Priory Healthcare Limited

The Priory Hospital North London

Quality Report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Overall summary

The Priory Hospital North London is registered to provide the following regulated services / activities:

- Accommodation for persons who require treatment for substance misuse
- Treatment of disease, disorder or injury
- Assessment or medical treatment for persons detained under the 1983 Act
- Diagnostic and screening procedures

It provides a range of specialisms including caring for children, caring for people whose rights are restricted under the Mental Health Act, people with mental health conditions, and people with substance misuse problems.

The service has three wards:

Birch Ward

Core service provided: Child and adolescent mental health wards

Male/female/mixed: Mixed

Capacity: 13 beds

Oak Ward

Core service provided: Child and adolescent mental health wards

Male/female/mixed: Mixed

Capacity: 9 beds

Lower Court

Core service provided: Acute wards for adults and Substance misuse services

Male/female/mixed: Mixed

Capacity: 28

The inspection found that the service provided by The Priory North London had many good aspects. The service followed national guidance, developing clear therapy programmes, which were delivered in the most part by skilled staff. Most aspects of people's care was planned for in a holistic manner. When incidents occurred these were reported by staff and learning points were identified and acted upon by management. The service had had a high level of nurse staffing vacancies, but had ensured that staffing levels were maintained at safe levels by using bank and agency staff.

However, we found some areas the service needed to improve: People's mental capacity to consent to each aspect of care and treatment was not always being assessed robustly; the Lower Court ward was not managed in a manner which ensured it followed single gender guidance; and there were some maintenance concerns in the child and adolescent wards.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The service was safe. Staff knew how to report incidents. When incidents happened they were investigated and learning identified. Emergency equipment was regularly checked and was kept in a place where it was readily accessible. Staff had been trained and knew how to make safeguarding alerts. Medicines were managed well. However, some ligature risks identified in the provider's ligature risk assessment did not have management plans associated with them; and some of the furniture in the CAMHS wards had tears, meaning there could be an infection control risk. The Lower Court ward did not meet single gender standards.

Are services effective?

People had up to date, holistic care plans which addressed their individual needs. People had access to a wide range of therapies. Staff were able to access training and there was a strong multidisciplinary team. However, there were gaps in the physical health monitoring. There was also some lack of clarity about the way the Mental Capacity Act was used in practice.

Are services caring?

The staff were caring. We observed thoughtful and caring interventions. Most feedback from people was positive. People were given information when they were admitted to the wards. In the child and adolescent wards, families were contacted frequently regarding care for young people.

Are services responsive to people's needs?

The service was responsive to people's needs. There were clear pathways for admission, treatment and discharge through the service. An extensive therapeutic programme was provided to people undertaking the programmes. The ward was aware of the diverse needs of people who use the service and responded appropriately. Staff knew how to support people who wanted to make a complaint, and people who had done so were happy with how these had been dealt with. However, there was limited space on the child and adolescent wards; staff on Lower Court found it difficult to manage multiple admissions in a single day; and some people on the addiction found it difficult being on a shared ward with people being treated for other conditions.

Are services well-led?

The service was well led. There was a clear system of governance to monitor the service. Staff were able to explain the professional

Summary of findings

values that underpinned their work. Staff felt supported by their team and managers. However, some staff told us that high staff turnover and high vacancy rates had a negative impact upon staff morale. The provider had introduced innovative therapy programmes, some of which were only available at this location.

Summary of findings

What we found about each of the main services at this location

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

The general psychiatry and obsessive compulsive disorder programmes were providing a good service. Most risks were assessed and plans put in place to manage risks. People were generally supported by suitably qualified staff. However, the provider must ensure that people using the service's capacity to consent to treatment is assessed fully. Staff spoke to us of the challenges of maintaining high standards of care when there were multiple admissions to the ward in one day. The Lower Court ward did not meet single gender standards.

Child and adolescent mental health wards

The child and adolescent service was providing a good service. People had up to date, holistic care plans which addressed their individual needs. Patients had access to a wide range of therapies. Physical health was monitored regularly. We observed thoughtful and caring interventions by staff. However, some improvements were required. Some ligature risks identified in the provider's ligature risk assessment did not have management plans associated with them. The ward manager was not clear when some areas of the ward, for example one of the lounge areas, had had a 'deep clean'. Some of the furniture had tears, meaning there could be an infection control risk. There were gaps in the physical health monitoring. There was also some lack of clarity about the way in which people's mental capacity to consent to care and treatment was being assessed.

Substance misuse services

The Addiction Therapy Programme service was providing a good service. People using the service had their risks assessed. Care plans and their supporting assessment tools were comprehensive and complemented the group work programme. Therapy staff were skilled and experienced and facilitated the provision of a quality addiction therapy programme. However, the provider should consider whether locating the addiction therapy programme on a mixed ward appropriately meets patient needs. The provider gathers information addressing abstinence maintenance and relapse for patients who complete the addiction therapy programme, and should consider analysing this information as part of its outcome measurements. The Lower Court ward did not meet single gender standards.

Summary of findings

What people who use the location say

During the inspection we spoke with 12 people who were being treated at the hospital.

Most people we spoke with were aware of their care plan and had been offered a copy. Some people told us that they had not seen a copy of their care plan and did not think that their views in relation to their care and treatment were listened to.

The people using the service were generally positive about staff. When they had raised concerns with managers these had been followed up.

Some people in the care and adolescent wards told us they felt there should be more activities and the service was boring.

In the addiction therapy programme the people we spoke with told us that they, or their representative, had chosen the programme because of the provider's reputation in this area.

Most people we spoke told us that the structure of the programme had been clearly explained to them and felt they were benefitting positively from the treatment they were receiving.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that mental capacity assessments in relation to consent are related to the specific decision. We found examples where someone's consent had not been recorded appropriately.
- The provider must ensure that mixed the mixed gender adult ward complies with guidelines for gender separation.

Action the provider SHOULD take to improve

- The provider should ensure that all physical health checks are completed as appropriate. Some records we reviewed in the child and adolescent wards had not been completed.
- The provider should ensure that management plans for ligatures identified in ligature risk assessments are in place and related to the needs of the people using the service.
- The provider should record in incidences of restraint in accordance with the MHA Code of Practice.
- The provider should assess the environment in all areas regularly to ensure furniture is in a good state of repair. On Birch ward we found damaged furniture.
- Staff spoke to us of the challenges of maintaining high standards of care when there were multiple admissions to the ward in one day. The provider should consider ways to support staff facilitate these admissions.
- The provider should review some of the blanket restrictions in the child and adolescent wards to see if they are required to manage risks to all the young people using the service.
- The provider should consider whether locating the placing people on a range of different programmes on the mixed Lower Court ward appropriately meets people's needs. Some staff and people on the addiction therapy programme commented that they were disturbed by noise from other patient groups and found the restrictions on mixing with other patient groups challenging whilst sharing a ward environment.
- Not all nursing and health care staff had received specialist training, such as in substance misuse. The provider should consider providing this as core training as all the staff we spoke commented that it would further improve the quality of care they were able to provide.
- The provider gathers information addressing abstinence maintenance and relapse for patients who complete the addiction therapy programme, and should consider analysing this information as part of its outcome measurements.

Summary of findings

Good practice

- We found that the addiction therapy programme care plans and their supporting assessment tools were comprehensive and complemented the group work programme. Therapy staff were skilled and experienced and facilitated the provision of a quality addiction therapy programme.
- The Obsessive Compulsive and related disorders programme is a specialist service in which people receive a specialised programme of therapy.

The Priory Hospital North London

Detailed findings

Services we looked at:
Acute wards for adults and psychiatric intensive care units; Child and adolescent mental health wards; Substance misuse services.

Our inspection team

Our inspection team was led by:

Team Leader: George Catford, Care Quality Commission.

The team that inspected the hospital consisted of eight people: an inspection manager, three inspectors, two Mental Health Act reviewers and two nurses.

Background to The Priory Hospital North London

The Priory Hospital North London has 50 beds providing a range of services, including acute mental health services for adults, child and adolescent mental health wards, and substance misuse services (through its Addiction Therapy Programme).

The child and adolescent service consists of two wards: Birch, which is 13 bedded including five beds that had been designated as a high dependency unit; and Oak which is nine bedded. These beds were all occupied during our inspection visit. They were available to people in the 12-18 age group and both wards were mixed gender.

The other inpatient services at the hospital are provided in the Lower Court ward. Accommodation is provided in 28 en suite rooms.

Outpatients are also seen within the hospital.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme.

How we carried out this inspection

To get to the heart of 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?

Detailed findings

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

During the inspection visit, the inspection team:

- Spoke with 29 members of staff including management, therapists, medical staff, nursing staff and housekeeping staff.
- Interviewed the hospital director, medical director, support services manager and the director of quality for Priory Health.
- Spoke with the manager / person in charge on each of the wards.
- Spoke with 12 patients who were using the service.
- Observed interactions between staff and people using the service.
- Attended handover meetings.
- Attended a ward round in the CAMHS wards.

