Nightingale Hospital

Quality Report

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Date of inspection visit: 21-23 February 2017
Date of publication: 21/06/2017

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated the Nightingale Hospital as **requires improvement** overall because:

- We previously inspected the Nightingale Hospital in October 2015. At this inspection we found that the requirements from the inspection in October 2015 had been mostly met and improvements had been made.
- However, some of the previous requirements from the inspection in October 2015 had been partly met and where needed, ongoing requirement notices have remained in place.
- In October 2015, the provider had not addressed risks from ligature anchor points as part of its environmental risk assessment. Clear timescales were not available to remove ligature anchor points. At this inspection, building works to remove ligature anchor points had started and this work was due to be completed by December 2017, so some wards, including two acute wards, still had ligature anchor points in place. Each ward had a ligature risk assessment, but during the inspection these documents could not be found on some wards and staff could not clearly articulate how they minimise risks from ligature points and keep patients safe.
- In October 2015, the provider was not ensuring that when rapid tranquilisation was administered, physical health checks were carried out and recorded. At this inspection we found that while rapid tranquilisation was used very rarely this recording still needed to improve.

There was an outstanding recommendation from the inspection in October 2015, which was now a requirement from this inspection:

- In October 2015, the wards did not have wall-based fixed alarms and staff did not have personal alarms. At this inspection we found staff did not have access to an effective alarm system in all of the wards to alert other staff that they needed urgent assistance.

During this inspection we also found that:

- Supervision levels and appraisal rates in all the services were not adequate..
- Allegations of abuse were not routinely being notified to the Care Quality Commission.
- Staff were not receiving specialist training to support them to be able to deliver effective care to patients on the CAMHS ward or the substance misuse and detoxification ward.
- Children safeguarding training completion rates were low across the hospital and not all staff working on the CAMHS unit had received children's safeguarding training.
- Staff were not completing appropriate assessments on the substance misuse and detoxification ward and withdrawal and rating scales were not routinely used.
- In the substance misuse and detoxification ward, the service did not always inform the patient's GP that the patient had been admitted and to corroborate the patient's medical history, and staff did not routinely ask patients about the safety of children they cared for.
- Staff did not always know the whereabouts of patients as patients had access to a number of areas throughout the hospital, even when they were potentially at risk of harming themselves or others.
- Systems were not in place to ensure all clinical staff had the opportunity to learn from incidents. Following the inspection in October 2015, the service no longer graded incidents.
- The service did not implement the actions required as evidenced by its infection control audit in 2016.
- Young people in the CAMHS unit did not have daily regular access to fresh air.
- Young people were being asked to sign a document giving their consent to being restrained in the event of them having violent behaviour. This did not reflect their individual needs.

However we also found areas where the care provided was very positive:

- The service delivered individualised care plans according to patients' needs and patients spoke highly of the care and treatment from nursing staff and therapists.
- Patients had access to a large range of rooms and equipment to support their treatment and therapy.
- The service offered a range of psychological therapies and a dietician had input into the wards.
- Morale was high and the staff group felt supported by their peers and their manager.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	**Requires improvement** 	• Staff did not all understand the ligature risks on their ward and could not explain how these would be mitigated. Ligature work was still taking place and would not be complete until December 2017. • In October 2015, we asked the provider to ensure that when rapid tranquilisation is administered, physical health checks are carried out and recorded. At this inspection we found an instance of rapid tranquilisation where this was not done adequately. • In October 2015, we found that wards did not have wall-based fixed alarms and staff did not have personal alarms. At this inspection we found that an effective system for staff to alert other staff that they needed urgent assistance was still not in place. • We found that the level of supervision and appraisal in all the services was not adequate. • We found that staff did not always know the whereabouts of patients within the hospital who could be at risk of harming themselves or others. • We found that most staff could not describe the learning from incidents. Since the inspection in October 2015, the service did not grade incidents. Also, incidents of young people admitted to an adult ward were not being correctly reported to the local authority. • Allegations of abuse were not routinely being notified to the Care Quality Commission. • Patient records did not include a discharge plan. • Some capacity assessments were not being appropriately recorded. However: • Each patient had an individualised care treatment plan which included access to group therapy and one to one sessions.

Summary of findings

- Patients spoke highly of the care and treatment from nursing staff and therapists.
- Patients had access to a large range of rooms and equipment to support their treatment and therapy.
- In October 2015, we found that the provider was not compliant with same sex accommodation guidance. At this inspection we found that the provider was grouping bedrooms according to gender and was trying to keep two different wards single sex only.
- In October 2015, we found that the provider was not auditing and recording incidents of restraint adequately. At this inspection we found that the provider had amended its incident sheet and that restraints were adequately recorded according to hold, staff, positions on body and length of time.
- In October 2015, we found that the provider was not ensuring daily checks to emergency equipment were recorded and monitored regularly. At this inspection we found that all the emergency equipment was checked and monitored regularly and that there was a system in place for doing so.

Child and adolescent mental health wards

Requires improvement

- Staff had not identified all ligature risks in the environment risk assessment.
- Not all staff working on the unit received specialist training in working with young people or young people with an eating disorder.
- There was no outdoor space within the ward and patients lacked opportunity to go outside regularly on a daily basis.
- The provider did not ensure the regular supervision of nursing staff and did not have an action plan to ensure that supervision was taking place regularly.
- The provider could not verify that all staff working with children and adolescents had received safeguarding training.
- Feedback from incidents did not consistently reach all clinical staff.
- A written contract was in place which was signed by the young people saying that in the

Summary of findings

event of challenging behaviour they agreed to the use of restraint. This was a blanket approach and did not reflect the individual needs or wishes of the young person.

However:

- In October 2015, we found occasions where the provider was not sharing child safeguarding concerns with external social services agencies. At this inspection we found that the provider was sharing safeguarding concerns with social services.
- Staff assessed risks for each patient on admission and updated this regularly.
- Staff completed detailed and personalised assessments for each patient and updated these regularly.
- The service offered a range of psychological therapies and a dietician had input into the ward.
- Patients gave positive feedback about staff and we observed supportive and caring interactions between staff and patients.
- The service had clear admission and exclusion criteria and a care pathway for people accessing the service.
- Morale was high and the staff group felt supported by their peers and their manager.

Substance misuse/ detoxification

We found the following areas of concern:

- The service did not provide staff with regular supervision or appraisal.
- Concerns about staff performance were not addressed.
- The staff used a generic assessment form which meant they did not have detailed information about the patient's history of drug or alcohol use.
- The service did not routinely test patients for blood borne viruses.
- The service was not consistent in its use of rating scales to measure the severity of withdrawal.

Summary of findings

- The service did not always inform the patient's GP that the patient had been admitted and to corroborate the patient's medical history.
- Staff did not routinely ask patients about the safety of children they cared for.
- Adrenaline was not stored on the ward to use in a medical emergency.
- The service did not have an adequate system in place for staff to alert other staff that they needed urgent assistance.
- The staff team did not have team meetings.

However:

- The service was provided in a clean, quiet and well-presented environment.
- Staff were caring towards patients and responsive to their needs.
- Patients spoke positively about their experiences of care and treatment on the ward.

Summary of findings

Contents

Requires improvement

Nightingale Hospital

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Substance misuse/detoxification;

Summary of this inspection

Background to Nightingale Hospital

Nightingale Hospital is an independent hospital that provides mental health care and treatment for informal patients and patients detained under the Mental Health Act 1983. The hospital offers general psychiatry, eating disorder and addiction treatment for adults and general psychiatry and eating disorder treatment to young people (adolescents), as well as outpatient services.

The service has three acute wards for adults of working age, one child and adolescent mental health ward, one substance misuse and detoxification ward and a specialist eating disorder service for adults. All wards are mixed sex accommodation, except for two acute wards. The hospital has 80 beds over the six wards.

The ground floor ward is an 11 bed acute ward for adults of working age. The first floor has an 11 bed acute ward for adults of working age and a six bed adult ward for specialist eating disorders. The second floor has a 17 bed acute ward for adults of working age. The third and fourth floors are a 16 bed substance misuse and detoxification ward for adults. There is also a 12 bed children and adolescent mental health ward.

There are over 55 consultant psychiatrists who have practicing privileges at the Nightingale Hospital. This means that they can admit their patients who they see in the community, for an in-patient bed and remain their consultant while the patients are on the ward.

We have inspected the Nightingale Hospital four times since December 2011 and published reports of these inspections between January 2012 and July 2016.

Our inspection team

The team that inspected the Nightingale Hospital comprised of 12 people. This included one CQC inspection manager, three CQC inspectors, one CQC assistant inspector, one CQC medicines management expert, and specialist advisors consisting of a consultant psychiatrist, three nurses, and one expert by experience. The expert by experience had expertise in relation to health services through using them.

Why we carried out this inspection

We undertook this inspection to find out whether the Nightingale Hospital had made improvements to their acute wards for adults of working age and children and adolescent mental health (CAMHS) ward since our last comprehensive inspection of the service that we undertook in October 2015, where we rated the service as good overall.

When we inspected the service in October 2015, we rated acute wards for adults of working age as good overall. We rated this core service as requires improvement for safe, good for effective, good for caring, good for responsive and good for well-led. We inspected but did not rate the CAMHS ward. We did not inspect the substance misuse and detoxification or the specialist eating disorder ward as stand-alone services.

Following the October 2015 inspection, we told the provider it must make the following actions to improve acute wards for adults of working age:

- The provider must share child safeguarding concerns with external social services agencies.
- The provider must ensure they are compliant with mixed sex accommodation guidance.
- The provider must ensure works needed to address ligature risks have a completion date.
- The provider must appropriately audit and record all incidents of restraint.
- The provider must ensure that when rapid tranquilisation is administered, physical health checks are carried out and recorded.
- The provider must ensure daily checks to emergency equipment are recorded and monitored regularly.

Summary of this inspection

We issued the provider with requirement notices at the previous inspection. These related to the following regulations under the Health and Social Care Act (Regulated Activities) 2014.

Regulation 10 Dignity and respect

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding service users from abuse and improper treatment.

Regulation 17 Good governance

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 visiting, we reviewed a range of information we hold about the Nightingale Hospital. We carried out a short notice announced visit between the 21-23 February 2017.

We looked at information provided to us on site and requested additional information from the provider both immediately before and following the inspection visit relating to the services.

We also made a number of recommendations at the last inspection which is where we think the provider should take actions to improve services. We followed up those recommendations at this inspection.

We visited the specialist eating disorder ward, however there was insufficient evidence to report on this service.

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 17 patients who were using the service
- spoke with managers for each of the wards
- spoke with 44 other staff members; including doctors, nurses, occupational therapist, psychologist, the pharmacist and domestic staff
- attended and observed four hand-over meetings and two multi-disciplinary meetings
- looked at 30 care and treatment records of patients
- reviewed 52 patient medication charts
- carried out a specific check of the medication management on all of the wards
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

The patients we spoke with during this inspection gave positive feedback about their stay at the Nightingale Hospital. They told us that they got on well with the staff who were supportive. Patients told us that the environment was comfortable and clean and that the therapies on offer had a positive impact on their recovery.

The comments from the patient satisfaction survey between July 2016 and October 2016 were positive. Patients complemented the professionalism and approachability of staff, and patients found the substantive staff, including the housekeeping staff, as caring and attentive. Patients also found the therapy groups made a positive contribution to their recovery. However patients complained of staff on the substance misuse and detoxification ward using the communal lounge as a handover room, so that they could not use it during those times. Patients also said that the hospital should have recycling facilities available.

On the substance misuse and detoxification ward, patients said that staff had managed the symptoms of their withdrawal well and that they had felt safe throughout the process.

However some patients told us that they wanted more one to one therapies and that the wireless internet

connection in the building was poor. Some patients said that the agency staff sometimes did not engage positively with them. Young people in the CAMHS ward said that they would like the opportunity to have more frequent access to fresh air and outside space.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

In October 2015, we rated the acute wards for adults of working age as requires improvement for safe. We inspected, but did not rate, the children and adolescent ward. We did not inspect the substance misuse and detoxification ward. At this inspection, we rated acute wards for adults of working age as requires improvement for safe. We rated the children and adolescent ward as requires improvement for safe. We inspected, but did not rate, the substance misuse and detoxification ward.

We rated safe as **requires improvement** because:

- In October 2015, we asked the provider to ensure that when rapid tranquilisation is administered, physical health checks are carried out and recorded. At this inspection we found that rapid tranquilisation was happening very rarely but for one incident the physical health checks had not been adequately recorded.
- In October 2015, we found that wards did not have wall-based fixed alarms and staff did not have personal alarms across all the wards. At this inspection we found that an effective system for staff to alert other staff that they needed urgent assistance had still not been put into place (except in the CAMHS service).
- In October 2015, we found that staff knew how to report an incident but were not able to identify examples of learning from incidents. At this inspection some staff we spoke to could not give examples of learning from incidents.
- In October 2015, the provider had not addressed risks from ligature anchor points as part of its environmental risk assessment. Clear timescales were not available to remove ligature anchor points. At this inspection, building works to remove ligature anchor points had started and this work was due to be completed by December 2017, so some wards, including two acute wards, still had ligature anchor points in place. Each ward had a ligature risk assessment, but during the inspection these documents could not be found on some wards and staff could not clearly articulate how they minimised risks from ligature anchor points and keep patients safe.
- Child safeguarding training across the hospital was completed by 58% of staff and on the CAMHS ward, the provider could not ensure that all staff in contact with children had completed the child safeguarding training.
- The provider had completed an infection control audit for 2016, but had not implemented changes necessary to mitigate the risks the audit highlighted.

