

Lakeside View







Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

Our rating of this service improved. We rated it good because:

On this inspection we saw many improvements since our last inspection in September 2018. We saw improvements regarding the following:

- The wards had enough nurses and doctors. Staff assessed and managed risk well, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However;

- Wards were not always clean. A non-patient area on Finch Ward was cluttered and visibly soiled.
- Staff on the wards did not always follow infection control procedures. Staff on Swan ward had not always recorded the temperature of food before serving.
- Staff left sharps bins open and we found one oxygen cylinder unattached. Staff had left blood vials exposed on top of a clinic counter.
- Some staff had been using an old document which imposed a blanket restriction on informal patients returning to the ward at a specific time.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Lakeside View	5
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Mental Health Act responsibilities	11
Mental Capacity Act and Deprivation of Liberty Safeguards	11
Outstanding practice	24
Areas for improvement	24
Action we have told the provider to take	25

Good 

Lakeside View

Services we looked at

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

Summary of this inspection

Background to Lakeside View

Priory Lakeside View is an independent hospital which provides inpatient care to adults of working age who have acute mental health needs.

The hospital takes NHS patient referrals only. The hospital received referrals from the National Health Service from across England. The service had a contract of block booked beds with two NHS trusts.

The hospital had three acute mental health wards, each of which we visited as part of this inspection:

Swan Ward – female ward with eight beds

Robin Ward – male ward with eight beds

Finch Ward - male ward with 12 beds.

The hospital provided the following regulated activities:

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

At the time of our inspection there was a registered manager in place, who was the hospital director.

Priory Lakeside was last inspected September 2018, as part of the scheduled inspection programme. The hospital was rated as requires improvement overall, with requires improvement in safe, effective, responsive, caring and well led domains. Following that inspection, we told the provider it must:

- Ensure that governance systems are operating effectively across the hospital site, feeding into regional board level and ward level. They must ensure that they continue to monitor and improve the quality and safety of the services provided in the carrying out of regulated activity.
- Ensure they have sufficient and adequately skilled staff to meet the requirements of the service they offer.

- Ensure they have appropriate staffing levels on all wards to ensure there is enough staff to carry out treatment and care. Acorn ward staffing levels must be reviewed to ensure staff and patients are fully supported, patients receive their medicines on time and staff can access emergency drugs.
- Ensure that emergency equipment has appropriate safety checks and that emergency medicines are available to staff.
- Ensure that the hospital is clean and infection control procedures are in place.
- Ensure that all medical equipment is well maintained and calibrated in line with manufacturer's instructions.
- Ensure that blanket restrictions are not in place without due cause and that patients receive individual risk assessments to maximise their independence.
- Ensure that a patient care and treatment is designed to make sure it meets all their needs, this includes a clear care and treatment, which includes agreed goals and access to therapeutic recovery-based interventions.
- Actively seek the view of people using their service and those lawfully acting upon their behalf, about how care and treatment meets their needs. The provider must be able to show that they take action in response to feedback.
- Ensure they investigate any complaint received and take necessary and proportionate action in response to any failure identified by the complaint or investigation.

Since the comprehensive inspection in September 2018, the hospital has had five interim hospital directors in place until April 2019, when a substantive hospital director was appointed. During this period the hospital changed its service specification and now only provides acute mental health inpatient services. The three wards have been renamed and Acorn ward (previously a four bedded step-down ward) has been closed.

Summary of this inspection

Our inspection team

The team that inspected comprised of a lead CQC inspector, one CQC inspector, one assistant inspector, one inspection manager and one specialist advisor. The

specialist advisor was a registered mental health nurse. We were also supported by one expert by experience. An expert by experience is someone who has previously used services.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with ten patients who were using the service
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with 19 other staff members; including doctors, nurses, occupational therapist, psychologist, administration and housekeeping staff
- spoke with an independent advocate
- attended and observed one hand-over meeting
- looked at 17 care and treatment records of patients
- carried out a specific check of the medication management on all three wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Although the service had improved since our last inspection, we found areas of concern where the service still did not meet legal requirements, so we could not rate this above requires improvement.

We rated it requires improvement because;

- Wards were not always clean. A non-patient area on Finch Ward was cluttered and visibly soiled.
- Staff on did not always follow infection control procedures. Staff on Swan ward had not always recorded the temperature of food before serving.
- Staff left sharps bins open and we found one oxygen cylinder unattached. Staff had left blood vials exposed on top of a clinic counter.
- Some staff had been using an old document which imposed a blanket restriction on informal patients returning to the ward at a specific time.