We also:

- Checked a sample of care records and medication records on all the wards.
- Looked at policies, procedures and other documents relating to the running of the services

Is the service safe?

Our findings

Safe and clean ward environment

- Ward layouts allowed staff to observe the wards. Blind spots had been identified on Birch ward. There were CCTV cameras with viewing stations in the nurses' office to mitigate the risks of these.
- The provider had conducted an assessment of ligature risks in August 2014. This identified a number of risks in the child and adolescent mental health wards. However, the provider had not devised a clear plan to manage these risks. For example, the assessment identified a toilet roll holder in room B43 and handles and rails in communal areas but had not stated what it would do about this. Those who had undertaken the risk assessment had not explained how staff should manage the presence of ligature points considered a high risk to patients; such as the bathroom areas outside of the high dependency unit. They had not, for example, detailed how they may use observation or understanding of the individual need of patients to keep patients safe.
- Emergency equipment, including an external defibrillator and oxygen, was available and checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Emergency drugs were available and checked regularly. Mandatory training addressing basic life support was provided to staff, and staff we spoke with were able to explain how they would respond in the event of an emergency.
- There were some maintenance and cleanliness issues on Birch ward, including two sofas which were torn in one of the lounge areas. We were told that these were being replaced. Lower Court and Oak wards were clean and well presented.

Safe Staffing

- Turnover of staff has been high. In 2014 there was a 43% turnover in all substantive staff.
- The vacancy rate at the hospital was 9.3% in January 2015. There were four vacancies for qualified nurses in the child and adolescent service. These roles were being recruited to.
- The provider ensured that there were enough staff to ensure safe care on each of the shifts. However, there had been a high turnover of staff and the provider filled a high number of shifts with bank and agency staff. In the three months prior to the inspection 594 bank and 310 agency shifts had been filled in the child and adolescent service. 392 bank and two agency had been filled in the Lower Court. In total there had been 15 shifts that had not been filled.
- People on the child and adolescent wards raised concerns with us about the high turnover of staff. There had been five ward managers in the last 2.5 years. Two new consultants were due to join the ward in April. This meant there may be an unsettled feel to the ward with some lack of consistency for the young people there.
- The provider had assessed the staffing needs for the patient group and had ensured staffing had been maintained at safe levels. A consultation had been undertaken. The provider was looking to develop a strategy to improve recruitment and retention.

Assessing and managing risk to patients and staff

- Staff had a good understanding of safeguarding processes and when to make referrals. There was information on display in the ward offices explaining safeguarding processes and contact details. All nursing staff were trained to level 3 safeguarding children. However, one member of staff in the child and adolescent service told us they did not get feedback about safeguarding processes when they made referrals. This meant that there was a risk that learning from safeguarding incidents may not be embedded.
- There were some blanket restrictions in place as a part of the ward rules in the child and adolescent service. These may have been consistent with providing a secure environment for the young people, but they needed to be adapted to reflect individual needs. For example, the kitchen area and some lounge areas were locked during the time when young people were usually in education. If a young person was not in the education this may limit their ability to access these areas inappropriately.
- Staff only occasionally used physical restraint. In the six months prior to the inspection restraint had been used 28 times. Staff were trained on prevention and management of difficult behaviours; including how to restrain people physically when necessary. However, not all records of restraint were comprehensive. The record of one person did not indicate how they were restrained

or for how long they were held in the restraint. This patient was admitted to the hospital as an informal patient, but it was not recorded whether consideration had been given as to whether they should be detained.

- When people were admitted to the wards, a comprehensive package of assessments was completed. This included carrying out a risk assessment. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of people by staff were increased.

Track record on safety

- Four serious incidents were recorded in the child and adolescent service wards between January and December 2014. These had been reported appropriately through the organisation and information had been shared about learning from incidents.
- We were given examples by staff of changes made in response to previous incidents. For example, staff told us that a noticeboard with the name of each patient due to attend group was displayed outside of each group room. This meant that all staff would be aware of where each patient should be, and could take appropriate action if patients were found to have left the ward unexpectedly.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents on the provider's electronic incident recording system. Staff told us that, if an incident occurred, they were given the opportunity to debrief with the ward manager.
- The ward manager reviewed all incident reports.
- Most permanent staff across the service were aware of recent incidents and learning from incidents. Feedback was disseminated to staff from the ward manager.
- Clinical governance meetings were held regularly at the hospital. These discussed a range of indicators and feedback. The provider collected information on incidents and compared this across its services.
- The quality improvement lead for the organisation reviewed incidents and asked for comments and feedback to ensure that lessons could be learnt. Post incident reports are produced after 24 hours.

Is the service effective?

Our findings

Assessment of needs and care planning

- The case notes we reviewed had up to date care plans which were reviewed regularly. They had entries logged from members of the multidisciplinary team (MDT) and ensured that holistic assessments were in place
- There was variability in the checking of people's physical health. On Lower Court each person was assessed by a doctor and nurse on admission and nursing and medical care plans developed. Any physical health care needs that were identified during this process were addressed and managed effectively. However, in the CAMHS we found some inconsistency. For example, we saw a record where someone's weight was recorded but not their height or BMI. Another person's care plan stated "staff will need to regularly check my blood pressure as deemed necessary with the MDT". This had led to confusion as there no indication what 'regularly' meant.
- People's needs were assessed and care was delivered in line with their individual care plans.
- Assessments and care plans were stored electronically and could be accessed by ward and therapy staff. We saw that these care plans were regularly reviewed and updated to reflect changes in the person's needs.

Best practice in treatment and care

- People had access to a wide variety of therapies that are recommended by NICE (National Institute of Health and Care Excellence) guidance for the treatment of mental health difficulties, including cognitive behavioural therapy and dialectical behaviour therapy. There was also input from occupational therapists, family therapists, drama therapy and art therapy.
- Outcome measures were used to gauge the effectiveness of the service, such as HoNOSCA (health of the nation outcome scales for children and adolescents) and CGAS (children's global assessment scale).
- People participating in the addiction therapy programme benefitted from a structured group work programme that ran each day from 9 am until 5 pm, with some individual exercises or optional group programmes each evening. The addiction therapy programme was based on the "Minnesota" 12 step abstinence model.
- The provider used a database to record the date on which people were discharged and to record monitoring contacts made with them at discharge and then every three months until one year post discharge. These monitoring contacts included information on whether the person had maintained abstinence. We noted however that the provider had not developed processes for analysing these data to monitor short, medium and longer term outcomes for patients.

Skilled staff to deliver care

- On the child and adolescent wards a range of professionals provided input into the wards including medical and nursing staff, and occupational therapists. There was also input from therapists, including cognitive/ dialectical behavioural therapy trained therapists. There was no internal social work input and all social work support and input was provided by external agencies related to specific young people. A pharmacist visited the ward weekly.
- On Lower Court a junior doctor, nurses and health care assistants provided care and treatment on the ward, with regular visits from a pharmacist. Each person had a responsible clinician. There were a number of consultant psychiatrists who were either employed or had practising privileges. Two of these having a substance misuse specialism. Therapies staff were specialised in the treatment of addiction and had appropriate training, skills and knowledge in the treatment of substance misuse and the model preferred by the provider.
- Staff undertook mandatory training relevant to their role, including safeguarding children and adults and basic life support.
- Staff told us that they had regular supervision and there was an expectation that staff would receive supervision ten times a year as a minimum. Supervision was taking place. However, in the minutes we reviewed on the child and adolescent wards it was not clear that incidents and complaints were discussed at an individual level with staff. Therapy staff had access to external supervision, which they told us was helpful. However, this was not available to occupational therapy staff. Bank staff did not always have access to formal supervision sessions.
- On Lower Court nursing staff and health care assistants were providing care to three specific patient groups and staff we spoke with commented that they would benefit from specialist training, for example in substance

misuse or the treatment of obsessive compulsive disorder, to improve their knowledge, skills and understanding of the patients they were caring for. The provider had undertaken some sessions with staff to develop their specialist knowledge.

Multi-disciplinary and inter-agency team work

- In the substance misuse programme the consultant psychiatrist, therapists and nurses joined a weekly multi-disciplinary ward review. Care plans and risk assessments were reviewed as part of this process. We found that practitioners and clinicians from a range of disciplines were involved in the assessment, planning and delivery of people's care and treatment.
- In the child and adolescent wards there were regular multi-disciplinary meetings on the ward. Ward rounds involved a range of professionals including invitations to external teams as appropriate.
- The child and adolescent service had tried to develop closer links with local community child and adolescent teams to help ensure a smooth pathway of care for the young people using the service.
- Education was provided on site with teaching staff. There was a room which was set aside to for education on Birch ward.

Adherence to the MHA and MHA Code of Practice

- Most staff had a good understanding of the Mental Health Act and the Mental Capacity Act as it related to young people. There was training available on the Mental Health Act and Mental Capacity Act.
- For two young people, we were unable to locate a mental capacity assessment form in relation to capacity to consent to treatment. In both cases, a 'consent to treatment' form had been completed that stated that the young person had capacity to consent to treatment, but no details of the treating clinicians were included in the form.
- People undertaking the addiction therapy programme were informal, and were not subject to the Mental Health Act. However, staff we spoke with demonstrated an understanding of the Act appropriate to their role.