Summary of this inspection

- The provider was not routinely sending in notifications to the Care Quality Commission regarding allegations of abuse that they were aware of.
- Staff did not always know where the patients were in the hospital which was a potential risk for patients who might harm themselves or other people.
- Young people were being asked to sign a document giving their consent to being restrained if they had disturbed or violent behaviour. This was a blanket approach that did not reflect the individual needs of each young person.

However:

- In October 2015, we found that the provider was not sharing safeguarding concerns with external social services agencies. At this inspection we found that the provider was sharing safeguarding concerns with social services.
- In October 2015, we found that the provider was not compliant with same sex accommodation guidance. At this inspection we found that the provider was grouping bedrooms according to gender and was working at keeping two wards single sex only.
- In October 2015, we found that the provider was not auditing and recording incidents of restraint adequately. At this inspection we found that the provider had amended the incident recording form and restraints were adequately recorded.
- In October 2015, we found that the provider was not ensuring daily checks to emergency equipment were recorded and monitored regularly. At this inspection we found that all the emergency equipment was checked and monitored regularly and that there was a system in place for doing so.
- In October 2015, we found that formalised risk assessment documents relating to patients' safety with an overview of all updated risks were not accessible in one place. In this inspection we found that risk assessments were completed, holistic, and easy to find.

Are services effective?

Requires improvement

In October 2015, we rated the acute wards for adults of working age as good for effective. We inspected, but did not rate, the children and adolescent ward. We did not inspect the substance misuse and detoxification ward. At this inspection, we rated acute wards for adults of working age as requires improvement for effective. We rated the children and adolescent ward as requires improvement for effective. We inspected, but did not rate, the substance misuse and detoxification ward.

We rated effective as **requires improvement** because:

Summary of this inspection

- In the supervision records of 61 nursing staff, 30 had not received supervision in 2016, and 12 had received supervision once. Some of the supervision notes we saw were very brief and did not provide any indication that supervisors assessed the staff members' competencies. On the substance misuse and detoxification ward, some staff had not received annual appraisals.
- In October 2015, we found that most staff did not receive specialist training in addition to mandatory training. At this inspection we found that most staff on the CAMHS unit and the substance misuse and detoxification ward did not have specialist training necessary for treating these groups of patients.
- On the substance misuse and detoxification ward, staff did not use withdrawal rating scales consistently. Staff used a generic assessment form which meant they did not have detailed information about the patient's history of drug or alcohol use. The service did not routinely test patients for blood borne viruses. On the substance misuse and detoxification ward, the staff did not always inform the patient's GP that the patient had been admitted and to corroborate the patient's medical history. There was no adrenaline in the emergency medicines for patients. The service did not ensure that any risks to children cared for by patients were identified when patients were admitted.
- Staff did not always complete mental capacity assessments comprehensively.

However:

- Staff assessed patients comprehensively on admission in an MDT assessment which included the use of an assessment booklet.
- Patients on wards had access to group therapy programmes and one to one sessions that catered to their needs, and a dietician had input onto the wards.
- Patients had access to specialist physical health treatment for physical health problems.
- In October 2015, we found that the MDT meetings were not taking place. At this inspection we found that there were MDT meetings on the children and adolescent mental health (CAMHS) ward. On the acute wards and substance misuse and detoxification ward we found that the calibre of the handover notes was sufficient to give all staff the necessary information from the different disciplines concerning patients' care.
- Staff on the CAMHS unit could contact a consultant psychiatrist at all times.

Summary of this inspection

Are services caring?

Good

In October 2015, we rated the acute wards for adults of working age as good for caring. We inspected, but did not rate, the children and adolescent ward. We did not inspect the substance misuse and detoxification ward. At this inspection, we rated acute wards for adults of working age as good for caring. We rated the CAMHS ward as good for caring. We inspected, but did not rate, the substance and detoxification ward.

We rated caring as **good** because:

- In October 2015, patients on the CAMHS ward said that some staff did not respect their privacy. During this inspection, we found that patients on the CAMHS ward said that staff respected their privacy.
- We observed positive interactions on wards between staff and patients and patients spoke highly of care and treatment from staff.
- Patients had access to an independent advocate.

However:

- Some patients said that sometimes the agency staff did not engage in a positive way.

Are services responsive?

Good

In October 2015, we rated the acute wards for adults of working age as good for responsive. We inspected, but did not rate, the children and adolescent ward. We did not inspect the substance misuse and detoxification ward. At this inspection, we rated acute wards for adults of working age as good for responsive. We rated the CAMHS ward as good for responsive. We inspected, but did not rate, the substance misuse and detoxification ward.

We rated responsive as **good** because:

- In October 2015, the provider did not have a dedicated multi faith room within the wards. At this inspection, patients spoke highly of the access to spiritual support, although there still was no dedicated multi faith room.
- In October 2015, staff were unable to tell us the number of complaints that occurred on each ward. At this inspection the provider had monitored and analysed the trends in complaints and staff said that they received feedback from the senior management team on complaints.
- In October 2015, we found that the provider did not provide patients with a dedicated quiet area on wards. At this inspection, we found that patients had access to dedicated quiet areas on the wards.

Summary of this inspection

- Patients had access to a large range of rooms and equipment to support their treatment and therapy.
- Patients knew how to make a complaint. Staff supported patients with complaints and information was available in the form of leaflets and posters.
- The choice of food met dietary requirements of religious and ethnic groups.
- The CAMHS unit had clear admission and exclusion criteria and a care pathway for people accessing the service.
- The service was accessible for people with disabilities.
- The service admitted a number of patients from other countries. Staff were familiar with accommodating other cultures. The service could arrange therapy for patients in other languages.

However:

- Many patients' care plans did not have a discharge plan.
- In the CAMHS ward, there was no outdoor space within the ward and patients lacked opportunity to regularly go outside on a daily basis.

Are services well-led?

Good

In October 2015, we rated the acute wards for adults of working age as good for well-led. We inspected, but did not rate, the children and adolescent ward. We did not inspect the substance misuse and detoxification ward. At this inspection, we rated acute wards for adults of working age as good for well-led. We rated the CAMHS ward as good for well-led. We inspected, but did not rate, the substance misuse and detoxification ward.

We rated well-led as **good** because:

- Staff were aware of senior managers in the organisation and told us they regularly visited the ward.
- Staff morale was high and the staff said that they felt supported by their peers and their managers.
- Staff spoke of teamwork and recognition of their work
- Staff told us they enjoyed their work and felt that morale throughout the team was good.
- There were no concerns about bullying or harassment.

However:

- Governance processes had not ensured staff had access to appropriate support including training to meet the specialist needs of the patients, supervision and access to regular team meetings where there were opportunities to learn from incidents.

Summary of this inspection

- Whilst many improvements had taken place following the previous inspection some areas needed further work and the provider had not assured itself that this work was complete, for example, the provision of a system for staff to have urgent assistance and copies of the ligature risk assessments on each ward.

Detailed findings from this inspection

Mental Health Act responsibilities

- 84% of staff had received training in the Mental Health Act 1983 (MHA). Staff showed a good understanding of the MHA, Code of Practice and guiding principles.
- MHA documentation in the service was good.
- Staff were aware of who they needed to contact for advice regarding the MHA. A senior manager supported adherence to the MHA. We found evidence that specialist MHA training was given to staff when there were changes to the MHA Code of Practice.
- Patients had access to an independent mental health advocate. Staff displayed posters and leaflets on wards with information about the advocate.
- Patient's rights were read to them on admission and those we spoke to understood their rights, including the right to leave the ward subject, on the CAMHS unit, to parental consent.

Mental Capacity Act and Deprivation of Liberty Safeguards

- 86% of staff had training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had a good understanding of the MCA 2015.
- The hospital had a policy in place to support staff in the use of the MCA and DoLS.
- The provider had made no DoLS applications in the previous six months.
- For people who might have impaired capacity, staff assessed and recorded capacity to consent appropriately. We looked at three examples where staff had determined that the patient lacked capacity, but did not find a full capacity assessment form or best interests form filled in for these three patients. Staff had access to templates for completing a full capacity assessment and best interests form, but on occasions these were not used and appended to patients' care records.
- At the time of the inspection, all the young people on the CAMHS unit were assessed as being Gillick competent. In the event that a young patient was not Gillick competent to make a specific decision, staff told us that they would seek parental consent. Staff were aware of who they needed to contact for advice regarding the MCA and Gillick competency (whether a child – 16 or younger is able to consent to his or her own medical treatment, without the need for parental permission or knowledge). A senior manager was available to support staff with adhering to the MCA and the Gillick competency.
- The substance misuse and detoxification staff assessed patients' capacity to consent to admission and treatment during the initial assessment. Staff received training on the MCA. Staff said that occasionally the service admitted patients without capacity to consent to treatment due to alcohol intoxication. Staff said that in these situations they would act in the patient's best interests by monitoring their physical health to ensure their safety.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Child and adolescent mental health wards	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Substance misuse/ detoxification	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Notes

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

Requires improvement

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

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

Requires improvement

Safe and clean environment

- The three wards of the acute wards for adults of working age were located on three floors. On the ground floor was the mixed gender acute admissions ward, on the first floor was the women only acute ward, and on the second floor was the men only acute ward.
- When we inspected in October 2015, we noted that the wards had poor lines of sight and did not allow staff to observe all areas. At this inspection the environment was the same. They layout of the wards meant that it was difficult to observe all parts of the ward. All bedrooms were small and the doors opened inwards to the room which posed a potential risk of patients becoming trapped or of barricading themselves in their room. Staff mitigated the risk presented by blind spots by assessing patients' risk and checking patients at heightened risk every 15 minutes.
- All wards were well maintained, clean and had good furnishings. Cleaning records were up to date. The weekly environmental risk assessment identified maintenance needed on the wards and highlighted broken or damaged items. The patient satisfaction survey between July 2016 and October 2016 stated that 97% of patients rated the cleanliness of the services as good or excellent.
- At the time of inspection the provider did not have an infection control lead and had not carried out an infection control audit since May 2016. The provider had identified this gap and had recruited a staff member to take on this role, although at the time of our visit they had not started yet. The most recent infection control audit did not clearly outline what outstanding actions had been completed or provide a clear date for completion for all items. 18 of 80 issues were marked as on-going, but did not provide a date for completion. A further five issues had completion dates ranging from October 2015 to February 2016, but there were no updates provided to record whether they had been completed. This meant the provider was not effectively managing risks from the spread of infection to ensure a safe environment for patients and staff.
- When we inspected in October 2015, we saw that all wards had a number of ligature anchor points in patients' bedrooms, bathrooms, corridors and communal spaces. In October 2015 staff had completed an environmental risk assessment for the hospital. However, the assessment did not indicate timescales for works to address ligature risks and staff did not have a copy of it on the ward. At this inspection we found that the provider had set a deadline of December 2017 to address the ligature risks in the patient environment. The provider had produced an audit of the types of ligature risks to be found on each floor and a management plan for these, which was in a folder and to be placed in each ward. However on two of the three wards we visited, there was no folder with this information in it. Four of the staff we talked to said that they did not know about the ligature audit or management plan. This meant that the staff did not have the information they needed to mitigate the risks of ligature anchor points in the wards.

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

Requires improvement

- When we inspected in October 2015, we found that the wards were breaching guidelines relating to same sex accommodation. At this inspection, we found that the first floor ward was predominately female and the second floor ward was predominately male. Where the wards were with mixed genders, bedrooms had been grouped to ensure as much separation as possible between the genders. Each patient had access to en-suite facilities. This meant that the provider was meeting the national guidance on same sex accommodation of patients. However, on the mixed sex ward, there was no female only lounge in line with recommendations from national guidance on same sex wards.
- Wards had fully equipped clinic rooms that were clean, organised and tidy. There were emergency medicines and equipment available on all the wards. When we inspected in October 2015, we found that staff had not conducted daily checks in clinic rooms on the second floor and recorded these daily checks appropriately. At this inspection, we found that staff conducted daily checks in all the clinic rooms. Medicines were stored securely and appropriately. Fridge temperatures were monitored daily and seen to be in range. However, minimum and maximum temperatures were not checked to ensure the medicines had remained at the safe temperature throughout. One infrequently used medicine was found to be out of date and removed during the inspection. All prescribed medicines were available for people when they needed them.
- Emergency medicines and equipment were available and checked weekly to ensure they were correct and available for use.
- When we inspected in October 2015, we found that wards did not have wall based fixed alarms along corridors and staff did not carry personal alarms. Staff were unsure what would happen if an incident occurred. At this inspection we found that there were no alarms in the corridors or common areas of the wards and that staff did not have personal alarms. Four members of staff said that they felt unsafe on the wards. There was a recent serious incident involving an assault of one patient on another. During that incident, the staff member who attended the scene had no way of summoning help, which put the staff member at risk of harm and delayed help and assistance to resolve the incident.
- Staff told us that if there was a problem on the ward and they needed support, they would go to the nurses' station and call the bleep holder (a senior nurse who was available to respond to emergencies). However there was an incident logged in December 2016 which showed that the emergency call system was not working. The emergency call system was repaired within the hour. This meant that there was a risk that staff may not be able to quickly call for assistance in an emergency.