However

- All wards were, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. The service managed patient safety incidents well. Staff recognised

Requires improvement



Summary of this inspection

incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Are services effective?

Our rating of this service improved. We rated it good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.
- The ward team included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills need to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Good



Are services caring?

Our rating of this service improved. We rated it good because:

Good



Summary of this inspection

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Our rating of this service improved. We rated it good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout and furnishings of the ward/service supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Good



Are services well-led?

Our rating of this service improved. We rated it good because:

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

Good



Summary of this inspection

- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local and national quality improvement activities.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of inspection staff training compliance was 98%. This training is mandatory for all clinical staff.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. However, although there were patient posters and some informal patients told us they knew their rights, we were not assured this was consistent. One informal patient told us he was not always allowed to leave the ward when he wanted to. Additionally, whilst on inspection we observed a member of staff tell an informal patient that if they attempted to leave they would be sectioned. The ward manager also witnessed this and addressed the situation ensuring that the correct information was passed onto the patient and said staff member.

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

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of inspection 98% of staff were compliant with training.

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






Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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

Good 

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

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

Requires improvement 

Safe and clean environment

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. The hospital undertook regular fire drills.

Staff could observe patients in all parts of the wards. Convex mirrors were strategically placed to help staff monitor areas with blind spots.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The hospital had up to date, visual and written ligature risk assessment in place for each ward.

All wards complied with guidance and there was no mixed sex accommodation.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Most ward areas were clean, well maintained, well-furnished and for purpose. Staff kept up to date cleaning records and followed a cleaning schedule.

Managers had recruited additional cleaners since the last inspection and we found on this inspection the overall cleanliness of the hospital environment had improved.

However, we found one non-patient area on Finch Ward that that was unclean and cluttered. We notified the ward manager, and this was rectified immediately.

Staff did not always follow all infection control policies. On Swan Ward we found staff had not always recorded the food serving temperature and were therefore not assured that they were testing the food before service. Staff had not recorded their actions on six days throughout September 2019 and records showed random recording in August 2019.

Staff, patients and visitors had access to hand gel. On our previous inspection we had found hand gel dispensers empty.

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Clinic room and equipment

Since the last inspection the hospital had opened a physical health suite which staff used to assess and monitor patient's physical health. The room was visibly clean and organised. It was had a clinical couch, equipment to monitor basic health observations and take bloods. However, the oxygen cylinder had not been attached to the wall, the blood vials were left on the counter in an open box and should have been covered and sharps bins were on the floor with the lids open.

Each ward had its own clinic room, for storage and dispensing of medicines. Staff kept these organised and tidy. However, the lids to the sharps bin had been left open on all three wards.

Staff on each ward had access to emergency equipment and emergency medicines. We found that staff checked these regularly to ensure all equipment/ medicine was present and in working order. This was an improvement since our last inspection in September 2018 when we told the provider that they must ensure that emergency equipment has appropriate safety checks and that emergency medicines are available to staff.

Safe staffing

Nursing staff

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. This had improved since our last inspection in September 2018, when the hospital did not have enough staff to cover the step-down ward or to offer a dialectical behaviour therapy informed service, which it had been commissioned to do so. Since then the step-down ward has been closed and the hospital no longer provides a rehabilitation service with a dialectical behaviour therapy informed approach.

The hospital nursing establishment calculated to work across all three acute wards for registered qualified nurses was 24 whole time equivalents. At the time of our inspection there were 10.85 whole time equivalent vacancies. The identified establishment for nursing assistants was 26.4 whole time equivalents, at the time of inspection there were 1.54 whole time equivalent nursing assistant vacancies. Although, the vacancy rate was the same as when we last inspected, it is acknowledged that the hospital had changed its service specification and consequently lost some staff because of this and its restructuring. The hospital was actively recruiting staff.

The number and grade of nurses and healthcare assistants required on the wards had been calculated as part of the Priory safer staffing ladder, a hospital wide staffing calculation.

An additional supernumerary night nurse role had been created as part of a pilot project. This role was one whole time equivalent and worked across all three wards to assist clinical staff and focus on quality improvement initiatives with night staff.

During the day the director of clinical services and hospital director were also available to support ward staff.