Good practice in applying the MCA

- We looked at mental capacity and consent for young people and adults over 16. Some staff had access specific training around the Mental Capacity Act and demonstrated an understanding of it. There had been a recent training day over both child and adolescent wards around competency and capacity.
- We saw some examples of mental capacity being assessed and documented comprehensively. However, in reviewing the records of young people using the service we identified some concerns. One person, who had been admitted informally, had been assessed to 'have capacity' to make a decision about their treatment and they were over 16. The mental capacity assessment did not identify specific aspects of the care and treatment for this person. For example, it did not include the potential need to restrain.
- We found that a consent to treatment form had been completed by each person undertaking the addiction therapy programme. This was signed and kept on file.

Is the service caring?

Our findings

Kindness, dignity, respect and support

- We observed kind, respectful care being delivered by staff on the wards.
- Most people told us that staff were respectful towards them.
- Staff we spoke with had a good knowledge and understanding of the needs of people on the ward and were aware of individual preferences.
- People using the service told us that staff treated them with respect. We observed staff interacting with people in a caring and compassionate way. Staff presented as enthusiastic and engaged in providing good quality care to the people using the service.

The involvement of people in the care they receive

- The service had an information pack to introduce people to the service.
- When people arrived on the addiction therapy programme they were buddied with a person already taking the programme to support their orientation to the ward. There was comprehensive and detailed addiction therapy programme information available that was given to new people using the service either before their admission, or at the point of admission. People were involved in developing their own care plans.
- Advocates visited the wards regularly and there was information available about advocacy services for people on the ward.
- Community meetings took place weekly in CAMHS.
- In the CAMHS families were contacted daily regarding updates regarding their family members.

Is the service responsive?

Our findings

Access, discharge and bed management

- The hospital had mean bed occupancy of 94.7% from July – December 2014.
- There was a clear admission and treatment pathway through the service.
- When we visited the child and adolescent wards, one person was on leave. Beds were not occupied when people were on leave so there were no concerns about a bed not being available when someone returned from leave.
- The addiction therapy programme could accept people at any point during the 28 days of the programme. The person could be admitted as soon as a bed became available. We were told that there was no fixed number of beds on the ward for addiction therapy, and that as soon as any bed on the ward became available someone could be admitted.

The ward optimises recovery, comfort and dignity

- There were different lounge areas on Birch ward. Some were used for meetings or activities and were locked at different times in the day. This meant that sometimes space was not available for people to meet in different areas of the ward. On Oak ward there was one lounge area. There was no area for people to be examined in the clinic room, which meant that physical examinations took place in bedrooms.
- There was a separate education area on Birch ward which had six computers. These were used with guidance and supervision. However, there was not enough space in the education room for all the young people to use it at the same time. While young people who were at different stages of recovery may not be using the room at the same time, the lack of capacity to do so might mean that there is a risk that some education timetabling might not be convenient for all young people.
- Lower Court had a full range of rooms and equipment. This included two lounges that were used for therapeutic groups. When not being used for group sessions these could be accessed for recreation by people using the service. In addition a large, open plan communal lounge had been created in the main ward area.
- People undertaking the programmes on Lower Court were able to receive visitors on the ward, in a family room off the ward, or if appropriate in their bedrooms.
- The hospital is located in large gardens and there is access to this outside space for people as appropriate. A smoking shelter had been erected in the gardens.

Meeting the needs of all the people who use the service

- People had access to interpreter services if they did not speak English well enough to communicate.
- Staff respected people's diversity and human rights. Attempts were made to meet people's individual needs including cultural and language needs. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to eat appropriate meals.
- The Lower Court was a mixed ward. Staff and people on the addiction therapy programme told us that they were encouraged not to mix with other patients as part of their group process. They commented that at times this could be difficult when other patients tried to engage with them. Some people also commented that they could be disturbed at night by noise from people not on the programme on the ward.

Listening to and learning from complaints

- People we spoke with on the ward were aware of how to complain. Information was available on the ward about complaints processes.
- People could raise concerns in community meetings and people we spoke to commented that this was usually effective.
- Information on advocacy services was displayed.
- In the previous 12 months there had been eight complaints in the Lower Court and two in the child and adolescent wards. We reviewed a selection of the complaints. They had been investigated and responded to appropriately.

Is the service well-led?

Our findings

Vision and values

- Most staff were aware of the goals of the ward and organisation.
- Most nursing staff told us that the local leadership were supportive.
- Staff we spoke told us that values of compassion, consistency, creative engagement and building trusting relationships underpinned their work.

Good governance

- Clinical governance meetings are held regularly at the hospital. These discuss a range of indicators and feedback.
- Weekly consultant lunches are held giving consultants a forum to discuss governance issues and issues relating to patients in their care.
- The provider has a system in place to manage consultant appraisal and professional development. In order to be granted practising privileges evidence must be supplied of these.
- The Priory group had recently updated its clinical governance policy. This provided a clear structure for reporting and responding to concerns. If a concern was raised about a service it could became a 'watch' or 'focus' site. This meant it had increased central management supervision.
- The Priory group has a child and adolescent service quality monitoring group. This monthly meeting allows staff at different services across the group to share information and learning
- The wards had effective systems in place to monitor quality in most areas. Staff had received mandatory training and regular supervision. Audits had been undertaken. Incidents were reported. However, we identified some areas of concern regarding how ligature risks were managed, the assessment of capacity and the monitoring of cleanliness.
- People using the service had recently undertaken quality walk rounds on the wards. This involved them visiting the wards and assessing them against set criteria.
- The service has a weekly audit of risk assessments and care plans.
- The hospital participates in the quality network for inpatient child and adolescent mental health services with the Royal College of Psychiatrists.

Leadership, morale and staff engagement

- Most staff told us that they were aware how to raise concerns locally and in the organisation.
- There had been a high turnover rate of staff in the six months prior to the inspection. Some members of staff told us that this had had an unsettling effect. Some told us this this had had a negative impact on staff morale.
- There was a leadership training programme through The Priory. Some staff we met told us they appreciated this support.
- Staff told us that they had been involved in an engagement exercise with the organisation regarding the poor retention rate of staff but they were unsure of the outcomes of this and were not sure it was being followed up.
- Feedback from therapies and ward staff was positive about the support they received from their team and line managers. They told us that they felt comfortable raising any issues with their manager.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- Staff talked to us of their commitment to providing "a world class service", and discussed innovations in the addiction therapy programme that included the introduction of equine assisted therapy. The service had recently provided specialist training for facilitators and was providing a trauma therapy programme, which had not previously been available in the UK.
- A minority of staff commented that senior management did not always seem to understand some of the issues relating to the provision of an addiction therapy programme, and in their view this could have an impact on continuous quality improvement. They cited examples of mixed patient groups sharing the same ward and difficulties in gaining funding approval for some staff to undertake specialist training. However, other staff told us that they made a case to senior management and had received funding for specific training to support their continuous professional development.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Lower Court is a 28 bed mixed sex ward providing general psychiatric care, an obsessive compulsive disorder therapy programme and an addiction therapy programme. Information contained in this report relates to the general psychiatric care and obsessive compulsive disorder therapy programmes provided on Lower Court.

Summary of findings

Safe

The general psychiatry and OCD programme was safe. The layout of the ward meant that staff could readily observe people using the service in corridors and communal areas. Emergency equipment was regularly checked and was kept in a place where it was readily accessible. There were sufficient staff working on the ward and in the therapies directorate, with clear communication between the two. Staff had been trained and knew how to make safeguarding alerts. Medicines were managed well. Processes to ensure that front line staff benefited from the learning from serious incidents were in place. The service had not grouped bedrooms to achieve as much gender separation as possible. There was no female only lounge.

Effective

The general psychiatry and OCD programme was effective because patients were comprehensively assessed on admission. This included an appropriate assessment of people's physical health needs. The provider used an electronic system and paper files for recording and storing information about the care of patients. Multi-disciplinary teams were effective in supporting patients. Staff had received training in the use of the Mental Capacity Act.

Caring

The general psychiatry and OCD programme was caring. Staff were kind and respectful to people and recognised their individual needs. Staff actively involved people in

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

developing and reviewing their care plans. Staff also made sure that families and carers were involved when this was appropriate. People received regular one-to-ones with a named therapist.

Responsive

The general psychiatry and OCD programme was responsive to people's needs. The staff were aware of the diverse needs of people who use the service and responded appropriately. Staff knew how to support people who wanted to make a complaint, and patients who had done so were happy with how these had been dealt with.

Staff commented that they found it difficult to manage multiple admissions in a single day whilst maintaining high standards of patient care.

Well Led

The general psychiatry and OCD programme was well led. Staff were able to explain the professional values that underpinned their work. Staff had access to systems of governance that enabled them to monitor and manage the ward.

The ward was well led, and staff felt supported by their team and managers. Some staff told us that high staff turnover and high vacancy rates had a negative impact upon staff morale.