Safe staffing

- The provider used the hours per patient day tool to determine staffing levels. As a baseline, the provider had one qualified nurse for every three patients and a health care assistant on each floor. Charge nurses could request additional staff when needed, for example when a patient needed one to one support or increased levels of observation.
- The service operated a system of two shifts each day. The day shift started at 7.30am and ended at 9.00pm. The night shift began at 8.30pm and ended 8.00am. The service allocated half an hour for nurses to handover information to staff coming on to their shift. The number of staff on each shift varied according to the number of patients.
- Staff levels were safe and vacancies had not impacted safety on the ward. Bank staff were from a pool of substantive staff used by the provider who worked additional shifts. Bank staff were familiar with the ward and this helped promote continuity of care. Staff said that there were usually enough staff on the wards to safely take care of patients.
- The total number of substantive staff for the Hospital was 142. Of these 50 worked in the nursing team. There were eight healthcare assistants (HCAs) and 42 qualified nurses. The provider stated that the nursing team often rotated between the services as required.
- Staff turnover from March 2016 to February 2017 was 31% of substantive staff for the whole hospital. When we inspected in October 2015, we noted that the nursing manager post was vacant and in the process of being recruited. At this inspection we found that the nursing manager post was vacant, after being filled during the time between the inspections. At the last inspection we noted that charge nurses were supernumerary on the ward. At this inspection charge nurses told us that they

had patients to care for as well as their charge nurse duties. One charge nurse, the bleep holder, per shift was supernumerary, and they responded to emergencies in the building.

- There were vacancies for eight qualified nurses and two HCAs for the hospital. In addition, four qualified nurses had already been recruited and were awaiting the start date of their employment.
- The provider filled vacancies with bank and agency staff. Between August 2016 and February 2017, 14% of qualified nurses working at the hospital were bank staff and 24% were agency staff. During the same period, 34% of HCAs were bank staff and 28% were agency staff. In November 2016, 46% of qualified nurses working in the hospital were either bank or agency staff, and 67% of HCAs were bank or agency staff.
- Staff sickness rates for the hospital, between March 2016 and February 2017, was 2.6%.
- Ward doctors were on site from 9am to 5pm Monday to Friday. The senior nurse who held the bleeper each shift was dual qualified in general nursing and in mental health nursing. This meant that patients' physical and mental health needs could be assessed on a daily basis.
- At the weekend and after 5pm on weekdays a doctor provided on-call medical cover.
- Not all staff had completed mandatory training within the timescales set by the provider. 69% of mandatory training had been completed by staff. Mandatory training was a mixture of face-to-face training and e learning. Training included basic and advanced life support, health and safety, fire safety, manual handling, safeguarding, Mental Health Act, Mental Capacity Act and diversity training. The best attended training was health and safety and fire safety training with 88% and 89% attendance by staff. Basic and advanced life support was completed by 80% of nursing staff. The areas where the average mandatory training fell below 75% included safeguarding adults level one and two and safeguarding children level one, with 58% rate completed for each; and breakaway training with 63% completed.
- The provider had developed a training action plan to address mandatory training of staff and to achieve a target of 90 per cent compliance across all mandatory training courses. This plan included ensuring that all training is completed before managers signed off on staff probationary periods to ensure that all mandatory training is completed before processing staff bonuses at the end of each year.

Assessing and managing risk to patients and staff

- A nurse and doctor completed a risk assessment for each patient when they were admitted. Staff asked patients if they presented any risks to themselves or other people, or if they were at risk from other people. If the patient identified risks, staff graded these as being low, medium or high. The assessment then stated the level of observation that the staff would provide to manage the risk. The form stated whether the patient had consented to that level of observation. The form did not include any details of harm the patient had experienced in the past due to identified risks. These assessments were updated daily, based on a discussion between the nurse and the patient about how the patient was feeling that day. Staff rated daily risks as low, medium or high. The nurse and the patient both signed the daily risk assessment. If staff identified any risks as medium or high, the staff would create a risk management plan. This plan stated the nursing intervention that would be used to address the presenting risk and any restrictions on the patient's movement. The plan also included confirmation that the patient was consenting to the risk management plan.
- When we inspected in October 2015, we found it unclear how staff developed plans to mitigate risks. We found that there was no single place within the patient notes where risk assessments were available. At this inspection we found that staff produced and updated risk profiles for each patient. Holistic and comprehensive handover notes were produced every day to make sure all staff were aware of current risk. The provider had provided staff with a computerised system to update each patient's risk. This meant that staff had up to date awareness of patients' risks.
- When we inspected in October 2015, we found that therapists did not document risks that may have risen during therapy sessions. At this inspection therapists told us that if there were any risks arising from therapy sessions, or any changes in risk that the therapists observed, they updated the handover notes, talked to ward staff at the time, and communicated their concerns directly to the responsible clinician. We saw

examples of therapists updating patient risks in handover notes. This meant that staff and therapists shared information about patient risks and that patient risk assessments contained information from therapists as well as staff.

- When we inspected in October 2015, we found that staff did not always carry out physical observations following the use of rapid tranquilisation. At this inspection there had been one incident of rapid tranquilisation during the previous three months. We found during this incident that vital signs, including blood pressure, pulse and respiratory rate, were only taken once following the rapid tranquilisation. The provider's policy on rapid tranquilisation states that staff must undertake and record physical observations of the patient every 15 minutes for an hour following a rapid tranquilisation and then every 30 minutes until the patient becomes active again. NICE guidance on rapid tranquilisation states that staff should monitor patient's vital signs every 15 minutes if the patient appears to be asleep or sedated, or every hour if not; until staff have no further concerns about the patient's physical health status. This meant that in this instance there was a risk that the patient was not being offered the protections according to the provider's policy or NICE guidance.
- Staff risk assessed patients daily and again before they went out on leave.
- Staff did not always know where the patients were in the hospital. The hospital policy on observation, the Safe Supportive Observation and Engagement with Patients at Risk policy, stated that the location of all patients should be known to staff at all times and that this policy applies to both informal and detained patients. This policy was in line with NICE guidelines on safe observation of patients. However the wards in the main building were all unlocked. Patients could easily access all parts of the hospital, including other wards, the canteen and therapy rooms in the basement, and the courtyard. We did not observe staff in the communal areas of the hospital during the time of the inspection. In the senior management meeting minutes for November 2016 we noted that this issue was brought up. It stated that patients were going to different floors and being told by staff to get off the ward. It stated that staff should be aware if patients were not attending their scheduled group therapy session and that staff should know where their patients are. At the time of our inspection, some staff said that in evenings many patients went to the basement while the ward nurses are on the ward completing patient care notes. Staff we spoke to did not know if there were any staff observing patients in the basement. This meant that there was a risk that staff did not know where their patients were at all times and this was a potential risk for patients who might harm themselves or other people.
- Prescriptions and medication administration records were clear and included important information such as allergies, dose changes, indications for use and maximum doses of medicines prescribed 'when required'. All administrations were signed or coded to show why they had been omitted. 'Do Not Disturb' tabards were used by nurses when administering medicines to enable them to concentrate medicines administration.
- Some patients were supported to manage some of their own medicines (for example inhalers) with monitoring from nurses. Individual secure storage was available for this.
- Pharmacists were not routinely involved in medicines reconciliation on admission and the relevant part of the medicines chart was not always completed, but two doctors we spoke with described how they would ensure they had confirmation of a patient's current medicines wherever possible before they prescribed for them. This meant that the provider ensured medicines reconciliation when staff prescribed medicine for patients.
- Ward doctors responded quickly to an emergency out of hours. There was a rota where they took turns covering out of hours' calls to the hospital. Doctors said that they could attend within 30 minutes of receiving a call.

Track record on safety

- During the previous eight months, the provider notified the Care Quality Commission of three incidents where children were being admitted to an adult ward. The provider did not have a policy concerning the admission of children to adult wards. The provider did not notify the local authority of these instances. They did not raise it as an incident on their internal incident reporting process. This meant that the provider was not following best practice on reporting incidents of children being admitted to adult wards to the local authority and children were not being adequately safeguarded in these situations.

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

Requires improvement

Reporting incidents and learning from when things go wrong

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- Staff we spoke with knew how to report incidents. Staff recorded incidents on electronic forms and then sent them to be investigated by a senior manager. Incidents and changes to patients' risk rating were logged in the daily handover notes and were discussed at shift changes. We saw that the handover notes were comprehensive and gave a clear indication of incidents that had happened and how staff were to support patients at higher risk.
- Staff we spoke with were not able to tell us any learning that they had had from incidents. When we inspected the provider in October 2015, we found that staff could not describe changes made as a result of incident. During this inspection, staff were able not able to tell us of any changes that had been made as a result of incidents. Consultants and ward doctors told us that there was not much learning from incidents and that there was no bulletin or system for feeding back learning points from incidents. This meant that the provider did not ensure staff learned from incidents.
- We saw that incidents were discussed at monthly senior managers meetings between September 2016 and January 2016. We saw evidence of discussion about learning from incidents, such as in December 2016, where nursing competencies were being looked at following a series of seven medication errors. This meant that senior management had discussed incidents and proposed changes in response to incidents.
- Staff were aware of their responsibilities under the duty of candour and talked about times when they would be open and honest with patients and their relatives if something went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.
- When we inspected the hospital in October 2015, we noted that there was a risk that the provider was not grading incidents in a consistent manner. For example, they had given the same risk rating for an incident involving a suicide attempt as that for a patient caught smoking in their bedroom. The rationale for this was not included in the incident report. We found that this lack of clarity as to what constituted a serious incident still remained. In the last six months the provider told us that there no serious incidents. However we saw evidence from the provider's senior managers' meeting minutes between September and January 2017 that incidents occurred which had significant impact on patient care but had not been recorded as serious. These included incidents of self harm necessitating a hospital admission and a medical emergency necessitating a hospital admission. It was not clear from the documents and policies we looked at what the provider deemed to be a serious incident.
- The provider told us that there had been no RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) incidents reported in the previous six months, however the senior managers meeting minutes noted an occasion where a staff member had been locked in the kitchen, and another where a shower door fell on a patient. Both of these incidents should have been reported under RIDDOR. This meant that the process for identifying and reporting incidents was not clear.
- The provider told us that there had been no incidents of restraint in the previous six months. However we saw from the senior managers meeting minutes that in December 2016 a patient was restrained in order for medication to be administered.
- The lack of oversight concerning incidents and how serious they were meant that the provider would be at risk of not recognising incidents and promoting strategies to learn from incidents in the future.
- The provider did not notify CQC of all incidents that it should have. Providers are required to report all incidents of abuse or allegation of abuse in relation to a service user to the CQC. Between July and December 2016, the provider was aware of six safeguarding concerns which had involved police and/or social services, but did not send in notifications regarding these to the CQC.

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

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

Requires improvement

Requires improvement

Assessment of needs and planning of care

- The Nightingale Hospital is a private hospital which has granted practicing privileges to over 50 consultant psychiatrists. These consultant psychiatrists use the hospital to care for their patients who require in-patient care. Referrals also come from members of the public who either pay directly or through their private health insurance. Patients may also be transferred from NHS providers to the Nightingale hospital through the admitting consultant psychiatrist.
- There was an on-call consultant to care for patients who self referred to the hospital and who did not have a consultant psychiatrist already or whose consultant psychiatrist did not have practicing privilege within the hospital. This included patients from abroad. Consultants sometimes used videoconferencing to help assess suitability of patients for admission. Ward doctors who had specialist training in both physical and mental health care and treatment, assessed new patients on the wards and their suitability for admission. Patients were sometimes redirected to a different hospital for treatment if the presenting problems were caused by a physical health problem.
- We reviewed the care records of 11 patients across all three wards. Staff had assessed patients comprehensively on admission. Assessments included both physical and mental health needs.
- A doctor undertook physical examinations and blood tests on admission. There was a comprehensive admission procedure done by the ward doctor. The doctor carried out a physical examinations of the patient, took blood tests, electrocardiograms, and risk assessed the patient. The doctor carried out a mental capacity assessment upon admission in order to assess capacity to consent to treatment. The consultant psychiatrist responsible for the patient's care in the hospital reviewed the patient within 24 hours of admission to hospital.
- Staff reviewed and updated care plans regularly. Staff discussed progress of patients collaboratively with each patient and regularly met to discuss activities and therapies.
- Information needed to deliver care was stored securely and available to staff when they needed it. Records were stored both in paper format as well as on the electronic care record system.