The ward manager could adjust staffing levels to take account of case mix as needed. If a patient needed one to one support, then the third healthcare assistant on duty would take responsibility for this. If additional one to one support were needed, the ward manager could request additional staff, either from the other wards in the hospital or through bank or agency bookings. When necessary, the ward manager deployed bank and agency staff to maintain safe staffing levels.

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

Good 

When agency and bank staff were used, they received an induction and where possible booked staff who were already familiar with the ward.

During the inspection, we observed a qualified nurse was always present in communal areas of the ward. Staffing levels allowed patients to have regular one to one time with a member of staff. We saw documented evidence of this in care records and patients confirmed nurses were available.

Staff shortages did not result in staff cancelling escorted leave or ward activities, but this did occasionally have to be rearranged. There were enough staff to carry out physical interventions (such as observations and restraint) safely, and staff had been trained to do so. Staff could also call for additional support from other wards if needed.

Medical Staff

The medical establishment had increased since our last inspection in September 2018. The hospital had two substantive consultant psychiatrists with experience in acute mental health in patient services, two specialist registrars and two registered medical officers. The registered medical officers worked and resided opposite shifts at the hospital. They were available 24 hours a day. If there was a medical emergency staff contacted the emergency services, however, they were supported by the registered medical officers.

Mandatory training

Staff had access to mandatory training. The average compliance rate for all mandatory training was above 85% for all modules. Mandatory training included, basic life support, data protection and confidentiality, Mental Capacity Act and Mental Health Act, Infection control, equality, fire safety, prevention and management of aggression and violence, breakaway, safeguarding children and vulnerable adults and handling complaints.

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

We looked at 17 patient care records during the inspection. All had an up to date risk assessment and management plan. We could see from records that staff updated the risk assessment and plan regularly, including after any incidents.

Management of patient risk

Staff were aware of and dealt with specific risk issues, such as falls or pressure ulcers. The hospital had registered medical officers, who provided triage to physical health care issues, such as soft tissue wounds.

Staff identified and responded to changing risks to, or posed by, patients. Evidence of this was observed throughout the inspection and recorded in patient care records.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points), staff behaviour and for searching patients or their bedrooms.

On our previous inspection, September 2018, we found numerous blanket restrictions across the hospital site. On this inspection we saw that staff individually risk assessed patients access to kitchens and the use of plastic cutlery had ceased. However, in four care records we found evidence of a contract with informal patients which stated that they must return to the hospital by seven p.m. These had not been care planned or individually risk assessed. We discussed this with the hospital director and director of clinical services. Neither were aware of this document or its intermittent use. It appeared to be an old document that some staff were still using, and others were not. Following this the hospital director deleted the document off the computer, so staff no longer had access to it and commenced an action plan to stop this practice.

Each ward had a sign by the exit stating that informal patients could leave the ward and advised how the door could be opened.

Use of restrictive interventions

In the 12 months before the inspection there were no episodes of seclusion or long-term segregation on the wards. The hospital did not have a functioning seclusion room.

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

Good 

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

Staff understood the Mental Capacity Act definition of restraint and worked within it.

In the six months prior to inspection there were 123 episodes of restraint. The data shows a decline in incidents since the hospital has changed its service provisions. None of the reported restraints were prone restraint.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff told us they followed National Institute of Health and Care Excellence guidance when using rapid tranquilisation. Six months prior to inspection staff had not used intramuscular rapid tranquilisations.

Staff did not have use of a seclusion room. If there were concerns about the safety of patients or increased risk of aggression, staff would support patients to leave communal areas and spend some time either in their rooms or a quiet area on the ward.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. Each ward had their own safeguarding lead.

Staff kept up to date with their safeguarding training. At the time of our inspection compliance with training was 100%.

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

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff access to essential information

All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in an accessible form. This included when patients moved between teams.

Staff used electronic patient records. Any paper documentation was filed appropriately and kept secure.

Medicines management

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

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

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to National Institute for Health and Care Excellence guidance.

Track record on safety

The hospital reported four serious incidents in the 12 months prior to inspection. This included patient self-harm, patient aggression towards staff resulting in prolonged restraint and staff injury and two unexpected deaths. The provider had completed or were completing at the time of the inspection an investigation. We saw evidence of lessons learnt and service improvements from investigations.

Reporting incidents and learning from when things go wrong

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with trust policy. Staff used an electronic form. All incidents were discussed in the daily morning meetings. Lessons learnt shared and documented internally and amongst the wider region and at national levels.

