family; Acting with integrity; and Striving for excellence. Staff knew and understood the provider's vision and values and applied this in the work of their team.
- The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service. Managers had reinforced the vision and values through a series of initiatives, including team building, and adoption of safe wards strategies, specifically, "clear mutual expectations for staff and patients" and "knowing each other".
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing. The provider held regular staff "your say forums", and managers had introduced a "solution box". Managers wanted to encourage staff to highlight an area for improvement and put forward their suggestions for addressing the issue. Managers rewarded staff with gift vouchers for all the ideas adopted by the hospital.
- Staff could explain how they were working to deliver high quality care within the budgets available.
- Managers used the hospitals vision and values as the basis for their interview questions and reinforced the vision and values at staff away days.
- Managers had incorporated the vision and values into the new Care Certificate workbooks for all healthcare support staff.

Good governance

- There were systems and procedures to ensure that wards were safe and clean. Managers were carrying out regular environmental walk about and audits and acting when needed.
- The provider had a formula for establishing staffing numbers, that was based on patients' needs and complexity. Staff and patients confirmed there were enough staff to meet all the patient and clinical needs. Staffing rosters confirmed that the number of staff on shift matched the establishment.
- The service adhered to the requirements of the Mental Health Act (MHA) and Mental Capacity Act (MCA). Mental Health Act administrators were knowledgeable and experienced, and offered staff advice and support as needed.
- Bed management and discharges were planned and well managed. Although bed occupancy, at 60%, was low. Managers felt this was necessary given the complexity of patients now admitted. They had also recognised that only recently had they secured a stable work force, some of whom were still undertaking orientation and training.
- There were robust systems in place for reporting and recording incidents. We saw evidence that managers had investigated all incidents, and acted on any lessons learned through action plans and monitored by a clinical governance group.
- Although overall mandatory training was 92%, on Lancaster ward mandatory training compliance was significantly lower in some of the mandatory training courses. We did we see convincing evidence that staff had addressed this effectively.
- Staff supervision processes were not robust. Processes for recording and monitoring supervision were not consistent, and supervision and appraisal records were difficult to find with some records appearing to be lost. However, the registered manager had already identified this as an issue and begun to address it by providing individual staff folders for copies all supervision records. This system was intended to run alongside the electronic recording of supervision dates. These records were to be stored in the administration office and would be audited to ensure quality consistency and accuracy.
- There was a clear framework of what must be discussed at a ward, team or directorate level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at service level.
- Staff took part in local clinical audits and acted on the results when needed.
- Staff understood the arrangements for working with other teams, both within and external to the service, to meet the needs of the patients.

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- Staff maintained and had access to the risk register at local and organisational level. Staff at ward level could escalate concerns when needed. Staff concerns matched those on the risk register.
- The service had plans for emergencies such as generator break down, adverse weather, or a flu outbreak.
- Where cost improvements were taking place, they did not compromise patient care. The service used systems to collect data from wards 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. The provider had recently invested in upgrading the network for the hospital in response to staff concerns that the previous network was unreliable.
- Information governance systems included confidentiality of patient records.
- Managers had access to information to support them with their management role, including information on the performance of the service, staffing and patient care. This information was in an accessible format, was correct and showed areas for improvement.
- Staff made notifications to external bodies as needed, including local safeguarding teams and CQC.

Leadership, morale and staff engagement

- Leaders had the skills, knowledge and experience to perform their roles. The provider offered leadership training through their learning academy. Managers encouraged staff to take up secondment and acting up positions to develop leadership skills and understanding of a leadership role within the Priory hospital group.
- Leaders had a good understanding of the services they managed. They could explain how the teams were working to provide high quality care.
- In the previous two months the provider had implemented a successful recruitment drive for permanent staff, and improved staff engagement had reduced the number of staff leavers.
- Leaders were visible in the service and approachable for patients and staff.
- Staff felt respected, supported and valued. Managers had introduced staff wellbeing sessions, providing relaxation training and complimentary therapies, during work hours. Pre-arranged flexible working hours allowed staff a better work life balance.
- Staff felt positive and proud about working for the provider and their team. A recent staff survey highlighted the following areas which had improved. Staff feedback recognised; management and staff engagement; staff recognition for high performance; opportunities for promotion; and focus on staff wellbeing.
- Staff felt able to raise concerns without fear of retribution, and they knew how to use the whistle-blowing process, most staff we spoke with also knew about the role of the Speak Up Guardian, and the providers 24/7 free hotline for whistleblowing.
- Managers dealt with poor staff performance when needed. Teams worked well together and when there were difficulties managers dealt with them appropriately.
- Staff reported that the provider promoted equality and diversity within the hospital and there were opportunities for career progression. We saw how the hospital celebrated black history month, mental health awareness day, international day of people with learning disability, and world aids day. The hospital had lesbian, gay, bi-sexual and transgender champions who supported both patients and staff in their choices of diversity.
- Data provided by managers showed that between September 2018 and December 2018 staff sickness rate was averaging 3%, while prior to this the average sickness rate had been 6.5%. The service's staff sickness and absence rates were now similar to the average for the provider.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Although we did not see evidence in those supervision records we were able to review, staff told us their appraisals included conversations about career development and how their plans would be supported.
- The provider recognised staff success within the service through employee recognition events such as,

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employee of the month, team of the quarter, employee of the year and team of the year. In addition to this, highly performing employees were nominated for the Priory's national staff awards.

- Staff, patients, and carers had access to up-to-date information about the work of the provider and the services they used – for example, through the intranet, bulletins, and newsletters.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs. Examples included, on line feedback, comments boxes, ward meetings and feedback surveys.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.
- Patients and carers were involved in decision-making about changes to the service.
- Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback. Directorate leaders engaged with external stakeholders – such as commissioners and Healthwatch.

Commitment to quality improvement and innovation

- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.
- Staff had opportunities to take part in research, and innovations were taking place in the service.
- Staff used quality improvement methods and knew how to apply them. Staff took part in national audits relevant to the service and learned from them.
- Wards took part in accreditation schemes relevant to the service and learned from them. Schemes included Quality Network for Forensic Mental Health services annual review.