Best practice in treatment and care

- Patients had access to their responsible clinician at least three times a week, and some patients saw their responsible clinician every day. Care planning was person centred and patients had one to one time with their responsible clinician. Patients received access to psychological therapies.
- Staff considered National Institute for Health and Care Excellence (NICE) guidelines when making treatment decisions; for example, when prescribing medicines and psychological interventions. Staff said that they accessed NICE guidance from the internet and through e-learning.
- Staff devised programmes of treatment for patients following the completion of the admission assessment. These programmes included group psychological therapy. Where a patient failed to attend aspects of the programme, one to one support and/or occupational therapy were involved. The provider tailored the programme to individual patient needs and this included cognitive behavioural therapy, interpersonal psychotherapy and dialectic behavioural therapy. Patients had the option to have a one to one at the end of therapy with a psychologist. A consultant agreed care packages upon admission with patients. Staff sent reviews of progress in therapies to consultants. This meant that therapeutic and clinical involvement with patients was coordinated.
- Patients had access to specialist physical health care when needed. Doctors referred patients to specialists where abnormal tests or physical health issues arose. Staff arranged appointments and escorted patients to appointments.
- Staff used a client self-report questionnaire designed to be administered before and after therapy. The provider used the clinical outcome in routine evaluation – outcome measure (CORE-OM) to gauge responses to questions and indicate the level of psychological distress. The hospital also used health of the nation outcome scales, goal attainment scaling and the Becks Anxiety Inventory. The results of these assessments were included in patients' care records.

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

Requires improvement

- Therapists discussed attendance and incidents with nurses in handover meetings after therapy sessions. Therapists met weekly in clinical team meetings to discuss progress of patients and a report was written for each consultant psychiatrists involved in the patients' care. If a patient did not attend two therapy sessions in a row, the therapist would reassess the patient's suitability for the treatment plan, in conjunction with the patient's consultant.
- Clinical staff participated in clinical audits. We saw one that was completed in March 2016. It was an audit of the completeness of patient care records across the hospital. The provider said that it had completed all the actions arising from that audit. Clinical staff also completed a range of other audits, which included discharge against medical advice, pharmacy, infection control, environmental risk, incidents and accidents and Mental Health Act audits.
- Patients said they felt confident in the staff to care for their physical health needs. For example, one patient said they got a sore throat the week before, and staff treated it right away.

Skilled staff to deliver care

- The hospital had a full range of mental health disciplines to provide care and treatment. These included nurses, doctors, occupational therapists, psychologists, pharmacists, and therapists. The hospital had a large number of consultant psychiatrists, psychologists and sessional therapists that worked with patients on an individual basis.
- New staff received a six month induction when they started working at the provider. This included mandatory training and prevention of violence and aggression training. While substantive staff were on induction, they received supervision every month. We reviewed the induction notes and monitoring information for three staff and found them well filled out. We found that charge nurses were identifying and managing performance issues and monitoring this in induction records. Agency staff also had an induction to ensure they were familiar with the wards. Bank staff were from a pool of substantive staff and had already been trained and inducted by the provider.
- We found that the level of supervision that nursing staff received was inadequate. The provider had a target for permanent staff receiving supervision every six weeks. Supervision logs showed that some nursing staff had not received supervision during 2016. In the supervision records of 61 nursing staff, 30 had not received supervision in 2016, and 12 had received supervision once.
- We looked at the senior managers' meeting minutes for the previous six months and nursing supervision was not mentioned. We looked at the provider's risk management strategy for the service for October 2016, November 2016 and February 2017 and noted that nursing supervision was not included in the list of risks to be addressed. The hospital did not have a supervision policy and stated that it is for each discipline to follow their regulatory body's guidelines. This meant that lack of supervision for nursing staff had not been recognised by the provider as an issue and was not being addressed.
- Staff said that they had an appraisal within the last year. The provider did not provide any figures for appraisal rates within the service, but confirmed that the appraisal rate was above 75%. Information on staff appraisals was not contained in the staff files we looked at.
- Ward doctors were all from an agency that provided regular supervision and appraisal. Ward doctors stated they could access their supervisor when required and also met regularly with them for supervision.

Multi-disciplinary and inter-agency team work

- The service did not hold multi-disciplinary team meetings. Consultants and junior doctors held discussions regarding patients and the junior doctor would then convey this to charge nurses. When we inspected the provider in October 2015, staff said that this method of communication was an issue as the majority of staff did not meet each other and contact was through email and by telephone. At this inspection we looked at handover notes and patient records and found that the staff caring for patients had up to date and detailed information from therapists and consultants.
- Some nursing staff said that consultant psychiatrists sometimes met with patients without informing nursing staff a review was taking place. Following the review meeting consultant psychiatrists left the hospital without informing nursing staff of updates regarding care or treatment of the patient and did not update patient records. We reviewed the care records of 11 patients, they all showed that the consultant

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

Requires improvement

psychiatrists updated the handover notes for staff as soon as they had completed their review of patients. The hospital was aware of this as a previous concern and stated that they had improved this communication.

- Handover meetings between nurses took place twice a day when there was a change of shift. The notes of these meetings were very thorough, providing information about why the patient was admitted and an update on each patient's progress during the previous shift. Notes also included any changes to each patient's risk status, their observation level and their vital signs. A handover from the therapy team took place once a day. The therapy team recorded their notes on the electronic patient record.
- The handover notes were very comprehensive and allowed staff in charge of a patient's care to have the information they needed to deliver effective and coordinated care.

Adherence to the MHA and the MHA Code of Practice

- At the time of the inspection, there were three patients detained under section 2 or section 3 of the Mental Health Act, and 25 patients who were informal. Patients told us that they knew their rights. Some patients, who were informal, said that they could go out of the hospital on their own when they wanted, but said that it would depend on their risk level.
- Some patient files did not have informal rights forms filled in and signed by patients. For example, on the first floor ward, two of the nine files we looked at did not have the informal rights form filled in and signed, although all of these patients were informal.
- An audit of the MHA had been done for 2016, but was not available at the time of the inspection.
- MHA documentation for people detained under the Act was in order and the original paperwork was stored in the compliance manager's office. Staff kept copies of the MHA paperwork on the wards.
- Patients had access to an independent mental health advocate and information about the advocacy service was provided on the wards.

Good practice in applying the MCA

- The service completed an assessment of each patient's capacity to consent to admission and treatment during the initial assessment. The assessment form asked if there were reasons to suggest the patient may lack capacity. If there were doubts about capacity, the doctor and nurse completing the assessment were required to complete a thorough capacity assessment form and inform the hospital compliance manager.
- At the time of the inspection, staff indicated that there were three patients that had been assessed as lacking capacity at some time during their admission and treatment. We looked at the care records for these three patients and found that the mental capacity assessment was not completed comprehensively. When we asked to see the full capacity assessment and best interests documentation, staff could not find it. Templates for mental capacity assessment and best interest decision making were present however these were not filled out in the assessments we reviewed.

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

Good

Kindness, dignity, respect and support

- We observed positive staff attitudes and behaviours when interacting with patients throughout the inspection. For example, we saw how staff were patient and calm with two patients who were at risk of challenging behaviour.
- In the patient satisfaction survey completed by the hospital between July 2016 and October 2016, 97% of patients rated the level of respect they got from staff as good or excellent. 97% of patients during the same time period rated that level of trust and confidence they had in staff as good or excellent. 97% of patients also thought that the quality of staff's response to their questions as good or excellent.
- Patients felt safe on the wards and well cared for. They said staff were respectful and polite and always knocked on their bedroom doors before entering.
- We spoke to 18 patients and they all said that the substantive staff were caring and attentive. We saw many thank you letters from patients to staff in the nurses' stations.

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

Requires improvement

- Two of the patients we talked to said that the agency staff were not as caring and professional as the substantive staff. They said that the agency staff could be rude or abrupt at times.

The involvement of people in the care they receive

- When patients arrived at the ward, the admitting nurse introduced them to the staff and showed them to their room. Nurses offered patients a cup of tea. Nurses gave the patients a tour of the hospital and introduced them to the cooks in the canteen to discuss the food on offer.
- In the patient satisfaction survey between July and October 2016, 98% of patients rated their level of involvement in decision making as good or excellent.
- Patients could access an advocacy service. Contact details of the advocacy service were displayed on notice boards.
- Families and carers were welcome to attend the ward if patients wanted them to do so. The service facilitated a family support group one evening each week.
- The service asked patients to complete an inpatient satisfaction survey. This survey asked them to rate their experience of admission, the environment, care and treatment and outcomes of their treatment.
- Patient said that they had weekly community meetings, however these meetings were not minuted and we had no examples of any changes that may have come from them.

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

Good

Access and discharge

- When we inspected the provider in October 2015, we noted that discharge forms were expected to be completed upon admission, but we did not see evidence of this. At this inspection, we also saw that many care plans did not have a discharge plan. At the senior managers' meeting in October 2016, the subject of discharge summaries being overdue was discussed. The minutes stated that the importance of discharge planning was not recognised by staff and patients. There was no mention of a resolution to this issue. This meant that staff were not preparing patients for a smooth transition back to the community to minimise the risk of relapse and readmission. This also meant that there was a risk that patients may remain longer in the hospital than required and early discharge was not being facilitated.
- The average bed occupancy for the entire hospital between August 2016 and January 2017 was 45 patients. This ranged from 36 patients in August 2016 to a high of 57 patients in November 2016. Bed occupancy was not broken down into service type. Staff said that most patients were in hospital for two weeks to a month.
- When we inspected, we found that 28 beds were occupied of the available 36 beds on the ground, first and second floor wards.
- The threshold for admission to the hospital was variable as there were over 50 consultant psychiatrists who referred patients to the site and remained their responsible clinician while they were on the wards.
- When patients were newly admitted, staff welcomed them and offered them a drink, then they took any medication that they were on in the community and did a property search. Staff then introduced them to the other staff and showed them the fire exits, admission office, restaurant, therapy group rooms and gym. They went through patients' dietary needs with the chef in the restaurant. Staff gave new patients an admission booklet explaining the services and facilities in the hospital.
- We looked at the hospital's patient satisfaction survey results covering July 2016 to October 2016, which had 37% of patients completing the survey. It stated that 96% of patients rated the information about the service given to them as good or excellent.

The facilities promote recovery, comfort, dignity and confidentiality

- The patients' bedrooms were all well-furnished and homely. Each room had a nurse call button by the bed and in the toilet. Patients did not have keys to their bedrooms. Nurses kept keys to patients' bedrooms and locked them when patients were not there..
- Each ward had a lounge, laundry facilities, a small kitchen for patients, the nurses' office and consulting rooms. The lounge for each of the wards was large and spacious with comfortable furnishings. There was a TV in each lounge, daily newspapers and magazines.

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

Requires improvement

- Patients we spoke to said that the food was good. The food was prepared daily on site and patients went to the restaurant in the basement to eat. If patients were not well enough to go to meals in the restaurant, staff would bring their meals to their rooms. The restaurant was spacious and comfortable. The menus were varied and had two vegetarian options every meal as well as a continental salad bar. Between July 2016 and October 2016, 78% of patients rated the quality and selection of food as good or excellent.
- Patients could have coffee and tea whenever they wanted.
- Most patients had mobile phones and could make calls when they wanted. Some patients complained that the signal was poor. There were no computers on the wards for patients to use, but most patients brought their own computers.
- There were group activities in the morning and afternoon, seven days a week. Patients were taken out for walks. Activities include yoga, mindfulness, salsa dance and art therapy.
- The main hospital had within it the three acute wards for adults of working age, the specialist eating disorder ward and the substance misuse and detoxification ward, with the canteen and the therapy rooms in the basement. There was an enclosed courtyard where patients smoked beside the canteen and which was unlocked. There was a lock on the front door of the hospital which was opened by the receptionist located in front of it. There was a receptionist available 24 hours a day. This meant that patients were given a great deal of freedom within the hospital setting, however this also meant that patients could be vulnerable to other patients if there were no staff available to observe and supervise patients in the common areas of the building.
- Patients said that it was a peaceful setting; patients said there were no arguments, violence, alcohol or drugs. We noted that it was a very quiet and calm environment.

Meeting the needs of all people who use the service

- There was a lift up to both floors of the ward. This meant the service could be accessed by people using a wheelchair.
- This was an international service that admitted patients from other countries. The service routinely provided information in other languages and arranged interpreters.
- When patients' children came to visit them on the wards; they would meet either in their bedroom, in the lounge on the ward or in the canteen in the basement. Staff risk assessed the patient receiving the visitors and the other patients on the ward before children were allowed on the ward.
- Staff supported some patients to restart work on a graded return to work programme as agreed by patient and employer.
- The service could arrange appropriate spiritual support if patients requested this. Two patients said that the access to spiritual support was good. There was not a dedicated spiritual room within the service.

Listening to and learning from concerns and complaints

- Patients knew how to complain, there were complaint cards available on the wards and staff said that they encouraged patients to complain if they had an issue.
- There were 82 complaints made to the service in 2016, however the provider was not able to break this down into core services. The provider kept a clear system of logging complaints and assessing them for trends. In December 2016, there were four written and three verbal complaints which were all resolved with an apology as appropriate and the patient accepted the outcome. For December 2016, there were three complaints from patients to nursing staff and two complaints to the therapy team. Two complaints were made by patients to the finance department. In November 2016 there were 12 complaints, nine were resolved with an apology and the patient accepted the outcome, one patient was still not happy after the apology and was considering going further with it, one was at a stage one dispute resolution, and one was at stage three dispute resolution.

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

Good

Vision and values

- The staff knew and followed of the values of the provider, which were compassion, commitment,

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

Requires improvement

recognition, respect and one team. Most of the patients we talked to said that the staff were compassionate, respectful and committed, and that the care they got in general was very good.
- Staff knew who the senior managers were and that these managers frequently visited the ward.