The provider had introduced an innovative obsessive compulsive disorder programme, which was only available at this location.

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

Safe clean ward environment

- The ward layout included two nursing stations that allowed staff to see the communal areas and corridors.
- The ward offered mixed sex accommodation. Each person had their own bedroom that they were able to lock and all rooms provided en suite facilities. However, bedrooms were not grouped to ensure as much gender separation as possible. There was no female only lounge.
- Emergency equipment, including an external defibrillator and oxygen, was easily accessible in the nurses' office. This was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Emergency drugs were available and checked regularly. Mandatory training addressing basic life support was provided to staff, and staff we spoke with were able to explain how they would respond in the event of an emergency.
- The ward was well maintained and the furniture was in good condition. The corridors were clear and clutter free. People told us that standards of cleanliness were good.
- Staff told us that individual risk assessments were considered when allocating bedrooms to patients. We were told that some people may be allocated accommodation closer to the nursing station or nurses office where their assessment did not warrant increased observations, but staff wanted to "keep an eye" on them.
- A number of bedrooms on the ward had been designated as high dependency. These were located away from the main ward area to reduce disturbance. We saw that these rooms had been adapted to reduce potential ligature points.

Safe staffing

- The Lower Court aimed to have a minimum staffing of one member of staff for five people using the service. Many people using the service spent a lot of their time with therapists away from the ward. Five staff were on

duty on the adult ward during the day, two qualified nurses and three health care assistants. At night there were four staff on duty, two qualified nurses and two health care assistants.

- Nursing and support staff levels were increased according to the needs of the people being supported on the ward. The ward manager told us they were able to obtain additional staff when the needs of people using the service changed and more staff were required to ensure their safety. We observed that the ward ensured at least one qualified member of staff was working in the communal area.
- There were a high number of staff vacancies on the ward, resulting in a significant use of temporary staff to maintain standards of quality and safety. In the three months before the inspection the wards had used 392 bank and two agency shifts. This was c. 25% of all shifts. Where possible the ward tried to use regular temporary staff that were familiar with the ward, people using the service and ward routines. Temporary staff, who had not worked on the ward before, were given a brief induction to the ward.
- Ward staff told us that there were adequate medical staff available day and night to attend the ward quickly in an emergency.

Assessing and managing risks to patients and staff

- People using the service we spoke with told us that they felt safe on the ward.
- We found that when a person was admitted to the ward, a range of assessments was completed. This included carrying out a risk assessment. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of people by staff were increased.
- Individual risk assessments that we reviewed took account of person's previous history, as well as their current presentation. Risk assessments were reviewed as frequently as needed and were always reviewed at a weekly multi-disciplinary ward review.
- Therapies staff met with a member of nursing staff from the ward each morning for a handover addressing each person undertaking the obsessive compulsive disorder programme. In addition, a separate handover meeting covering all patients on the ward occurred when nursing shifts changed.
- There were notices on the ward informing informal patients of their right to leave.
- Staff we spoke with had received training in safeguarding vulnerable adults and children and were able to give examples that indicated they knew how to recognise a safeguarding concern. Some staff provided examples of safeguarding concerns they had raised.
- We checked the management of medicines on the ward. Medicines were stored securely in the clinical room and temperature records were kept of the medicines fridge. These were within the guidelines for maintaining the effectiveness of the medicines. Keys to the clinical room were held by a nurse.

Track record on safety

- In December 2014 the service had recorded 2.27 serious service user incidents per 1000 bed days. This was benchmarked against other services delivered by the provider and monitored for any differences.

Reporting incidents and learning when things go wrong

- Staff we spoke with on the ward knew how to recognise and report incidents on the provider's electronic incident recording system. Staff told us that, if an incident occurred, they were given the opportunity to debrief with the ward manager.
- The ward manager reviewed all incident reports. We were told that plans were underway to include a review of incidents in team meetings to share learning.
- Clinical governance meetings are held regularly at the hospital. These discuss a range of indicators and feedback.

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

(for example, treatment is effective)

Assessment of need and planning of care

- People's needs were assessed and care was delivered in line with their individual care plans.
- We found that each person was assessed by a doctor and nurse on admission and nursing and medical care plans developed. Any physical health care needs were identified during this process and were addressed and managed effectively. These assessments and care plans

were stored electronically and could be accessed by all staff. We saw that these care plans were regularly reviewed and updated to reflect changes in a person's needs.

- Staff we spoke with identified that they were finding it challenging to meet the needs of one patient who was detained under the Mental Health Act on the ward. Some staff expressed the view that their needs could not be appropriately met on the ward. We were told that the patient had been transferred from the NHS as a result of bed pressures. We were concerned that the patient may not have been comprehensively assessed by the provider prior to their admission.

Best practice in treatment and care

- We found that appropriate guidance was followed when prescribing medication.
- Regular physical health checks were taking place where needed.
- Ward staff assessed people using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled clinicians to assess patients' responses to interventions.
- Patients participating in the obsessive compulsive therapy programme benefitted from a structured group work programme that ran each day. Outcomes for people undertaking the programme were measured.
- People using the service were able to meet with the pharmacist one afternoon each week to discuss any issues relating to their prescribed medication.

Staff skilled to deliver care

- A junior doctor, nurses and health care assistants provided care and treatment on the ward. A pharmacist visits regularly. Each patient had a responsible clinician. Noon-employed consultant psychiatrists were assessed for practising privileges. Therapies staff were specialised in the treatment of obsessive compulsive disorder and had appropriate training, skills and knowledge in the treatment of obsessive compulsive disorder and the model used by the provider.
- All staff undertook mandatory training relevant to their role, including safeguarding children and adults and basic life support. We found that staff were able to deliver care safely and to an appropriate standard.
- Nursing staff and health care assistants were providing care to three specific patient groups. Staff commented that they would benefit from specialist training, for example in the treatment of obsessive compulsive disorder, to improve their knowledge, skills and understanding of the patients they were caring for.
- Staff told us they received regular clinical and managerial supervision, where they were able to reflect on their practice. There were regular staff meetings and staff we spoke to felt well supported by their manager and colleagues on the ward.

Multi disciplinary and interagency working

- A member of nursing staff met with therapists each morning to share and handover relevant information.
- Each week, the consultant psychiatrist, therapists and nurses joined a multi-disciplinary ward review. Care plans and risk assessments were reviewed as part of this process. We found that practitioners and clinicians from a range of disciplines were involved in the assessment, planning and delivery of people's care and treatment.
- Staff were able to give us examples where they had liaised with appropriate external agencies when child safeguarding concerns were identified at assessment or during treatment.

Adherence to the MHA and MHA code of practice

- Staff we spoke with demonstrated an understanding of their responsibilities under the Mental Health Act.
- Staff had received training on the Mental Health Act and the Code of Practice and knew how to contact the Mental Health Act office if needed.

Good practice in applying the Mental Capacity Act

- Staff had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- We observed that one informal patient had been placed on one to one observations. We looked at the patient's records and saw that their risk assessment and care plan did address the need for one-to-one observations and that these had been signed by the person. The need for one-to-one observations had also been discussed with the patient's family. However, no assessment addressing the patient's capacity to make this decision had been completed. The provider must ensure that mental capacity assessments are completed as appropriate.
- The manager advised they had not made any applications under DoLS.

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

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

Kindness, dignity, respect and support

- People told us that staff treated them with respect. We observed staff interacting with people in a caring and compassionate way. Staff presented as enthusiastic and engaged in providing good quality care to people using the service.
- When staff spoke to us about people using the service, they discussed them in a respectful manner and showed a good understanding of their individual needs.

The involvement of people in the care they receive

- All but one of the patients we spoke with told us they felt involved in their care. Records we reviewed showed the views of people were being sought.
- Details of advocacy services were displayed on the ward.
- The ward held community meetings with all patients to gather their views about the ward. Minutes of the meetings were kept, and a "you said, we did" notice detailed action the provider had taken as a result of these meetings.

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

Access, discharge and bed management

- On the day of the inspection one person on the ward had been placed by the NHS. All other people were privately placed. Access was managed depending on the needs of people. There was no set number of beds for the different programmes offered by the hospital.
- Staff we spoke with commented that on some occasions, there could be up to five new admissions to the ward in a day, either for the specific therapies programmes or for a general psychiatric bed. They commented that this felt pressurised and that in days when there were multiple admissions it was difficult to manage to ensure that the quality of care was not compromised.

The ward optimises recovery, comfort and dignity

- The ward had a full range of rooms and equipment. This included two lounges that were used for therapeutic groups. This meant that people who were not involved in therapy programmes had limited access to the lounges, and the recreational materials that they contained.
- People were able to receive visitors on the ward, in a family room off the ward, or if appropriate in their bedrooms.
- The ward had access to a pay phone located in a private area. The hospital is located in large gardens and there is access to this outside space for people on the ward. A smoking shelter had been erected in the gardens.
- People's feedback about food was generally positive.

Meeting the needs of all people who use the service

- Staff respected people's diversity and human rights. Attempts were made to meet people's individual needs including cultural and language needs. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to eat appropriate meals.
- Access to Lower Court was via a small flight of stairs, which meant that access for wheelchair users was restricted.