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

Good 

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

There was evidence that changes had been made as a result of feedback. For example, the team have reviewed and amended their admission processes to ensure all relevant information is received prior to accepting an admission. The hospital also reviewed staff access to defibrillators.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

We looked at 17 care records during inspection and found staff completed a comprehensive mental health assessment of each patient either on admission or soon after. Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. Staff regularly reviewed and updated care plans when patient's needs changed. Care plans were personalised, holistic and recovery-orientated. Staff documented if the patient had been too unwell to contribute to the care plan and evidenced how they followed this up during the patient's recovery. This is an improvement since our last inspection in September 2018 when we told the provider they must ensure that a patient care and treatment is

designed to make sure it meets all their needs, this includes a clear care and treatment, which includes agreed goals and access to therapeutic recovery-based interventions.

Best practice in treatment and care

Staff provided a range of care and treatment suitable for the patients in the service, in line with best practice and national guidance. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). This included access to physical health care and psychological therapies.

Staff identified patients' physical health needs and recorded them in their care plans.

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Staff identified patients' physical health needs and recorded them in their care plans.

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

Good 

Patients had access to physical health care, including specialists as required.

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

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. For example, smoking cessation.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients. They had recently introduced digital displays on each ward. Staff had asked patients to suggest what information they wanted displayed. This ranged from positive affirmation quotes to practical information such as time of ward round.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. For example, staff completed audits of physical health care, the Mental Health Act and care plans. Ward managers and charge nurses undertook quality walk rounds, where they would visit other wards on the hospital to assess and rate the quality of the care provided. We saw evidence that managers used results from audits to make improvements.

Skilled staff to deliver care

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

As well as ward consultants, nurses and healthcare assistants, the ward also had access to occupational therapists and psychologists. A pharmacist also visited the ward on a weekly basis and was available for advice and support as needed.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Managers provided new staff with appropriate induction. Agency staff were also given an induction to ensure they were familiar with the ward. When possible, the hospital used agency staff on longer placements or who had experience of working at the hospital.

Managers provided staff, including agency staff, with supervision (meetings to discuss case management, to reflect on and learn from practice and for personal support and professional development) and appraisal of their work performance. The percentage of staff that had had an annual appraisal in the year before the inspection was 100%.

Staff told us they had access to regular team meetings. We observed one team meeting and reviewed meeting minutes. We saw that the manager gave information to those staff that could not attend.

Managers made sure staff received any specialist training for their role. The ward manager identified the learning needs of staff through supervision and learning from complaints and incidents and provided them with opportunities to develop their skills and knowledge.

Managers recognised poor performance, could identify the reasons and dealt with these. At the time of the inspection no staff were being performance managed.

Multi-disciplinary and inter-agency team work

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Staff invited care coordinators to meetings.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The hospital held daily flash meetings every morning to discuss staffing, safeguarding, risk and any other key issues as a hospital.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations. Representatives from the local mental health trust who block booked beds at the hospital attended ward rounds to support and facilitate discharge planning.

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

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. At the time of inspection staff training compliance was 98%. This training is mandatory for all clinical staff.

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

Good 

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up to date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

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

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated it as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

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

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this. However, although there were patient posters and some informal patients told us they knew their rights, we were not assured this was consistent. One informal patient told us he was not always allowed to leave the ward when he wanted. Additionally, whilst on inspection we observed a member of staff tell an informal patient that if they attempted to leave they would be sectioned. The ward manager also witnessed this and addressed the situation ensuring that the correct information was passed onto the patient and said staff member.

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

Good practice in applying the Mental Capacity Act

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles. At the time of inspection 98% of staff were compliant with training.

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

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

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

Good 

Kindness, privacy, dignity, respect, compassion and support

Staff were discreet, respectful, and responsive when caring for patients. We observed this on several occasions throughout the inspection and patients told us that staff usually behaved in this manner.

Staff gave patients help, emotional support and advice when they needed it. Staff supported patients to maintain social activities they had an interest in.

Staff supported patients to understand and manage their own care treatment or condition. Staff discussed different options of treatment and the service had a variety of treatment information leaflets.

Staff directed patients to other services and supported them to access those services if they needed help. For example, maintaining appointments with other professionals in community settings.

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

Good 

We spoke with ten patients. Their feedback was mainly positive. Patients told us staff were kind and treated them with respect. However, one patient told us that sometimes staff were too busy and did not always have the time to support patients.