Good governance

- Compliance with mandatory training was below 70% across the hospital. Staff did not receive regular supervision. Team meetings were very rarely held, meaning that staff had few opportunities to discuss any incidents or complaints. However, there were sufficient staff on the ward at all times and staff maximised the time they spent on direct care activities.
- Charge nurses felt that they had sufficient authority to run the wards. The wards did not have specific administrative support. Most administration was carried out by a centralised team covering the whole hospital.
- The provider kept a risk management log and updated it monthly. Policy reviews and changes were posted on the provider intranet to alert staff.
- The provider kept a health and safety environmental risk plan for all wards and communal areas with an action plan and dates.
- There was a medical advisory committee chaired by the chief executive and the medical director of the hospital. Consultants could give advice and feedback to these monthly meetings.
- The senior managers' meeting, the Care Quality Management Group, met monthly. This was attended by the medical director, the hospital director, the compliance manager, the head of marketing and the nursing lead. The agenda of the meeting followed the five domains of the Care Quality Commission inspection framework. The committee generated a monthly report which was forwarded to the charge nurse to be disseminated to all staff during monthly meetings.
- The hospital carried out a range of audits in 2016, including as pharmacy, discharge against medical advice, care records and staffing. The staff survey had not been done for 2016.

Leadership, morale and staff engagement

- Most staff said they were not aware of any bullying or harassment within the service.
- Staff said that it was a great place to work. They thought that the organisation was good and managers were very supportive. Staff felt able to raise concerns without fear of victimisation, but staff said they tried to deal with problems before they became too big.
- Staff enjoyed having plenty of time to spend with patients. Staff felt that patients received a good quality of care and they regularly received positive feedback from patients.
- Some staff had worked at the hospital for over 15 years. There was a cohesive group of staff which was stable, experience and communicated well with one another.

Requires improvement

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Requires improvement

Safe and clean environment

- The CAMHS ward was in an annex behind the main hospital. The ward had several blind spots that staff managed through individual risk assessments and regular observation. They completed detailed risk assessments for individuals when they were admitted and carried out regular observations to manage this.
- All areas were visibly clean and well maintained. A domestic staff member cleaned the environment each day. The environment was welcoming and decorated with artwork done by young people. Young people said the environment was comfortable and welcoming.
- Medicines were generally stored securely and appropriately. Fridge temperatures were monitored daily and seen to be in range, however minimum and maximum temperatures were not checked to ensure the medicines had remained at the safe temperature throughout. All prescribed medicines were available for people when they needed them. Controlled drugs which require additional storage were stored and recorded appropriately, and nurses did daily checks on stock levels of controlled medicines.
- Emergency medicines and equipment were available and checked weekly to ensure they were correct and available for use.
- Staff did not carry personal alarms which meant they could not easily call for help or alert other staff to incidents in all areas of the unit. However, in bedrooms and communal areas wall alarms could be activated to alert staff to an incident.
- When we inspected in October 2015, we saw that all wards had a number of ligature anchor points in patients' bedrooms, bathrooms, corridors and communal spaces. During this inspection we saw that building works had been carried out to address identified risks.
- Staff completed a weekly ligature risk assessment of the environment and were aware of how to mitigate risks. However, we found some ligature risks that had not been identified. We shared this information with staff at the time. Also, three different corridors across three floors were not differentiated on the ligature risk assessment meaning it was not clear to staff where identified risks were.
- At the time of inspection the provider did not have an infection control lead and had not carried out an infection control audit since May 2016. The provider had identified this gap and had recruited a staff member to take on this role, although at the time of our visit they had not started yet. The most recent infection control audit did not clearly outline what outstanding actions had been completed or provide a clear date for completion for all items. 18 of 80 issues were marked as on-going, but did not provide a date for completion. A further five issues had completion dates ranging from October 2015 to February 2016, but there were no updates provided to record whether they had been completed. This meant the provider was not effectively managing risks from the spread of infection to ensure a safe environment for patients and staff.

- The ward had appropriate fire safety practices in place. Fire extinguishers had been serviced and were placed strategically throughout the ward. Fire exits were signposted and signs on each floor gave detail about fire assembly points. A fire log book showed staff completed weekly fire alarm tests in January and February 2017. There were some incomplete records for 2016 with only one test in April 2016, and three in March 2016.
- There was a first aid kit kept in the nursing office on the ground floor. Contents were within date, but records indicated the last time it was checked was in October 2015.
- When we inspected the service in October 2015, we found that informal patients on the young person's unit were given and asked to sign a 'consent to management of physically disturbed or violent behaviour' contract. This contract was not appropriate as all informal young persons were expected to consent to physically restraint if required. At this inspection, we found that this contract was still being used on the young person's unit. This contract was a blanket restriction and did not reflect the individual needs or wishes of the young person.

Safe staffing

- The provider set a minimum ratio of staff to patients on the ward at all times. This was one staff member to every three patients in the day and one staff member to every four patients at night. The provider set a minimum level of two qualified nursing staff working at any time. Nurses were supported by healthcare assistants.
- The provider stated that the nursing team often rotated between the services. However, staff told us that staffing requirements were consistently met.
- Each patient had a keyworker who was responsible for ensuring they had regular one to one meetings with patients. This was meant to take place once a week, but both staff and patients said they didn't happen formally at a set time each week. We did not see regular records of these one to ones in case notes. However, there was detail about other interactions patients and staff had. Staff recorded which patients were involved in giving regular feedback about their care.
- Staff were trained to carry out physical interventions with patients who were violent and/or aggressive. However, patients and staff said incidents of violence or aggression did not happen often. Staff said if a patient required frequent physical intervention, a more appropriate placement would be found for them at a different hospital. Room searches only took place where it was absolutely necessary in order to mitigate specific risks that had arisen.
- Consultant psychiatrists shared an out of hours rota and ward staff could contact them at all times if medical advice was needed. Information about the rota and contact details were easily accessible to ward staff.
- The provider did not provide mandatory training figures for staff which was broken down by service. This lack of oversight over the training needs of core service staff meant that we had no evidence that all staff on the CAMHS ward had completed all the children safeguarding modules. Children safeguarding training was poorly attended by staff at the hospital, with 58% of staff completing safeguarding children level one, 63% of staff completing safeguarding children level two, and 57% of staff completing safeguarding children level three.
- Mandatory training was a mixture of face-to-face training and e learning. Staff had completed 69% of mandatory training. The provider had developed a training action plan to address mandatory training of staff and to achieve a target of 90% compliance across all mandatory training courses.

Assessing and managing risk to patients and staff

- Staff completed a comprehensive assessment of risks for each patient soon after they were admitted and discussed risks regularly. All five records we looked at contained thorough, up to date risk assessments and staff engaged patients in self-assessing their own risk on a daily basis. Young people then had the chance to discuss their assessment with staff who composed a written interpretation in the patients' notes.
- We were told by the staff on the CAMHS ward that the qualified nurses on the ward were regularly there and that they had received the appropriate level of safeguarding training. The permanent nurses we talked to could clearly describe how to identify and manage a safeguarding concern. In two records we saw that staff identified, reported and managed safeguarding concerns well. The provider was unable to give us a breakdown of the regular staff on each core service. We were unable to tell whether the HCAs working on the ward received the appropriate level of safeguarding

training. Agency and bank staff could not describe how to identify a safeguarding concern, which meant there was a risk to patients being subjected to abuse without these staff identifying it.

- Prescriptions and medication administration records were clear and included important information such as allergies, dose changes, indications for use and maximum doses of medicines prescribed 'when required'. All administrations were signed or coded to show why they had been omitted. 'Do Not Disturb' tabards were used by nurses when administering medicines to enable them to concentrate on the medicines management.
- Some patients were supported to manage some of their own medicines (for example inhalers) with monitoring from nurses. Individual secure storage was available for this.
- Pharmacists were not routinely involved in medicines reconciliation on admission and the relevant part of the medicines chart was not always completed, but two ward doctors we spoke with described how they would ensure they had confirmation of a patient's current medicines wherever possible before they prescribed for them.

Track record on safety

- The provider did not provide incidents or accidents by ward, so we were unable to assess the level of risk or the amount of mitigation for this core service.

Reporting incidents and learning from when things go wrong

- Staff could describe how to report an incident and what the threshold for reporting an incident was. We saw that staff reported incidents that took place on the ward, for example, safeguarding concerns that had arisen due to use of mobile phone applications to make contact with strangers.
- Once an incident was reported this was kept with the hospital compliance manager who collated information about incidents and fed them back to senior ward staff at monthly clinical governance meetings. Incidents and complaints was a standard item on the meeting agenda.
- Permanent staff were able to describe recent incidents and changes that had been made as a result. For example, CDs and DVDs were now kept locked in the lounge as they had been used to self-harm in the past. There was a notice about this in the nursing office.
- Staff were aware of their responsibilities under the duty of candour and talked about times when they would be open and honest with patients and their relatives if something went wrong. Duty of candour is a legal requirement, which means providers must be open and transparent with patients about their care and treatment. This includes a duty to be honest with patients when something goes wrong.
- Feedback following review of incidents with all staff who worked on the ward did not ensure that feedback reached all clinical staff. The ward manager fed information back verbally to staff at weekly clinical meetings. Staff told us that current issues relating to incidents such as inappropriate use of mobile phones were discussed at the clinical meeting. Staff did not have an agenda for this meeting, and they were not minuted, so there was no record of what was discussed, when it was discussed and which staff were present. The ward manager had introduced these meetings four months before the inspection as a forum to distribute information and was in the process of embedding them. In addition to agency staff who sometimes worked on the unit, all healthcare assistants were pooled, and did not always work on the same ward. There was no embedded system to ensure these staff received ward specific, up to date information about incidents and related learning. There was a group email address available for permanent nursing staff on the ward, which was used to share information and feedback from incidents.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We reviewed five patient care records. Staff carried out thorough assessments at the time of admission and kept clear and detailed records of these. Mental state examinations were repeated regularly in all of the cases that we reviewed. All but one of the records we reviewed contained a detailed patient history including relationships and previous medical and psychiatric history.

- The records we looked at showed staff identified any physical health needs of patients and supported and monitored these effectively throughout admission. Detailed physical health examinations took place on admission, followed by daily checks including blood pressure monitoring.
- Staff worked with patients to create personalised and recovery orientated care plans. These were updated regularly with the input from patients and family members where appropriate. Although therapists and the teacher produced written summaries that were included in patient's case notes, they did not develop additional or contribute to existing care plans. Nurses acted as key workers for individual patients. They took the lead on ensuring care plans were completed and reviewed regularly, producing care programme approach (CPA) reports and maintaining contact with home schools and local community CAMHS to ensure gradual re-integration to a normal routine when discharged. Parents of young people regularly attended CPA meetings.
- Information about patient care was stored securely and was easily accessible to staff. A board in the nursing office with patient identifiable information had a cover over it to ensure information could not be seen by other patients and visitors through the window.

Best practice in treatment and care

- Pharmacists were not routinely involved in medicines reconciliation on admission and the relevant part of the medicines chart was not always completed. Two doctors who we spoke with described how they would try to confirm patients' current medicines wherever possible before they prescribed for them.
- Staff did not carry out regular clinical audits on the ward. This meant that the service could not reliably consider improvements to clinical practice that may have been needed. The provider had a programme that indicated when audits were due to be completed. This included staff sickness and absence, infection control, complaints and incidents, as well as clinical areas including medical records, pharmacy and care programme approach. However, there were no recent audits available.
- Agency and bank staff were not as familiar with the ward as permanent staff. Young people we spoke with said that agency staff were not always aware of how to best support them. For example, supportive language and conversations at meal times. Meeting minutes from the young person's unit steering group in September 2016 showed that the provider acknowledged the need for a consistent staff group on the young persons' unit. This was to ensure staff on the ward had the appropriate training and skills and that staff knew the young people well enough to understand their behaviour and respond appropriately. Bank staff told us they would have liked more information and guidance about the ward and how best to support the young people and consistently enforce important rules. Local inductions, detailed checklists and information sheets were available, but staff records showed not all staff received these. However, we saw documents that outlined tasks to be undertaken during each shift and written information about general rules on the ward. These rules were appropriate to the ward and included patients not socialising in each other's rooms, restrictions on exercising after meal times for patients with an eating disorder, and intervening in discussion of food and weight during meal times.
- Psychological therapies recommended by NICE were on offer, such as cognitive behavioural therapy and family therapy. Two patients told us that the therapies on offer and group therapy sessions were useful, but that there were not enough one to one sessions available.
- A dietician developed meal plans with each patient on admission. The dietician attended ward rounds and was part of the multidisciplinary team. This meant patients nutrition and hydration needs were being assessed and supported. This reflected good practice standards for eating disorder CAMHS units produced by the Royal College of Psychiatrists.
- Staff used recognised rating scales to assess and record severity and outcomes. For example we saw that staff completed the health of the nation outcome scales for children and adolescentsfor each patient.