Listening to and learning from complaints

- Information on how to make a complaint was displayed on the ward, as well as information about independent advocacy services. Patients could raise concerns in community meetings.
- Staff told us they tried to address patients concerns informally as they arose and demonstrated an awareness of the formal complaints process.

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

Vision and values

- The majority of staff we spoke with felt valued by the provider. However, some did comment that communication was one way; from the board to the ward. They were not sure whether messages travelled effectively in the opposite direction.
- The acting ward manager told us that they had regular contact with their manager, and felt supported in their role.

Good governance

- Staff had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust.
- The acting ward manager told us that they had enough time and autonomy to manage the ward. They also said that, where they had concerns, they could raise them.
- Clinical governance meetings are held regularly at the hospital. These discuss a range of indicators and feedback.
- The ward had effective systems in place to monitor quality in most areas. Staff had received mandatory training and regular supervision. Audits had been undertaken. Incidents were reported.

Leadership, morale and staff engagement

- We found the ward to be well-led. There was evidence of clear leadership. The acting ward manager was visible on the ward during the day-to-day provision of care and treatment. They were accessible to staff and were proactive in providing support. The culture on the ward was open and generally supportive to staff.
- Feedback from therapies and ward staff was positive about the support they received from their team and line managers. They told us that they felt comfortable raising any issues with their manager. However, some staff did comment that they felt that senior management did not always value them. Other staff commented on high staff turnover and the negative impact this had had on staff morale.
- Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

- The obsessive compulsive disorder programme is a specialist programme, which has been designed to meet the needs of the specific group of people.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

The child and adolescent mental health service at The Priory North London consisted of two wards.

Birch ward: 13 beds, including five designated as a high dependency unit.

Oak ward: Nine beds.

Beds were available to people in the 12-18 age group. Both wards were mixed gender. All the beds were occupied during our inspection visit.

Summary of findings

Safe

The child and adolescent service required some improvements. Some ligature risks identified in the provider's ligature risk assessment did not have management plans associated with them.

The ward manager was not clear when some areas of the ward, for example one of the lounge areas, had had a 'deep clean'. Some of the furniture had tears, meaning there could be an infection control risk.

Staff had a good understanding of safeguarding processes and were aware of where and how to make referrals or ask for advice about referrals. The clinic room was well-equipped with emergency medicines and equipment.

Effective

The child and adolescent service was effective because people had up to date, holistic care plans which addressed their individual needs. Patients had access to a wide range of therapies. Staff were able to access training and there was a strong multidisciplinary team. However, there were gaps in the physical health monitoring. There was also some lack of clarity about the way the Mental Capacity Act was used in practice.

Caring

The child and adolescent service was caring. We observed thoughtful and caring interventions by staff. We received generally positive feedback from young people. People were given information when they were admitted to the ward and families were contacted frequently regarding care for young people.

Responsive

Child and adolescent mental health wards

The child and adolescent service was responsive. There were clear pathways for admission, treatment and discharge through the service in most incidences. The ward provided a therapeutic environment. However, there was little additional space and sometimes this could compromise the care and therapy on offer. The service was aware of different needs of people using the service and generally was able to adapt to meet them.

Well Led

The child and adolescent service was well-led. Staff felt supported at a local level. The ward manager had an understanding of the key issues on the ward. However, there had been a high turnover of staff and not all staff were aware of the outcome of a consultation exercise which had been undertaken around staff retention.

Are child and adolescent mental health wards safe?

Safe and clean ward environment

- Oak ward was clean and well presented. There were some maintenance and cleanliness issues on Birch ward, including two sofas which were torn in one of the lounge areas (room 49). We were told these were being replaced. The room in which meetings for staff took place had torn carpet. There was a door hanging off its hinges in the kitchen area.
- Maintenance staff are attached to the units and we were told that staff are able to log repairs when they arise.
- A ligature risk assessment had been completed in August 2014. We saw from this audit there were a number of identified potential risks. The management plans were not clear from the audit. For example, a toilet roll holder in room B43 and handles and rails in communal areas were identified as risks, but there were no actions specified. There was a lack of information to explain clearly how ligature points that may not be high priority to change, for example in the bathroom areas outside of the high dependency units, may be managed by observations and understanding of the individual needs of patients.
- Fridge temperatures were recorded daily, but staff were not always alerting managers when they varied from the regular temperature pattern.
- Blind spots, where staff could not easily observe the young people, had been identified on Birch ward. There were CCTV cameras with viewing stations in the nurses' office to mitigate the risks of these.
- The clinic room was equipped with emergency medication and equipment. Ligature cutters were accessible and staff knew where they were.
- Five beds on Birch ward were designated as 'high dependency'. Four of these rooms were ligature free. When people were in these rooms they were on higher levels of observation.

Safe Staffing

- There were five vacancies for registered nurses across the two wards. New staff had been recruited for three of these posts. Pre-employment checks being carried out.
- There had been a high use of bank and agency staff. In the three months before the inspection the wards had

used 594 bank and 310 agency shifts. When staff came onto the ward for the first time, they were given an induction. There was a preference for using bank and agency staff who were familiar with the service.
- The ward manager was able to access additional staff when necessary for observations.
- We were told on the wards that sometimes people could not attend therapy off site because there were not enough staff to escort people to the therapy areas.
- Patients on the ward raised concerns with us about the numbers of staff on the ward and the high turnover of staff. There had been five ward managers in the last 2.5 years. Two new consultants were due to join the ward in April. This meant there may be an unsettled feel to the ward with some lack of consistency for the young people there.
- There was a full therapy team. However, some non-nursing staff told us that they may be asked to cover nursing (non-clinical) roles when there is a shortage of staff.

Assessing and managing risk to patients and staff

- Risk assessments and risk management plans were in place and up to date.
- Details were recorded after multidisciplinary team (MDT) meetings with clear action points.
- Information about people's care was available in both electronic and paper formats. This ensured that staff who were new to the wards would have access to basic information about patients on the ward.
- Staff we spoke with had a good understanding of safeguarding processes and when to make referrals. There was information on display in the ward offices explaining safeguarding processes and contact details. All nursing staff were trained to level 3 safeguarding children. However, one member of staff told us they did not get feedback about safeguarding processes when they made referrals. This meant that there was a risk that learning from safeguarding incidents may not be embedded.
- There were some blanket restrictions in place as a part of the ward rules. These may have been consistent with providing a secure environment for the young people, but they needed to be adapted to reflect individual needs. For example, the kitchen area and some lounge areas were locked during the time when young people were usually in education. If a young person was not in the education this may limit their ability to access these areas inappropriately.
- When young people arrived in the service, they started on 1:1 observations. This was adjusted as further information about them was understood. Levels of observation were reviewed in the weekly ward round and young people were asked for their views about observation. Observation records were complete.
- The physical restraint or people by staff was not being used regularly. In the six months prior to the inspection restraint had been used 28 times. Staff were trained on prevention and management of difficult behaviours including how to restrain people physically when necessary.
- Not all records of restraint were comprehensive. The Mental Health Act Code of Practice Chapter 15.28 states "Where physical restraint is used staff should record the decision and the reasons for it and document and review every episode of physical restraint, which should include a detailed account of the restraint". We saw the record of one person and it was not indicated how they were restrained or for how long they were held in the restraint.
- The Mental Health Act Code of Practice, 15.34 states "If a patient is not detained, but restraint is any form is deemed necessary consideration should be given to whether formal detention under the Act is appropriate". One patient, who had been restrained, was admitted to the hospital as an informal patient.There was no indication of the need to consider whether formal detention was appropriate after they were restrained.

Track record on safety

- Four serious incidents were recorded in the CAMHS wards between January and December 2014.
- These had been reported appropriately through the organisation and information had been shared about learning from incidents.
- Some staff were able to explain the background and details of these incidents.

Reporting incidents and learning from when things go wrong

- Staff were aware of the systems to report incidents. Incident reports were completed online and reviewed by management.

Child and adolescent mental health wards

- The quality improvement lead for the organisation also reviews incidents and asks for comments and feedback to ensure that lessons can be learnt. Post incident reports are produced after 24 hours.
- Most permanent staff across the service were aware of recent incidents and learning from incidents. Feedback was disseminated to staff from the ward manager.
- Team meetings took place regularly. Incidents were reviewed in team meetings and supervision sessions.
- An incident had taken place a short time prior to our visit. We saw that this incident was discussed in a multi-disciplinary team meeting including therapy staff and actions which could be taken were discussed openly.
- It was not clear how incidents from across the organisation were shared. Staff on Birch ward did not have access to team meeting minutes.

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

Assessment of needs and care planning

- The case notes we reviewed had up to date care plans which were reviewed regularly. They had entries logged from members of the multidisciplinary team and ensured that holistic assessments were in place. Different types of care plan were completed depending on people's needs. We saw that people had discharge care plans in place. Other care plans included specific ones which addressed self-harm or risk of absconding.
- Some physical health information relating to health checks was not completed consistently. For example, we saw a record where someone's weight was recorded but not their height or BMI. Another person's care plan stated "staff will need to regularly check my blood pressure as deemed necessary with the MDT". This had led to confusion as there no indication what 'regularly' meant. The checks had been completed but it was unclear where and how the decisions to change the frequency had been decided.