Staff understood and respected the individual needs of each patient. This was reflected in care plans we reviewed.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences.

Staff followed policy to keep patient information confidential. For example, staff discussed patient care in private and ensured patient documentation was stored correctly.

Involvement in care

Staff introduced patients to the ward and the services as part of their admission. Staff had redesigned the welcome booklet since our last inspection in September 2018, when we told the provider they should ensure information booklets they give to patients are accurate and information on display up to date.

Staff involved patients and gave them access to their care planning and risk assessments. Staff and patients signed care plans. Patients and their families or carers' views, wishes and opinions were documented in care records.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this. Each ward held weekly community meetings. Patients or staff documented discussion and actions from these meetings. We could see from the minutes that actions had been taken for example a change to menus.

Patients were also encouraged to elect a representative to attend clinical governance meetings.

Staff had completed a patient and family/ carer audit to review patient involvement and feedback. From this a list of

questions devised from patients has been created to use in staff recruitment interviews. Staff also changed the digital displays on each ward following feedback from the patients.

The hospital director has an open drop in session once a week for any patient and or family and carer to attend. For family and carers that are unable to attend or prefer, a carers survey has been created by staff and available for completion.

Staff ensured patients had access to advocates to have their voice heard. An independent advocate visited the hospital weekly.

Staff supported patients to make advanced decisions about their care.

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

Good 

Staff managed beds well. Patients were not moved between wards unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.

The wards had clear exclusion criterion and would not admit a patient who had been violent in the previous week. The hospital did not have a seclusion room and would not admit patients who were considered to be a high risk. Staff told us following a recent review they always seek additional support from the doctors when more complex referrals are made, for example, a patient with ongoing physical health needs. Staff completed a pre-admission risk screen to ensure patients' needs could be met on the ward. The ward had refused or delayed admissions due to the high level of acuity on the ward if they felt that a person's needs could not be safely met at that time.

Due to the hospital changing its specification the average length of stay for the 12 months prior to inspection does not reflect the current patient group. The average length of stay for patients on the acute wards between March 2019 and 31 July 2019 was 21 days. At the time of inspection there were two delayed discharges. These patients had

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

Good 

been initially admitted to the rehabilitation wards. We saw evidence that the provider was working with commissioners to provide more suitable placements for the patients.

Beds were generally available when needed for patients living in the local area. There was always a bed available when patients returned from leave. When patients were removed or discharged, this happened at an appropriate time of day.

When needed a bed could be found on a psychiatric intensive care unit. Staff would start looking for available beds in other Priory group hospitals.

Staff planned for patients' discharge, including good liaison with care coordinators and family where appropriate. This process started from the point of admission.

Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

Each patient had their own en-suite bedroom, which they could personalise.

Patients had a secure place to store personal possessions.

Staff used a full range of rooms and equipment to support treatment and care. The hospital had recruited local fitness instructors to provide a range of recreational fitness activities three times a week in addition to the recreational activities already offered by support staff.

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

Patients could use their own mobile phones to make private calls or use a ward phone in private.

The service had an outside space that patients could access easily.

Patients could make their own hot drinks and snacks and were not dependent on staff. This was an improvement since our last inspection in September 2018, when patients did not have access to these facilities.

The service offered a variety of good quality food.

Patients' engagement with the wider community

Where possible, staff supported patients with activities outside the service, such as work, education and family relationships.

When appropriate, staff supported patients with preparation for and access to education and work opportunities. Staff also supported ongoing contact with current employers and workplaces as needed.

Staff supported patients to maintain contact with their families and carers. Staff also encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Patients spent time out of the hospital in the community as part of the discharge preparation process.

Meeting the needs of all people who use the service

The hospital could support and make adjustments for disabled people and those with communication needs or other specific needs. For example, wards were accessible using lifts and there were emergency evacuation chairs on stairs to support patients to evacuate the building if they were unable to use the stairs.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

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

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients.

Patients had access to spiritual, religious and cultural support. Staff supported patients to attend places of worship or invited spiritual leaders to the ward.

Listening to and learning from concerns and complaints

Patients, relatives and carers knew how to complain or raise concerns. Eight of patients we spoke to confirmed this.

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

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

Good 

Staff understood the policy on complaints and knew how to handle them. This was an improvement since our last inspection in September 2018 when we told the provider they must ensure they investigate any complaint received and take necessary and

proportionate action in response to any failure identified by the complaint or investigation.