Skilled staff to deliver care

- The ward manager provided clinical supervision to the eight permanent nursing staff employed on the ward. This was planned for four times a year, which is less than the recommended minimum amount of every 6-8 weeks from the Nursing and Midwifery Council. This meant staff may not be receiving as much support as needed to carry out their roles as effectively as possible. Minutes

from the young person's unit steering group in September 2016 outlined that the ward manager had identified the need to introduce supervision and had done this in the following months.

- Healthcare assistants and bank and agency nursing staff did not receive clinical supervision. This meant they did not have access to professional support and discussions about the practice on the ward, though they did tell us that the ward manager and other permanent staff were on hand to offer support with things they were not sure about.
- Not all staff on the ward were experienced in working with young people or with young people with an eating disorder. Healthcare assistants and agency staff did not all have a background and training in this area. Permanent nursing staff did not have formal CAMHS competencies training. This meant not all staff had the necessary training to meet the needs of the young people on the ward. Agency staff worked mostly on night shifts, which meant staff working at night may not have the same level of knowledge as staff working in the day. The permanent staff had received training from an external company in naso-gastric feeding, and had attended a family therapy programme for patients with eating disorders. They were also trained in supporting families with children who have an eating disorder, were able to attend conferences about mental health for young people and take part in a mentorship programme.
- Nursing staff and students received a thorough induction to the service at the start of their employment or placement. This included a thorough orientation to the hospital and introduction to how the service operated.
- A range of mental health professionals provided input to the unit. This included nurses, psychiatrists, occupational therapists, clinical psychologists, dieticians and family therapists and pharmacists.
- A teacher worked on site and supported patients to complete work set by their home school. They made regular contact with the home school to ensure their education needs were met, and involved them in gradual re-integration back to school towards the end of the young person's stay. Home schools were invited to attend CPA meetings if the patient consented, and these had been facilitated via teleconference or in person.

Multi-disciplinary and inter-agency team work

- Ward rounds were held each week where staff from different disciplines discussed the care and progress of each patient. We observed one ward round and saw that all team members had a detailed knowledge of each patient. We saw that staff discussed the range of individual needs and preferences of each patient as well as the views of family members. MDT members such as the teacher and occupational therapist wrote summaries about progress in care notes. However, there were no additional care plans relating to other disciplines. Some staff felt that their roles were very specific, and that they would provide a more holistic model if they collaborated more. The service made regular contact with CAMHS community services for patients when necessary, and maintained close contact with home schools where possible to ensure a smooth transition back into a regular routine.
- Handover meetings between nurses took place twice a day when there was a change of shift. The notes of these meetings were very thorough, providing key information about why the patient was admitted and an update on each patient's progress during the previous shift. Notes also included any changes to each patient's risk status, their observation level and their vital signs.

Adherence to the MHA and the MHA Code of Practice

- An independent mental health advocate occasionally visited the unit. Although young people who we spoke with knew about the advocate, there was no information about them on display.
- Records showed staff recorded patient consent to treatment on admission and checked this regularly throughout their admission. Although there were no patients detained under the Mental Health Act at the time of our visit, section 12 approved responsible clinicians did work on the unit and there was a MHA compliance officer available if staff needed advice. An audit of the MHA had been done for 2016, but was not available at the time of the inspection.

Good practice in applying the MCA

- Permanent nursing staff had a good understanding of mental capacity and Gillick competence. This is where a young person can be assessed as competent or not to make decisions for themselves, without the input of their parents. The ward manager delivered training on Gillick competence to the team as it was not included as

part of any e-learning. In the last 12 months staff also received training on this from an external company. All patients were assessed as being Gillick competent at the time of our visit. Young people were supported to make their own decisions.

- Assessing Gillick competence was part of the admissions process and information about whether each patient was assessed as competent was displayed in the nursing office for staff to see on a daily basis.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- Patients said that they got on well with staff and that they were supportive and understood their needs. We observed staff interacting with patients in very caring and supportive ways. Staff who we spoke with were positive, supportive and understood the individual needs of patients.
- In the ward round staff discussed different techniques to engage patients with different preferences. For example, using lists and diagrams rather than only face to face instructions.
- Written information developed for new staff showed that existing staff had a clear understanding of the needs of their patients and wanted to share good practice and keep a consistent level of care. For example, information sheets detailed how best to support individuals during meal times. These outlined the types of foods patients typically took longer to eat and did not want to finish, such as jam in yogurt and butter on toast, and information about how to manage this was included.

The involvement of people in the care they receive

- A thorough introduction on admission included written information and a tour of the unit. Written information was clear and young person friendly. One of the nurses had recently introduced the use of letters of encouragement. These were written anonymously by patients at discharge and were given to newly admitted patients.
- Staff actively involved patients in developing and reviewing their care plans and risk assessments. Patients could attend weekly ward rounds and discuss their care with staff. We saw that staff prepared for this meeting using the information from the previous week and had clear information set out for patients when they joined the meeting. Patients who we spoke with told us that they had been involved in their care plan, though one patient said that they had only seen their care plan for the first time during the week of our inspection.
- Each evening patients attended a group where staff asked them to rate their mood and say a highlight and lowlight from the day. Records of this were kept in the nursing office and started in November 2016.
- Families and carers were involved in their loved one's care where appropriate. Information and views from families and carers was evidenced in care records. Fortnightly parent education groups for those who lived close enough to attend were in operation. They acted as a support group as well as a psychoeducation session for parents of children with eating disorders.
- Advocacy services were available on the unit to offer support for patients to access information, be involved in decisions about their care and explore their choices. Young people said they were aware of the advocacy service and that the advocate visited the ward each month. Although patients said they knew about the advocate there was limited information about advocacy in the ward area, but details were written in ward information packs.
- Patients could attend weekly community meetings to give feedback about the ward. Minutes showed staff responded to most areas of feedback. For example, a large teddy bear was bought for the lounge and specific drinks that had been requested were on offer. However, sometimes issues were repeatedly mentioned by young people and there was an absence of a clear action plan or sufficient feedback being given at the following meeting. These included improved access to fresh air and the wireless internet connection being poor. Three of the same items were brought up over two weeks in February 2016 and the only recorded action was to discuss with staff. There were no updates discussed the following week or changes made. A feedback box was provided for anonymous feedback which was then discussed at community meetings. one patient who we

spoke with did not feel that suggestions were taken on board. Feedback from across all wards in the hospital were collated each month and fed back to senior ward staff in a report. This could then be shared with the wider staff group.

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

Good

Access and discharge

- The service had a young person's care pathway, last updated in May 2016, which set out clear inclusion and exclusion criteria. This clearly outlined steps to take before and during an admission, what was required in the first five to ten days of admission and how often to review information. Records showed that staff followed these guidelines.
- The average bed occupancy for the entire hospital between August 2016 and January 2017 was 45 patients. This ranged from 36 patients in August 2016 to a high of 57 patients in November 2016. Bed occupancy was not broken down into service type.
- Discharges were planned in advance and took place at appropriate times of day. Discharge from the service was not delayed for anything other than clinical reasons. We saw in ward rounds that staff considered discharge plans for each patient. Discharge planning was taking place during the admission to plan and facilitate discharge as part of the admission.

The facilities promote recovery, comfort, dignity and confidentiality

- The ward had a range of rooms including a lounge and kitchen that could accommodate all patients at once, individual bedrooms which were personalised with en-suite facilities, therapy rooms and rooms for education. There were three education rooms available with space for patients to work at desks or computers. The ward had a chill out room that patients could access on request. This had multi-sensory equipment and staff said it could be used for patients who wanted quiet space on their own but not in bedrooms. Patients were able to personalise their bedrooms and their artwork was displayed throughout the unit. This made the ward welcoming and comfortable. Personal belongings could be stored in bedrooms which were locked during education and activities. A safe was also available in the nursing office for valuables to be stored.
- Set visiting times were outlined by the ward. The ward did not have a dedicated visitors room and used the dining room, therapy rooms or bedrooms. Visitors ate meals with patients in the dining room. The unit was in a separate building from the adult wards and had its own entrance. The entrance was onto a mews which joined a busy road. The risk of unwanted visitors was mitigated through CCTV and two locked doors between the street and the ward.
- Use of mobile phones was managed throughout the day. Patients had daily access to their mobile phones at set times and at weekends, and could make calls in private. Phones were discouraged during education sessions and at meal times. Staff provided patients with information about when phones could be used on admission and asked patients to sign that they understood this. Staff said where the rules were not followed phones were confiscated for a set period of time, usually 24 hours.
- An activity timetable was in operation Monday to Friday, consisting of meal times, education time, group and individual therapy sessions and activities led by the occupational therapist. Activities were meaningful and recovery focussed. However, there was a lack of activities during weekends and all we spoke with stated weekends were boring and there was a lack of activities.
- The evening snack took place between 9.30pm and 10pm, which some patients said felt too late, and that this meant that it was often past 11pm by the time they went to bed. Because the unit was laid out over three floors, staff were unable to observe patients who wished to go to bed earlier than others. This meant not all patients were able to go to sleep at their preferred time and often stayed up late.
- Bedroom doors did not have observation panels and during night time observations staff entered patient bedrooms to carry out checks that the patient was safe. Staff said they kept towels over the top of the bedroom door so the door could be easily opened and closed without noise. However, this meant the bedroom doors were not fully closed at any point, which could impact on the comfort, privacy and dignity of patients.

Requires improvement

Child and adolescent mental health wards

- Patients could not access fresh air easily because there was no outside space. For fresh air patients had to leave the ward. The young people said that they were often unable to leave the ward as staff were not available to accompany them.

Meeting the needs of all people who use the service

- Spiritual support was available and one patient who we spoke with told us about spiritual support they had accessed. Dietary requirements were clearly stated in patient's notes and were catered for.
- The service was partly accessible to people requiring disabled access. There was an accessible toilet on the ground floor and a lift to access all floors. We did not see evidence of washing facilities for people with a physical disability. Information leaflets were available in the hall covering a range of mental health diagnoses. However, there was only one copy of each leaflet available, so patients could not have a copy of their own. A notice asked patients to return the leaflet once they read it and gave information of where to find the information online. However, young people told us they were aware of how to access advocates and how to complain.

Listening to and learning from concerns and complaints

- Patients said they knew how to make a complaint and what an advocate was, although there was no information on the ward about how to complain or access advocacy services. Staff were aware of the provider's complaints process and this information was available to staff in the nursing office. Patients who we spoke with told us they were confident to raise concerns as complaints and knew how to do this if necessary.
- There were 82 complaints made to the service in 2016, however the provider was not able to break this down into core services. The provider kept a clear system of logging complaints and assessing them for trends. Staff told us that no complaints had been made to the CAMHS service.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- The staff team's shared values reflected those of the organisation. Young people, relatives, carers and all staff members were treated with kindness and respect. Staff told us that the most senior managers in the hospital were visible and could easily be approached for information or advice.

Good governance

- The ward manager was supported in the running of the service, but there were limited systems in place for them to access information about key performance indicators for the ward. For example, safe staffing numbers, the number of agency staff used and number of shifts that were short staffed over time; as well as information on average length of stay for patients, and readmission rates.
- The ward manager had identified the need for supervision of nursing staff and had introduced a minimum of four supervision sessions a year. There was no system in place for pooled healthcare assistant staff to access supervision, which would have provided professional support and development.

Leadership, morale and staff engagement

- Morale was good and staff told us they enjoyed working on the unit and got on well with their colleagues. Staff did not report any cases of bullying or harassment, Staff were given the opportunity to provide feedback about the running of the service and have a say about service development, and they felt that this was taken on board. Staff reported that the unit was well managed and that they were well supported and could raise any concerns easily without fear of victimisation.

Substance misuse/detoxification

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse/detoxification services safe?

Safe and clean environment

- The ward was set out across two floors. On the third floor of the building there were 10 bedrooms, a lounge, laundry facilities, a small kitchen for patients, a bathroom, the nurses' office and consulting rooms. On the fourth floor, there were six bedrooms, a nurses' station and a lounge. On the day of our visit, the area on the fourth floor was closed to patients. All bedrooms had en-suite facilities. The layout of the ward meant that it was difficult to observe all parts of the ward. Patients had unrestricted access to the laundry room. There were blind spots on both floors. Staff mitigated the risk presented by blind spots by assessing patients risk and checking patients at heightened risk every 15 minutes.
- The service had installed many anti-ligature features. These included restrictors on opening windows, piano hinges on doors to en-suite facilities and anti-ligature wardrobes and curtain rails. However, there were standard taps throughout the wards and bedrooms had televisions attached to walls. Staff mitigated the risk of self-harm using ligatures by ensuring that patients presenting a heightened level of risk were placed on an enhanced level of observation.
- During our last inspection in October 2015, we found the service was not compliant with guidance on same-sex accommodation. During this inspection we found that all bedrooms had en-suite facilities and were grouped together according to gender. This meant that patients did not have to pass by bedrooms used by the opposite sex to reach the bathroom. However, this was a mixed sex ward and there was no female only lounge in line with recommendations from national guidance on same sex wards.
- Medicines were generally stored securely and appropriately. Fridge temperatures were monitored daily and seen to be in range, however minimum and maximum temperatures were not checked to ensure the medicines had remained at the safe temperature throughout. All prescribed medicines were available for people when they needed them. Controlled drugs which require additional storage were stored and recorded appropriately, and nurses did daily checks. Emergency medicines and equipment were available and checked weekly to ensure they were correct and available for use. However, the ward did not hold a supply of adrenaline for anaphylaxis which should be kept where Pabrinex injection is used. Adrenaline is a medication to counteract potential side effects following administration of Pabrinex.
- The service took steps to control infections. The service displayed notices to make visitors aware of infection control measures such as handwashing. The service mounted a disinfecting hand gel dispenser on the wall near the entrance to the ward. Staff used a sharps box in the clinic room. Bins in the clinic room had orange bags for clinical waste and a black bag for general waste. Staff wore gloves when they searched patients' property.
- Equipment was clean and well maintained. Each day, staff checked and recorded the fridge temperature and room temperature. Staff also checked the defibrillator, suction machine and oxygen each day. Staff checked the emergency trolley each week. Staff said they calibrated the ECG machine, but there were no records of this except for a sticker on the ECG machine. The provider said that the ECG machine was monitored by virtue of a contract between the hospital and St Georges Medical Physics.
- The service displayed cleaning records on the wall of communal areas and toilets. The housekeeper cleaned patients' bedrooms each day. The service carried out a deep clean of bedrooms after patients were discharged.