Best practice in treatment and care

- Young people using the service had access to a wide variety of therapies according to National Institute of Health and Care Excellence guidance for the treatment of mental health problems, including cognitive behavioural therapy and dialectical behaviour therapy.
- Occupational therapists, family therapists, drama therapy and art therapy were also available to support people.
- We saw that when someone had physical healthcare needs, they were supported to attend appointments.
- Outcome measures were used to gauge the effectiveness of the service. These included HoNOSCA (Health of the nation outcome scale for children and adolescents) and CGAS (children's global assessment scale).
- The service gave clinical staff the opportunities to carry out audits which could feed into improved practice.

Skilled staff to deliver care

- A range of professionals provided input into the ward. these included medical and nursing staff, occupational therapists, and other therapists, including CBT/DBT trained therapists. There was no internal social work input and all social work support and input was provided by external agencies supporting specific young people. A pharmacist visited the ward weekly.
- The education services were provided from a base room on Birch ward. A new deputy head teacher had been appointed shortly before our visit. We received positive feedback about this appointment from both the young people using the service and staff members.
- Staff were trained to level 3 safeguarding children. Most staff were up to date with mandatory training.
- Team meetings on the wards took place fortnightly with a child and adolescent service business meeting monthly. However, on the day of our inspection, previous minutes from ward meetings were not available on the Birch ward. This meant that there was a risk that people could not have up to date information if they were not present at the meetings as there was not easy access to past minutes.
- We saw supervision records on both Birch and Oak wards. Staff told us that they had regular supervision and there was an expectation that staff would receive supervision ten times a year as a minimum. Supervision was taking place. However, in the minutes we reviewed it was not clear that incidents and complaints were

discussed at an individual level with staff. Therapy staff had access to external supervision, which they told us was helpful. However, this was not available to occupational therapy staff. Bank staff did not have access to formal supervision on a regular basis.
- There was a clear induction process for new staff to ensure that they were aware of issues local to the ward.
- The wards arranged monthly training days on specific areas relevant to the client group on the ward. For example, training had been offered regarding mental capacity and competency. However, this was not available to bank staff, even if they worked on the ward regularly.

Multi-disciplinary and inter-agency team work

- There were regular multi-disciplinary meetings on the ward. Ward rounds involved a range of professionals including invitations to external teams as appropriate.
- Handovers took place between nursing teams twice a day and these were recorded. There were also handovers between nursing staff and medical, education and therapy staff each morning at 09 00 to ensure that information was shared by the nursing team with the wider multi-disciplinary team.
- Education was provided on site with teaching staff. There was a room which was set aside to for education on Birch ward.

Adherence to the MHA and MHA Code of Practice

- Most staff had a good understanding of the Mental Health Act and the Mental Capacity Act as it related to young people. There was training available on the Mental Health Act and Mental Capacity Act.
- For two young people, we were unable to locate a mental capacity assessment form in relation to capacity to consent to treatment. In both cases, a 'consent to treatment' form had been completed that stated that the young person had capacity to consent to treatment, but no details of the treating clinicians were included in the form.
- Young people on the ward had access to advocacy services and information about advocacy services was available on the ward.
- There was support available for staff from a central mental health act office to provide advice if necessary. The ward manager knew how to contact this team.

Good practice in applying the MCA

- We looked at capacity and consent for young people and adults over 16. Some staff had access specific training around the Mental Capacity Act and demonstrated an understanding of it. There had been a recent training day over both wards around competency and capacity.
- We saw some examples of mental capacity being assessed and documented comprehensively. However, in reviewing the records of young people using the service we identified some concerns.
- In the records for one young person, who was judged not to be Fraser competent to consent to their treatment, a note had been written "we are seeking advice from AMHP in order to contemplate Mental Health Act to guarantee [their] legal framework". We did not see that this had been followed up and the questions related to the detention remained unresolved.
- Another young person, who had been admitted informally, had been assessed to 'have capacity' to make a decision about their treatment and they were over 16. The capacity assessment did not detail the different aspects of care and treatment. There is a risk that there capacity to consent to different aspects of their care and treatment had not been assessed.

Are child and adolescent mental health wards caring?

Kindness, dignity, respect and support

- We observed kind, respectful care being delivered by staff on the ward.
- Most people told us that staff were respectful towards them. One young person told us that a lot of the new healthcare assistants were "very good".
- Staff we spoke with had a good knowledge and understanding of the needs of people on the ward and were aware of individual preferences.
- There were ring-fenced mealtimes so staff can use time therapeutically and engage with patients. We observed a lunchtime and saw that staff sat with young people and ate with them.

The involvement of people in the care they receive

Child and adolescent mental health wards

- People had access to an admission guide when they join the service. This contained information about therapies, education facilities, and information about advocacy and complaints.
- Advocates visited the wards regularly and there was information available about advocacy services for people on the ward.
- Community meetings took place weekly. We saw the minutes from these meetings, the most recent of which were displayed in the ward area. Young people were able to give feedback on a range of issues. However, we saw that some issues were raised repeatedly in meeting minutes. For example, the lack of a bin in one of the lounge areas. This could have been resolved more quickly. It was unclear how the actions which arose from the meetings led to changes.
- Families were contacted daily regarding updates regarding their family members.

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

Access, discharge and bed management

- There was a clear admission and treatment pathway through the service.
- When we visited the ward, one person was on leave. Beds were not occupied when people were on leave so there were no concerns about a bed not being available when someone returned from leave.
- The service had developed links with some local community services, although beds were commissioned nationally. As the service worked with different local areas, there could be delays in communication depending on the relationships with the 'home' areas.

The ward optimises recovery, comfort and dignity

- There were different lounge areas on Birch ward. Some of these were used for meetings or activities. They were locked at different times in the day. This meant that sometimes space was not always available for people to meet in different areas of the ward. There was no exclusive area for females. On Oak ward there was one lounge area. There was no area for people to be examined in the clinic room, which meant that physical examinations took place in bedrooms.
- There was a separate education area on Birch ward which had six computers. These were used with guidance and supervision. However, there was not enough space in the education room for all the young people to use it at the same time. While young people who were at different stages of recovery may not be using the room at the same time, the lack of capacity to do so may mean that there is a risk that some education timetabling may not be convenient for all young people.
- Activities were available during the week. An activities coordinator was dedicated to working in the child and adolescent service. They worked on some weekends and there were lists of activities which young people could participate in at the weekend with support of staff on the ward notice board.
- There was a weekly trip out arranged in the local area.
- There was a garden which young people had access to. There was a therapy room outside of the ward area. Young people needed to be well enough to access it and have leave arranged. This meant that some young people, who were restricted to the ward, may not have access to therapies that were part of their recovery programme.
- Patients had access to a variety of food options and most feedback we received about food on the ward was positive. We spoke with one patient who was vegan whose family brought food in for them. They said that often the choices they had were limited to rice and steamed vegetables.
- Young people were able to use their phones, which were locked away when they were not being used.

Meeting the needs of all the people who use the service

- Young people on the ward had access to interpreter services if they did not speak English well enough to communicate.
- There was access available to spiritual support which reflected the religious backgrounds of people who used the service. We saw one example of a local imam being involved with a Muslim patient. There was also access to culturally specific food, for example, halal food.

Listening to and learning from complaints

- People we spoke with on the ward were aware of how to complain. Information was available on the ward about the complaints processes.
- Most staff were aware of how to handle complaints.

Child and adolescent mental health wards

Are child and adolescent mental health wards well-led?

Vision and values

- Most staff were aware of the goals of the ward and organisation.
- Most nursing staff told us that the local leadership were supportive.

Good governance

- Clinical governance meetings were held regularly at the hospital. These discussed a range of indicators and feedback. Child and adolescent staff had representation at these. A risk register was maintained.
- The Priory group has a child and adolescent quality monitoring group. This monthly meeting allows staff at different services across the group to share information and learning
- The wards had effective systems in place to monitor quality in most areas. Staff had received mandatory training and regular supervision. Audits had been undertaken. Incidents were reported. However, we identified some areas of concern regarding how ligature risks were managed, the assessment of capacity and the monitoring of cleanliness. Not all bank staff had regular formal supervision.
- People using the service had recently undertaken quality walk rounds on the wards. This involved them visiting the wards and assessing them against set criteria.
- The service has a weekly audit of risk assessments and care plans.
- The hospital participates in the quality network for inpatient child and adolescent mental health services with the Royal College of Psychiatrists.