On this inspection we reviewed the complaints log and were assured that staff followed the providers complaint policy. We saw that complaints were logged and responded to in a timely manner, they were discussed at governance meetings and staff were given feedback. Staff protected patients who raised concerns or complaints from discrimination and harassment.

Patients received feedback from managers after the investigation into their complaint.

The hospital had received 32 complaints during the twelve months prior to inspection. Of these, eight had been upheld and two partially upheld. The provider told us the from analysis of the complaints the main concerns highlighted were; relationship with neighbours, noise and light levels on the wards and change of service line. During inspection we saw evidence that these had all been addressed with action plans in place.

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

Good 

Leadership

On this inspection we found leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles. This was an improvement since our last inspection in September 2018. At that time the hospital had an interim hospital director and further interim cover until the substantive posts were filled in March 2019.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were

working to provide high quality care. At the time of the inspection the leadership team was relatively new and had already established a good relationship with staff and identified the needs of the service. They had clearly been working hard to address issues we had found at the last inspection and to make improvements to the quality of care they offered patients.

Leaders were visible in the service and approachable for patients and staff. Senior leaders carried out regular quality walk rounds on the ward and were well known to staff and patients.

Vision and strategy

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in the service.

Staff had the opportunity to contribute to discussions about the strategy for their service. Staff had access to a "Your Say" forum where they were encouraged to feedback any issues. The hospital director undertook fortnightly 'pulse checks' with staff. The manager asked staff sample questions from the yearly staff survey to enable faster insight into issues.

Staff could explain how they were working to deliver high quality care within the available budgets.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

On this inspection it was heartening to see and hear from staff who felt positive and proud of working at Lakeside View. This was an improvement since our last inspection when morale was extremely low. Staff felt that the current leadership were open and transparent, they felt listened to and respected.

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

Good 

The provider recognised staff success within the service, for example, through staff awards.

Managers dealt with poor performance when needed.

The staff team worked well together and supported each other well.

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

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. This was an improvement since our last inspection in September 2018 when we told the provider they must ensure that governance systems are operating effectively across the hospital site, feeding into regional board level and ward level. They must ensure that they continue to monitor and improve the quality and safety of the services provided in the carrying out of regulated activity.

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and

accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were systems and procedures in place to ensure that the ward was safe, that there were enough staff who were trained and supervised, patients were treated well, and incidents and complaints were reported, investigated and learnt from. When systems did not work effectively (as with the medicines management issues we identified on site), the senior management team had processes in place to review and update these.

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

There were key performance indicators that the ward reported on which included supervision and training compliance, sickness monitoring, incidents and medicines management.

Staff undertook or participated in local clinical audits.

Audits included care plans, Mental Capacity Act, Mental Health Act and physical health. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

The ward manager had access to the risk register at ward level. Staff could escalate concerns as required. Staff concerns matched those on the risk register. All issues on the risk register were revisited monthly as part of the clinical governance meetings.

Staff told us that cost improvements did not compromise patient care. Where insufficient nursing staff had been identified as an issue, steps had been taken to increase the staffing in response to concerns raised.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service used systems to collect data from the ward that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve patient care. However, the record keeping system included both paper and electronic records, and it was not always immediately clear where information was located, or if this was recorded in paper or electronic format.

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

Good 

Information governance systems included confidentiality of patient records.

The ward manager had access to information to support them with their management role. This included information on the performance of the ward, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies such as the local authority and the CQC as needed.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

The service engaged well with patients, staff and equality groups to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. Patients and carers also had opportunities to give feedback on the service they received.

The ward manager had access to this feedback from patients, carers and staff and used it to make improvements.

Patients and staff could meet with members of the senior leadership team to give feedback.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods.

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

Staff were given the time and support to consider opportunities for improvements and innovation. This feedback was welcomed as part of the “Your Say” staff forum and the patient council meetings.

The ward did not participate in any accreditation schemes at the time of the inspection but were keen to do so in the future once the ward had a full complement of staff. There were no plans to start this process at the time of the inspection.

The site was currently following the Safe Wards model to improve safety on the ward.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

The provider must ensure that staff follow all infection control procedures.

The provider must ensure that all areas of the hospital are kept clean.

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12

Action the provider **SHOULD** take to improve

The provider should ensure that staff do not enforce blanket restrictions upon informal patients without individual assessment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 The provider did not ensure that staff followed all infection control procedures. Not all hospital areas were clean