Substance misuse/detoxification

- At the time of inspection the provider did not have an infection control lead and had not carried out an infection control audit since May 2016. The provider had identified this gap and had recruited a staff member to take on this role, although at the time of our visit they had not started yet. The most recent infection control audit did not clearly outline what outstanding actions had been completed or provide a clear date for completion for all items. This meant the provider was not effectively managing risks from the spread of infection to ensure a safe environment for patients and staff.
- The service had completed an environmental risk assessment, although staff had not updated this since March 2015. This risk assessment listed and rated risks on the ward but did not include any measures to mitigate these risks.
- The service had installed call buttons in all bedrooms. A panel in the nursing station indicated where someone had activated a call button. There were no call buttons in communal areas. The service did not provide personal alarms. Two nurses said this meant they did not always feel safe.
- Staff said that it was rare for any patient to require a physical intervention. Staff could not recall any incidents of restraint on the ward. Staff said that if they did require support with a specific incident, nurses from other ward would attend quickly. The service displayed the procedure for calling for assistance at the nurses' station.

Safe staffing

- The rota for the four weeks prior to the inspection showed the service had allocated the appropriate number of staff to the ward on all but one shift. On one shift, the service had allocated only one nurse to the ward. A member of staff said that on that occasion, a nurse from another ward had been transferred to ensure there were sufficient staff.
- The provider was unable to give us a breakdown of how many staff worked in each service as staff were often moved between wards depending upon need. Agency staff could be used during times when there were not enough permanent nurses and pooled healthcare assistants to meet staffing requirements. However, staff told us that staffing requirements were consistently met.
- The service operated a system of two shifts each day. The day shift started at 7.30am and ended at 9.00pm. The night shift began at 8.30pm and ended 8.00am. The service allocated half an hour for nurses to handover information to staff coming on to their shift. The number of staff on each shift varied according to the number of patients. If there were fewer than seven patients, the service would allocate two nurses to the ward. The service would also allocate a health care assistant to the ward if there were more than seven patients. If there were more than 10 patients, the service would open the additional area on the fourth floor. The service allocated two nurses to area this when it was open.
- The service used agency staff, predominantly to cover night shifts. The ward used the same four agency nurses to ensure that nurses were familiar with the ward. There was usually at least one permanent member of staff allocated to each shift. During the four weeks prior to the inspection, there was one occasion when a night shift was staffed entirely by agency nurses. During this four week period, one nurse had worked 22 out of 28 night shifts. Another nurse had worked 19 out of the 28 days. Two agency nurses had regularly been working up to 69 hours each week. This meant that agency nurses worked without the required breaks in between contracted hours and were not receiving necessary rest following working.
- The ward manager could increase the number of staff allocated to the ward if one or more patients required close observation or if there was a heightened level of acuity.
- A nurse was available in the communal area at all times.
- Nurses and patients said there were sufficient nurses available to ensure that each patient could spend time speaking to a nurse on their own when they needed to.
- Staff and patients said there were sufficient nurses to facilitate leave and activities when required. Therapists facilitated most activities.
- Between the hours of 9.00am and 5.00pm, ward doctors provided medical cover. Outside these hours, a duty doctor was available on-call. The duty doctor was based on site and covered all the wards at the hospital. Staff said that the duty doctor could respond quickly when required.
- Mandatory training was a mixture of face-to-face training and e learning. Staff had completed 69% of mandatory training. The provider had developed a training action plan to address mandatory training of staff and to achieve a target of 90% compliance across all mandatory training courses.

Substance misuse/detoxification

Assessing and managing risks to patients and staff

- A nurse and doctor completed a risk assessment for each patient when they were admitted. Staff asked patients if they presented any risks to themselves or other people, or if they were at risk from other people. If the patient identified risks, staff classified these as being low, medium or high. The assessment then stated the level of observation that the staff would provide to manage the risk. The form stated whether the patient had consented to that level of observation. The form did not include any details of harm the patient had experienced in the past due to identified risks. These assessments were updated daily, based on a discussion between the nurse and the patient about how the patient was feeling that day. Staff rated daily risks as low, medium or high. The nurse and the patient both signed the daily risk assessment. If staff identified any risks as medium or high, the staff would create a risk management plan. This plan stated the nursing intervention that would be used to address the presenting risk and any restrictions on the patient's movement. The plan also included confirmation that the patient was consenting to the risk management plan.
- There were some blanket restrictions. These were consistent with providing a therapeutic environment for patient to complete their detoxification from drugs or alcohol. Patients signed a document to confirm their agreement with these restrictions when they were admitted. The service did not permit patients to bring drugs or alcohol onto the ward, or to use drugs or alcohol whilst on leave. The service did not permit patients to enter other patient's bedrooms. The service did not allow patients to use mobile phones during therapy. The service only permitted visitors between 5.00pm and 10.00pm. If patients were not compliant with the restriction placed on them, their consultant would be informed. The consultant made a decision on what action to take based on the specific circumstances of the patient and the incident. For example, the service would not necessarily discharge patients if they took drugs or drank alcohol whilst they were off the ward.
- Patients could leave the ward if they wished to do so. However, staff discouraged patients from leaving the ward in the first 48 hours of their admission whilst the initial assessment was taking place. Staff could escort patients who wanted to leave the ward if necessary.
- The service provided four levels of observation. General checks of patients took place every hour. Level two observations involved staff checking patients every 15 minutes. Level three observations involved the patient being in sight of a member of staff at all times, and level four required the patient to be within arms-length of member of a staff. Nurses agreed the level of observation with the ward doctor and consultant. Nurses could not reduce the level of observation without the agreement of a doctor.
- Nurses searched patients on admission and when they returned from leave. Searches involved patients emptying their pockets and staff looking through their bags. Staff searched patients' bedrooms if they suspected there were items that could present a risk, such as drugs, alcohol or sharp objects. Patients were present if staff searched their bedroom. If patients did not co-operate with searches, staff negotiated with them. If the patient continued to be uncooperative, the nurse informed the consultant. The consultant decided on the most appropriate course of action.
- The service had a policy on safeguarding for children and for adults. This policy included the procedure staff should follow if they suspected abuse. Staff said they had received safeguarding training. Nurses told us that if they were concerned about a patient they would pass the information to the safeguarding lead for the hospital. The service did not routinely ask patients about arrangements for looking after any children they were responsible for or assess any risks to these children.
- Prescriptions and medication administration records were clear and included important information such as allergies, dose changes, indications for use and maximum doses of medicines prescribed 'when required'. All administrations were signed or coded to show why they had been omitted. Variable doses for detoxification regimes were clear and signed by the prescriber. 'Do Not Disturb' tabards were used by nurses when administering medicines to enable them to concentrate on the task. Pharmacists were not routinely involved in medicines reconciliation on admission and the relevant part of the medicines chart was not always completed, but two RMOs we spoke with described how they would ensure they had confirmation of a patient's current medicines wherever possible before they prescribed for them.

Substance misuse/detoxification

- Children were able to visit the ward during visiting hours if an adult accompanied them.

Track record on safety

- The provider could not give us a breakdown of incidents by core service.

Reporting incidents and learning from when things go wrong

- Staff said that they completed incident forms when incidents occurred. These were passed to the charge nurse and the nurse in charge of the hospital at the time.
- The service did not hold regular team meetings and, therefore, there were limited opportunities for staff to discuss and learn from incidents. A team meeting had taken place in September 2016. A specific serious incident involving the death of a patient on leave had been discussed at this meeting. Staff agreed to seek advice on how to prevent a re-occurrence of the incident, but there were no further notes on what was agreed.

Are substance misuse/detoxification services effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- There were no incidents of seclusion or restraint during the previous 12 months.
- A nurse and a doctor completed an assessment of each patient on admission. The nurse and doctor completed assessments on a standard admission form used throughout the acute admissions wards at the hospital. This meant the assessment covered the basic information such as the patient's vital signs, their mental state, and a brief history of their drug and alcohol use. When staff completed this form, they were not required to include detailed information relevant to the patient's use of drugs and alcohol. For example, the details of the patient's drug or alcohol history were brief. There were no details about whether patients had previously attempted or completed a detoxification. The service did not use a specific tool to assess the level of drug or alcohol dependency, such as the severity of alcohol dependence questionnaire (SADQ). Tools such as SADQ are used in substance misuse services to determine the starting dose of medication used to treat acute alcohol withdrawal. Failure to use a specific tool to measure the severity of withdrawal could result in patients being given an incorrect dose of medication. This practice was not consistent with the hospital's policy on alcohol and drug detoxification which recommended the use of SADQ. In addition, people with a history of high use of drugs and alcohol present a high risk of blood borne viruses. The physical examination did not include a blood test to identify whether a patient carried a virus. This meant there was a risk that the service would not identify significant health needs.
- Care records were completed routinely and up to date.
- The service operated two systems for recording patients' information. A paper file contained the initial assessment, care plan and some progress notes. The electronic record contained more comprehensive progress notes and daily risk assessments. Some consultants made records on the electronic system whilst others used the paper record. Operating two systems meant there was often duplication of records. It also created a potential risk that staff would not know where to find essential information.

Best practice in treatment and care

- Patients were prescribed medicines in accordance with national guidance. Most clients with alcohol dependency were prescribed the medicine chlordiazepoxide. The service did not offer ultra-rapid or accelerated detoxification regimes. There were up to date prescribing protocols for all of the recommended medicines prescribed in the service.
- The service provided a programme of psychological therapies facilitated by therapists. During the week, the service provided a structured of therapeutic groups covering anger management, relationships and relapse prevention. The service supported patients to complete the first three steps of the 12-step recovery programme. The service also provided groups on cognitive behavioural therapy, yoga and mindfulness.
- Patients had good access to physical healthcare assessments. Nurses regularly carried out physical observations. If a patient required specialist care and treatment they would be referred to a specialist doctor at a local hospital and supported to attend appointments if necessary.

Substance misuse/detoxification

- The service used the clinical institute withdrawal assessment from alcohol (CIWA) and the clinical opiate withdrawal scale (COWS). These are standard tools used to assess and measure the severity of patients' withdrawal symptoms. Records showed that a CIWA assessment was usually completed once on the first day and once on the second day. Staff's entries in the records did not explain why the assessments had stopped before the completion of the detoxification programme. On one record, we found that staff had used the COWS, even though the patient had been withdrawing from alcohol, which gave an inaccurate measurement of the patient's withdrawal. One record showed the service also used the Becks Depression Inventory to assess patients with depression.
- Nurses completed a weekly audit of the resuscitation equipment and stock medication held in the clinical room. Nurses recorded the fridge temperatures each day. The nurse in charge checked that admission forms were completed correctly.

Skilled staff to deliver care

- The multidisciplinary team included nurses, a doctor, a consultant psychiatrist and therapists. The service allocated a consultant to each patient. Therapists facilitated groups and gave a handover to the nursing staff.
- Staff had a good understanding of substance misuse services.
- Nursing staff received inadequate levels of supervision. We reviewed the employment records of five members of staff. Supervision sessions were infrequent and, in most cases, the supervisor had made very brief records. The supervision folder for one employee did not contain any documents. One nurse had not had any supervision for more than one year. Four employees had had one or two supervisions in the previous year. One nurse had transferred to the addictions service from the general psychiatric ward during 2016. This nurse had not received any supervision since the transfer. This nurse had no previous experience of working within an addictions and detoxification service. There was no assessment of their competency or development needs. This meant that the staff on this ward did not have the support of regular supervision and that training and performance issues were not addressed and monitored.
- Most nursing staff did not have an appraisal in the previous 12 months. This meant that nursing staff were not being properly supported in their roles.
- Staff told us that training involved learning from other staff on the ward. Staff said that the ward manager had provided a more formal training session on working within an addictions and detoxification service. Although the service provided an example of a training booklet, there were no records of when this training took place and who took it.
- The Nursing Services Manager (NSM) had raised concerns about performance with two members of staff following a complaint by a patient. The letter from the NSM to the employee stated that the ward manager would monitor their performance in relation to key objectives for four weeks. A form had been prepared to monitor objectives but it was not completed. Neither member of staff had received supervision since the NSM had raised concerns about performance.