Leadership, morale and staff engagement

- Most staff told us that they were aware how to raise concerns locally and in the organisation.
- There had been a high turnover rate of staff in the six months prior to the inspection. Some members of staff told us that this had had an unsettling effect.
- There was a leadership training programme through The Priory which the ward manager was being supported on.
- Staff told us that they had been involved in an engagement exercise with the organisation regarding the poor retention rate of staff but they were unsure of the outcomes of this and were not sure it was being followed up.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Information about the service

Lower Court is a 28 bed mixed sex ward providing general psychiatric care, an obsessive compulsive disorder therapy programme and an addiction therapy programme. At the time of this inspection, seven patients were receiving inpatient treatment as part of the addiction therapy programme.

Summary of findings

Safe

The Addiction Therapy Programme service was safe because the layout of the ward meant that staff could readily observe people using the service in corridors and communal areas. Emergency equipment was regularly checked and was kept in a place where it was readily accessible. There was sufficient staff working on the ward and in the therapies directorate, with clear communication between the two. Staff had been trained and knew how to make safeguarding alerts. Medicines were managed well. Processes to ensure that front line staff benefitted from the learning from serious incidents were in place. The Lower Court ward did not meet single gender guidelines.

Effective

The Addiction Therapy Programme service was effective because clinical and therapy staff made a comprehensive assessment of patients on admission. This included an appropriate assessment of people's physical health needs. The provider used an electronic system and paper files for recording and storing information about the care of patients.
Multi-disciplinary teams were effective in supporting patients. Staff had received training in the use of the Mental Capacity Act.

Caring

The Addiction Therapy Programme service was caring because staff were kind and respectful to people and recognised their individual needs. Staff actively involved

patients in developing and reviewing their care. Staff also made sure that families and carers were involved when this was appropriate. People received regular one to ones with a named therapist.

Responsive

The Addiction Therapy Programme service was responsive to people's needs. The ward was aware of the diverse needs of people who use the service and responded appropriately. Staff knew how to support people who wanted to make a complaint, and people who had done so were happy with how these had been dealt with.

Staff commented that they found it difficult to manage multiple admissions in a single day whilst maintaining high standards of care. Some staff and people on the programme stated that it could be difficult for people undertaking the addiction therapy programme to maintain the required distance from other people when situated on a ward with several different patient groups.

Well led

The Addiction Therapy Programme service was well led. Staff had access to systems of governance that enabled them to monitor and manage the ward. The ward was well led, and staff felt supported by their team and managers. Some staff told us that high staff turnover and high vacancy rates had a negative impact upon staff morale. The provider had introduced innovative therapy programmes, some of which were only available at this location.

Are substance misuse services (for people of all ages) safe?

Safe clean ward environment

- The ward layout included two nursing stations that allowed staff to see the communal areas and corridors.
- The ward offered mixed sex accommodation. Each person had their own bedroom that they were able to lock and all rooms provided en suite facilities. However, bedrooms were not grouped to ensure as much gender separation as possible. There was no female only lounge.
- Emergency equipment, including an external defibrillator and oxygen, was easily accessible in the nurses' office. This was checked regularly to ensure it was fit for purpose and could be used effectively in an emergency. Emergency drugs were available and checked regularly. Mandatory training addressing basic life support was provided to staff, and staff we spoke with were able to explain how they would respond in the event of an emergency.
- The ward was well maintained and the furniture was in good condition. The corridors were clear and clutter free. People using the service told us that standards of cleanliness were good.

Safe staffing

- The Lower Court aimed to have a minimum staffing of one member of staff for five people using the service. Many people using the service spent a lot of their time with therapists away from the ward.
- Nursing and support staff levels were increased according to the needs of the people being supported on the ward. The ward manager told us they were able to obtain additional staff when the needs of people using the service changed and more staff were required to ensure their safety. We observed that the ward ensured at least one qualified member of staff was working in the communal area.
- Ward staff told us that there were adequate medical staff available day and night to attend the ward quickly in an emergency.
- The addiction therapy programme was facilitated by therapists who did not have responsibilities on the ward outside of the provision of this programme.

- There were a high number of staff vacancies on the ward, resulting in a significant use of temporary staff to maintain standards of quality and safety. In the three months before the inspection the wards had used 392 bank and two agency shifts. This was c. 25% of all shifts. Where possible the ward tried to use regular temporary staff that were familiar with the ward, people using the service and ward routines. Temporary staff, who had not worked on the ward before, were given a brief induction to the ward.

Assessing and managing risks to patients and staff

- People using the service we spoke with told us that they felt safe on the ward.
- We examined four records for people using the service. We found that when a person was admitted to the ward, a comprehensive package of assessments was completed. This included carrying out a risk assessment. Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of people by staff were increased.
- Individual risk assessments that we reviewed took account of the person's previous history, as well as their current presentation. We noted that in one person's notes their risk assessment had been reviewed twice in one day, and that there were inconsistencies between the two assessments addressing previous history and the potential risk this presented. Based on other information recorded in the person's records and our discussions with staff we formed the view that this had not impacted upon the quality or safety of the care provided as staff were aware of the person's needs and were able to explain how they were supporting the person to manage potential risks.
- Risk assessments were reviewed as frequently as needed and were always reviewed at a weekly multi-disciplinary ward review.
- Therapies staff met with a member of nursing staff from the ward each morning for a handover addressing each person undertaking the addition therapy programme. In addition, a separate handover meeting covering all people using the service on the ward occurred when nursing shifts changed.
- There were notices on the ward informing informal patients of their right to leave. There was a blanket restriction in place for addiction therapy programme people using the service regarding access and use of mobile phones whilst receiving treatment. People using the service we spoke to told us that they were aware of the reasons for this, and that a telephone was available on the ward for them to use. We were told that based on individual assessment, some people undergoing the addiction therapy programme may also be asked to pass cash and debit cards to staff to be held during their admission.
- Staff we spoke with had received training in safeguarding vulnerable adults and children and were able to give examples that indicated they knew how to recognise a safeguarding concern. Some staff provided examples of safeguarding concerns they had raised. Our discussions with staff and examination of patient records evidenced that child safeguarding was appropriately addressed during assessment.
- For people using the service who requested visits from children, this had been assessed to ensure it was in the child's best interest. A separate room away from the ward was available to use for family visits.
- People using the service we spoke with who were being prescribed medicines confirmed they had received information about these and knew what they were for. We checked the management of medicines on the ward. Medicines were stored securely in the clinical room and temperature records were kept of the medicines fridge. These were within the guidelines for maintaining the effectiveness of the medicines. Keys to the clinical room were held by a nurse.
- Where people were assessed as requiring alcohol detoxification at the commencement of their treatment programme this was provided in accordance with guidance.

Track record on safety

- In December 2014 the service had recorded 2.27 serious service user incidents per 1000 bed days. This was benchmarked against other services delivered by the provider and monitored for any differences.

Reporting incidents and learning when things go wrong

- Staff we spoke with on the ward knew how to recognise and report incidents on the provider's electronic incident recording system. Staff told us that, if an incident occurred, they were given the opportunity to debrief with the ward manager.

Substance misuse services

- The ward manager reviewed all incident reports. We were told that plans were underway to include a review of incidents in team meetings to share learning.
- Staff gave us examples of learning which had been identified following previous incidents. For example, they told us that a noticeboard with the name of each patient due to attend group was displayed outside of each group room. This meant that all staff would be aware of where each patient should be, and could take appropriate action if patients were found to have left the ward unexpectedly.
- Clinical governance meetings are held regularly at the hospital. These discuss a range of indicators and feedback.

Are substance misuse services (for people of all ages) effective?
(for example, treatment is effective)

Assessment of need and planning of care

- People's needs were assessed and care was delivered in line with their individual care plans.
- We found that each person was assessed by a doctor and nurse on admission and nursing and medical care plans developed. Any physical health care needs that were identified during this process were addressed and managed effectively. These assessments and care plans were stored electronically and could be accessed by ward and therapy staff. We saw that these care plans were regularly reviewed and updated to reflect changes in the person's needs.
- In addition, each person was assessed by a member of therapy staff and an individual addiction therapy programme care plan developed with them. These paper documents were stored in the addiction therapies office and copied to the person. These care plans and their associated tools were person focused and were largely completed by the person. The care plans we saw were comprehensive and frequently reviewed.
- For each person undertaking the addiction therapy programme their support needs on discharge were assessed during their inpatient stay. A range of aftercare follow up was available for people.
- We were told that where people decide to leave the programme prematurely, their responsible clinician would meet with them to discuss the reasons for this and to advise on appropriate aftercare.

Best practice in treatment and care

- We found that appropriate guidance was followed when prescribing medication.
- Regular physical health checks were taking place where needed.
- Ward staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled clinicians to assess the person's responses to interventions.
- People participating in the addiction therapy programme benefitted from a structured group work programme that ran each day from 9 am until 5 pm, with some individual exercises or optional group programmes each evening. The addiction therapy programme was based on the "Minnesota" 12 step abstinence model.
- The provider used a database to record the date people were discharged and to record monitoring contacts made with them at discharge and then every three months until one year post discharge. These monitoring contacts included information on whether the person had maintained abstinence. We noted however that the provider had not developed processes for analysing these data to monitor short, medium and longer term outcomes for patients.
- The provider used the National Drug Treatment Agency Treatment Outcomes Profile (TOPs) form during admission to measure change and progress in key areas of the lives of people receiving treatment.