Multidisciplinary and inter-agency working

- The service did not hold multidisciplinary team meetings. Consultants usually visited patients three times each week. They met with their patients without other members of the multidisciplinary team present. At the end of their visit they made an entry onto the patient record.
- Handover meetings between nurses took place twice a day when there was a change of shift. The notes of these meetings were very thorough, providing key information about why the patient was admitted and an update on each patient's progress during the previous shift. Notes also included any changes to each patient's risk status, their observation level and their vital signs. A handover from the therapy team took place once a day. The therapy team recorded their notes on the electronic patient record.
- On admission, patients were asked to provide details of their GP. If the patient asked the service not to contact the GP, the service did not do so. The patient's consultant decided how these risks should be managed. This presented a number of risks. Firstly, this meant that the service did not have independently corroborated details of the patient's medical history. Further, the patient may have been receiving medication from the

GP that they had not declared to the hospital. This heightened the risk of medication being prescribed twice, and patients potentially taking more than the recommended dose of medications.

Good practice in applying the MCA

- The service completed an assessment of each patient's capacity to consent to admission and treatment during the initial assessment. The assessment form asked if there were reasons to suggest the patient may lack capacity. If there were doubts about capacity, the doctor and nurse completing the assessment were required to complete a thorough capacity assessment form and inform the hospital compliance manager.
- 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. The hospital policy stated that if a patient enters the hospital, this can be interpreted as implied consent to admission. The policy also stated that any action on behalf of a person who lacks capacity, even temporarily, must be completed in the person's best interests.
- If staff had any questions about the Mental Capacity Act, they would speak to the hospital compliance manager.

Are substance misuse/detoxification services caring?

Kindness, dignity, respect and support

- We observed positive staff attitudes and behaviours when interacting with patients throughout the inspection. For example, whenever a patient approached the nurse's station, nurses asked how they were and showed genuine interest in what the patient had been doing that day. Nurses responded straight away to patients requests.
- The three patients we spoke with were very positive about the service. Patients described nurses as kind, considerate, compassionate and interested in patients. Patients said that the staff had managed the symptoms of their withdrawal well and that they had felt safe throughout this process. One patient commented that staff treated patients like guests and made them feel very welcome.
- Staff had a good understanding of patients. When staff spoke with us about patients they knew the circumstances surrounding the patient's admission and the details of their care and treatment.

The involvement of people in the care they receive

- When patients arrived at the ward, the admitting nurse introduced them to the staff and showed them to their room. Nurses offered patients a cup of tea. Nurses recognised that patients were often anxious when they arrived. In order to reassure patients, a nurse would speak to the patient about exactly what would happen during the admission and answer any questions.
- Staff assessed patient needs and together they wrote care plans to meet the specific individual needs of each patient. Care plans were also recovery orientated, including a statement of the patients objectives for their detoxification and longer term recovery. Daily risk assessments were completed collaboratively by nurses and patients.
- Patients could access an advocacy service. Contact details of the advocacy service were displayed on notice boards.
- Families and carers were welcome to attend the ward if patients wanted them to do so. The service facilitated a family support group one evening each week.
- Patients were not involved in decisions to recruit staff.
- The service asked patients to complete an inpatient satisfaction survey. This survey asked them to rate their experience of admission, the environment, care and treatment and outcomes of their treatment. In the patient satisfaction survey completed by the hospital between July 2016 and October 2016, 97% of patients rated the level of respect they got from staff as good or excellent. 97% of patients during the same time period rated that level of trust and confidence they had in staff as good or excellent. 97% of patients also thought that the quality of staff's response to their questions as good or excellent.
- There had been three community meetings in the six weeks prior to the inspection. Staff made a record of these meetings. Community meetings provided an opportunity for patients to discuss any concerns they had about the service.
- Staff said the hospital was introducing a question about advance decisions onto the standard admission form.

Substance misuse/detoxification

Are substance misuse/detoxification services responsive to people's needs? (for example, to feedback?)

Access and discharge

- The average bed occupancy for the entire hospital between August 2016 and January 2017 was 45 patients. This ranged from 36 patients in August 2016 to a high of 57 patients in November 2016. Bed occupancy was not broken down into service type. Staff said that most patients were in hospital for two weeks to a month.
- The service did not admit new patients to bedrooms that were allocated to patients on leave.
- The service did not transfer patients to other wards during their admission. Occasionally, the service admitted patients from the general acute psychiatry service within the hospital.

The facilities promote recovery, comfort and dignity and confidentiality

- The ward had a patient lounge, a kitchen, a laundry room, a clinic room and a consulting room. 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.
- All areas of the ward were clean and well-maintained. Furniture was of good quality and well designed. Lounges were bright and colourful. Patients could adjust the lighting in their bedrooms.
- There were quiet areas on the ward where patients could meet visitors. Patients could also meet visitors in their bedrooms.
- Patient made telephone calls using their own mobile telephones. If a patient did not have a mobile telephone, the service provided a cordless telephone from the nurses' office.
- Patients had unrestricted access to a garden within the hospital until 9.30pm.
- The hospital restaurant provided a wide choice of good quality food.
- Patients were able to make hot drinks and snacks in the ward kitchen. The kitchen was clean, comfortable and well equipped with a fridge, kettle, microwave, water cooler and a toaster.
- There were facilities for patients to store their belongings securely.
- There was a comprehensive programme of activities throughout the week, including weekends.

Meeting the needs of all people who use the service

- There was a lift up to both floors of the ward. This meant the service could be accessed by people using a wheelchair.
- This was an international service that admitted patients from across the United Kingdom and from other countries. A number of patients were from the Middle East. The service routinely provided information in other languages and arranged interpreters. During the inspection, one patient was receiving individual sessions with a therapist who spoke Arabic.
- The service displayed information about treatment, patients' rights, advocacy services and advice on how to complain on notice boards on the ward.
- Meals were provided in a restaurant used by all patients at the hospital. Food was prepared and cooked by a chef on-site. Meals could be ordered to meet the specific cultural needs, dietary needs and preferences of the patients.
- The service could arrange appropriate spiritual support if patients requested this.

Listening to and learning from complaints.

- There were 82 complaints made to the service in 2016, however the provider was not able to break this down into core services. The provider kept a clear system of logging complaints and assessing them for trends. In December 2016, there were four written and three verbal complaints which were all resolved with an apology as appropriate and the patient accepted the outcome. For December 2016, there were three complaints from patients to nursing staff and two complaints to the therapy team. Two complaints were made by patients to the finance department.
- Patients we spoke to said they knew how to make a complaint if they needed to do so.

Are substance misuse/detoxification services well-led?

Vision and Values

- Staff demonstrated the organisation's values of respect, compassion, commitment, teamwork and recognition

throughout their work. For example, patients told us that staff treated them with respect and compassion. Staff said they valued working as a team with their colleagues.
- The service did not have any specific objectives, such as minimising the number of patients who discharged against medical advice.
- Staff knew who the senior managers were and said these managers frequently visited the ward.

Good governance

- The substance misuse and detoxification service did not have specific key performance indicators. However, the service did keep records of the number of patients who discharged themselves against medical advice. This indicated patients who had left the hospital without completing the detox programme. In the year prior to the inspection, there had been 10 such discharges. When patients wanted to self-discharge against medical advice, the consultant was contacted straight away. The consultant would speak to the patient and advise them of the dangers of recommencing the use of alcohol or opiates. The staff and consultant would encourage patients to continue taking their medication. The staff and consultant would assess the risk presented by the patient leaving. If staff were concerned that the decision was effected by a mental disorder, they arranged an assessment under the Mental Health Act 1983.
- The ward manager felt they had sufficient authority to run the ward. The ward did not have specific administrative support. Most administration was carried by a centralised team covering the whole hospital.
- Staff could submit items to the hospital risk register through the ward manager.

Leadership, morale and staff engagement

- Staff said they were not aware of any bullying or harassment within the service.
- Staff knew how to use the whistle blowing process and said that they could raise concerns without fear of victimisation.
- Staff were happy in their work and staff morale across the team was high. Staff said the team worked well together and there was a strong sense of mutual support.
- Staff gave examples of how they were open and honest with patients, and that they were willing to acknowledge any mistakes.
- Opportunities for staff to offer views on the service were limited due to the infrequency of team meetings. Some nurses said they would speak to the ward manager if there were any issues they needed to raise. Other staff said they were sceptical about whether their views would be listened to by the hospital managers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff have adequate access to support by ensuring that an effective system is put into place for staff to access assistance from other staff in an emergency.
- The provider must ensure all ligature risks are identified on wards and that all staff have access to the ligature risk management plan and can clearly articulate how they manage ligature risks on each ward. The provider must continue to ensure that ligature risks are reduced by refurbishing the environments of the wards where ligature risks are still present by December 2017.
- The provider must implement a supervision policy and ensure that nursing staff receive regular supervision and appraisal. The provider must ensure there are effective systems to address concerns about poor performance.
- The provider must ensure that all grades of staff working on the CAMHS and the substance misuse and detoxification ward are provided with formal specialist training to work in these specialist services. The provider must ensure that all grades of staff who have contact with children first complete children safeguarding training.
- The provider must notify the Care Quality Commission of all statutory notifications, including allegations of abuse.
- The provider must ensure that staff know where patients are in the hospital at all times as there is a potential of risk from patients harming themselves or others.
- The service must ensure there are effective systems in place to manage the risks of patients on the substance misuse and detoxification ward who do not consent to the service contacting their GP. The service must ensure that assessments on the substance misuse and detoxification ward address the specific needs and background risk and misuse histories of people admitted for drug or alcohol detoxification. The provider must ensure that screening for blood borne viruses is provided on the substance misuse and detoxification ward. The service must ensure that any risks to children cared for by patients are identified when patients are admitted. The service must ensure emergency medicines such as adrenaline for anaphylaxis, are on the substance misuse and detoxification ward.

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Action the provider SHOULD take to improve

- The provider should ensure that it grades incidents and accidents appropriately, so that it is clear when a serious incident has happened. The provider should ensure that lessons learned following incidents are implemented and monitored effectively. The service should ensure that staff regularly discuss their work as a team and understand any lessons learned from incidents or complaints. The provider should ensure ward meeting minutes are recorded.
- The provider should ensure that staff follow the Mental Health Act Code of Practice guidelines when rapid tranquilisation medication is administered and that physical health assessments are carried out and recorded.
- The provider should ensure that documentation of capacity assessments are routinely completed to an appropriate standard.
- The provider should ensure that staff complete discharge plans for patients on the acute wards.
- The provider should ensure that agency and bank staff working on the CAMHS unit receive relevant and specific information available to them about the ward and how to support young people during meal times.
- The provider should ensure that young people have regular daily access to outside space and that there are sufficient activities at the weekend for patients. In the CAMHS service, the provider should ensure that actions resulting from patient meetings and feedback are communicated to patients.
- The provider should stop using the consent to the management of physically disturbed or violent behaviour contract on the CAMHS unit and develop care plans based on individual patient need.
- The provider should ensure that young people on the CAMHS unit have regular daily access to fresh air breaks.

Outstanding practice and areas for improvement

- The provider should ensure that informal patients' rights forms are filled in and signed by patients.
- The service should ensure that fridge temperatures are monitored regularly and accurately.
- The provider should ensure that risks from the spread of infection are managed and that actions from infection audits are followed up.
- The provider should ensure that there are women only lounges available in wards which are mixed gender.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider was not always providing care or treatment in a safe way: The provider did not mitigate the risks of not contacting patients' GPs on the substance misuse and detoxification ward. The provider did not use assessments on the substance misuse and detoxification ward which addressed the specific needs and background risk and misuse histories of people admitted for drug or alcohol detoxification. The provider did not ensure that patients were screened for blood borne viruses on the substance misuse and detoxification ward. The provider did not assess the risks to children cared for by patients who are admitted to the substance misuse and detoxification ward. This was a breach of regulation 12 (1)(2)(a) The provider was not ensuring that the premises used by the service provider are safe to use for their intended purpose and are used in a safe way. The service did not have an effective system in place for staff to alert other staff when they needed urgent assistance.

This section is primarily information for the provider

Requirement notices

The provider did not ensure that staff knew where patients were in the hospital at all times.

Ligature reduction work was not due to be completed until December 2017. Staff did not always know about these ligature risks on each ward and how these should be mitigated.

This was a breach of regulation 12 (2)(d)

The provider did not ensure that there were sufficient quantities of medicine to ensure the safety of servicers and meet their needs.

The provider did not ensure that there were emergency medications available for staff in the substance misuse and detoxification ward.

This was a breach of regulation 12 (2)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider did not have systems and processes established and operated effectively to prevent abuse of service users. The provider did not ensure that all staff who had contact with children had first completed children safeguarding training. This was a breach of regulation 13 (2)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider was not providing appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform. The provider did not provide formal specialist training to all grades of staff working on the CAMHS and substance misuse and detoxification ward. Nursing staff had not received clinical supervision regularly. Nursing staff were not receiving routine appraisals. The service did not have an effective system to address concerns about poor performance of staff. This was a breach of regulation 18 (1) (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The provider was not notifying the CQC of all allegations of abuse as per Care Quality Commission (Registration) Regulations 2009 Regulation 18 (2) (h).