Staff skilled to deliver care

- A junior doctor, nurses and health care assistants provided care and treatment on the ward. A pharmacist visits regularly. Each patient had a responsible clinician. Non-employed consultant psychiatrists were assessed for practising privileges. Therapies staff were specialised in the treatment of obsessive compulsive disorder and had appropriate training, skills and knowledge in the treatment of obsessive compulsive disorder and the model used by the provider.

Substance misuse services

- All staff undertook mandatory training relevant to their role, including safeguarding children and adults and basic life support. We found that staff were able to deliver care safely and to an appropriate standard.
- Nursing staff and health care assistants were providing care to three specific patient groups. Staff commented that they would benefit from specialist training, for example in substance misuse or the treatment of obsessive compulsive disorder, to improve their knowledge, skills and understanding of the patients they were caring for. The provider had undertaken some sessions with staff to develop their specialist knowledge.
- Staff told us they received regular clinical and managerial supervision, where they were able to reflect on their practice. In addition to individual supervision, therapists were able to access group supervision every fortnight. There were regular staff meetings and staff we spoke to felt well supported by their manager and colleagues on the ward.

Multi disciplinary and interagency working

- A member of nursing staff met with therapists each morning to share and handover relevant information. Therapists met each day to feedback on group sessions held during the course of the day.
- Each week, the consultant psychiatrist, therapists and nurses joined a multi-disciplinary ward review. Care plans and risk assessments were reviewed as part of this process. We found that practitioners and clinicians from a range of disciplines were involved in the assessment, planning and delivery of people's care and treatment.
- As part of discharge planning, information about other resources (in addition to the aftercare available through the addiction recovery programme) was given to people using the service.
- Staff were able to give us examples where they had liaised with appropriate external agencies when child safeguarding concerns were identified at assessment or during treatment.

Adherence to the MHA and MHA Code of Practice

- People undertaking the addiction therapy programme were informal, and were not subject to the Mental Health Act. However, staff we spoke with demonstrated an understanding of the Act appropriate to their role.
- Staff told us that they had received training on the Mental Health Act and the Code of Practice and knew how to contact the Mental Health Act office if needed.
- We noted each person on the addiction therapy programme had their medicine chart annotated to reflect their informal status.

Good practice in applying the Mental Capacity Act

- We found that a consent to treatment form had been completed by each person undertaking the addiction therapy programme. This was signed and kept on file.
- Staff had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).
- The manager advised they had not made any applications under DoLs.

Are substance misuse services (for people of all ages) caring?

Kindness, dignity, respect and support

- People using the service told us that staff treated them with respect. We observed staff interacting with people in a caring and compassionate way. Staff presented as enthusiastic and engaged in providing good quality care to the people using the service.
- When staff spoke to us about the people using the service, they discussed them in a respectful manner and showed a good understanding of their individual needs.

The involvement of people in the care they receive

- When people arrived on the ward they were buddied with a person already taking the addiction therapy programme to support their orientation to the ward. There was comprehensive and detailed addiction therapy programme information available that was given to new people using the service either before their admission, or at the point of admission.
- People were involved in developing their own care plans. They completed large sections of their addiction therapy care plan and its supporting tools. People we spoke were aware of the content of their care plans. The care plans we saw evidenced that people were supported to develop coping and self-management skills.
- People using the service had regular one to one meetings with a named therapist to review their progress and discuss any issues.

Substance misuse services

- People using the service we spoke with who were being prescribed medicines confirmed they had received information about these and knew what they were for.
- People using the service were encouraged to involve relatives and friends in care planning if they wished, and family “conjoints” or conferences, were facilitated at the hospital to support patients' recovery.
- Details of advocacy services were displayed on the ward, although none of the people on the addiction therapy programme we spoke with had accessed this service.
- The ward held community meetings with all patients to gather their views about the ward. Minutes of the meetings were kept, and a “you said, we did” notice detailed action the provider had taken as a result of these meetings.

Are substance misuse services (for people of all ages) responsive to people’s needs?

(for example, to feedback?)

Access, discharge and bed management

- The programme could accept people at any point during the 28 day cycle. The person could be admitted as soon as a bed became available. We were told that there was no fixed number of beds on the ward for addiction therapy, and that as soon as any bed on the ward became available someone could be admitted.
- Addiction therapy patients were not granted overnight leave during their 28 day treatment programme. The people we spoke with had occupied the same room on the ward since their admission. Upon discharge people returned to their home in the community.
- Staff we spoke with commented that on some occasions, there could be up to five new admissions to the ward in a day, either for the specific therapies programmes or for a general psychiatric bed. They commented that this felt pressurised and was difficult to manage whilst ensuring that the quality of care was not compromised.

The ward optimises recovery, comfort and dignity

- The ward had a full range of rooms and equipment. This included two lounges that were used for therapeutic groups. When not being used for group sessions these could be accessed for recreation by people using the service. In addition a large, open plan communal lounge had been created in the main ward area.
- People undertaking the programme were able to receive visitors on the ward, in a family room off the ward, or if appropriate in their bedrooms.
- The ward had access to a pay phone located in a private area. The hospital is located in large gardens and there is access to this outside space for people on the ward. A smoking shelter had been erected in the gardens.
- Feedback about food was generally positive. One person commented that they had complained about the food and that there had subsequently been improvement. Hot drinks and snacks were available in the dining area outside of meal times.
- People undertaking the addiction therapy programme were occupied for a substantial part of their day in compulsory group sessions. One person we spoke with said that they would like recreational activities to be available outside of the therapy programme.

Meeting the needs of all people who use the service

- Staff respected people’s diversity and human rights. Attempts were made to meet people’s individual needs including cultural and language needs. A varied menu enabled people with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to eat appropriate meals.
- The ward offered mixed accommodation. Staff and people on the addiction therapy programme told us that they were encouraged not to mix with other patients as part of their group process. They commented that at times this could be difficult when other patients tried to engage with them. Some people also commented that they could be disturbed at night by noise from people not on the programme on the ward.
- Access to Lower Court was via a small flight of stairs, which meant that access for wheelchair users was restricted.

Listening to and learning from complaints

- Information on how to make a complaint was displayed on the ward, as well as information about independent advocacy services. People on the programme could raise concerns in community meetings and patients we spoke to commented that this was usually effective.

- People we spoke with knew how to raise concerns and make a complaint. They told us they felt able to raise a concern should they have one and believed that staff would listen to them. One person we spoke with had make a complaint, and told us that they were happy with how staff had dealt with this.
- Staff told us they tried to address concerns informally as they arose and demonstrated an awareness of the formal complaints process.

Are substance misuse services (for people of all ages) well-led?

Vision and values

- Staff we spoke told us that values of compassion, consistency, creative engagement and building trusting relationships underpinned their work.
- The majority of staff we spoke with felt valued by the provider, although some did comment that communication was one way, from the board to the ward meaning that they were not sure whether messages travelled effectively in the opposite direction.
- The acting ward manager told us that they had regular contact with their manager, and felt supported in their role.

Good governance

- Staff had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust.
- The acting ward manager told us that they had enough time and autonomy to manage the ward. They also said that, where they had concerns, they could raise them.

Leadership, morale and staff engagement

- We found the ward to be well-led. There was evidence of clear leadership, the acting ward manager was visible on the ward during the day-to-day provision of care and treatment, they were accessible to staff and were proactive in providing support. The culture on the ward was open and generally supportive to staff.
- Feedback from therapies and ward staff was very positive about the support they received from their team and line managers. They told us that they felt comfortable raising any issues with their manager. However, some staff did comment that they felt that senior management sometimes gave the impression that staff were dispensable. Other staff commented on high staff turnover and the negative impact this had had on staff morale.
- Staff were aware of the whistleblowing process if they needed to use it.
- The wards had effective systems in place to monitor quality in most areas. Staff had received mandatory training and regular supervision. Audits had been undertaken. Incidents were reported.

Commitment to quality improvement and innovation

- Staff talked to us of their commitment to providing "a world class service", and discussed innovations in the addiction therapy programme that included the introduction of equine assisted therapy. The service had recently provided specialist training for facilitators and was providing a trauma therapy programme, which had not previously been available in the UK.
- A minority of staff commented that senior management did not always seem to understand some of the issues relating to the provision of an addiction therapy programme, and in their view this could have an impact on continuous quality improvement. They cited examples of mixed patient groups sharing the same ward and difficulties in gaining funding approval for some staff to undertake specialist training. However, other staff told us that they made a case to senior management and had received funding for specific training to support their continuous professional development.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

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 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The provider did not have suitable arrangements in place to ensure they always obtained, and acted in accordance with, the consent of service users in relation to the care and treatment provided for them. We found examples were the person's capacity to consent to an individual decision was not decision-specific. The provider was failing to comply with Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The provider had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. It had not planned to ensure the welfare and safety of all the people using the service. On Lower Court, bedrooms had not been grouped to achieve as much gender separation as possible. There was no female only lounge. The provider was failing to comply with Regulation 9 (1) (a) (b) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.