The Priory Ticehurst House

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?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated The Priory Ticehurst House as good because:

- The service provided safe care. The ward environments were safe and clean and wards met the requirements set out in national guidance on mixed sex accommodation.
- Staff assessed and managed risk well. All patient records that we reviewed had a current and up to date risk assessment in place. Staff demonstrated a good knowledge of their patients and their associated risks. The service minimised the use of restrictive practices 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. Medicines were appropriately stored, administered and reconciled on all wards. All medicine was in date and labelled.
- Staff monitored patients' physical health regularly and managed patients' physical health needs well across all wards.
- The wards had enough staff on shifts. 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 appraisals. The ward staff worked well together as a multi-disciplinary 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.
- 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.
- The service demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

However:

- The provider failed to notify the CQC of incidents, including those that involved the police, as required by regulations set out in the Health and Social Care Act.
- Spare alarms were not consistently stored on the wards or accounted for on handover sheets. Staff alarms were not routinely tested to ensure their efficiency.
- The clinic room on Newington Court One had thick dust on medical appliances. The medicine cabinet in the child and adolescent ward clinic room was in reach of patients waiting outside.
- Whilst improvements were noted since the last inspection, not all agency health care assistants on the child and adolescent mental health wards had their induction checklists completed before working independently.
- On the child and adolescent mental health ward, some staff were unclear about what to do in the event of a fire.
- Whilst a comprehensive ligature point audit had been carried out and staff aware of the risks, the remedial works action plan did not indicate whether the work had been completed where the expected date of completion had passed.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Good	• The service provided safe care. The ward environments were safe and clean and Highlands complied with mixed sex accommodation guidance. The wards had enough staff on shifts. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding. • All patients reviewed had a current and up to date risk assessment in place. Staff demonstrated a good knowledge of their patients and the risks they posed. Risk management plans were in place for all identified risks in the patient care records. • 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 • 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 appraisals. The ward staff worked well together as a multi-disciplinary 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. • In the most recent satisfaction survey, 80% of patients stated that they would recommend the hospital to friends and family and 89% felt the hospital was caring and supportive of their needs and recovery journey.

Summary of findings

- The service had clear inclusion and exclusion criteria and there was a risk screening tool used by the central triage team. We saw appropriate discussions and referrals made for more intensive care units for patients requiring them
- 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.
- The service demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

However:

- Spare alarms were not consistently stored on the wards or accounted for on handover sheets. Staff alarms were not routinely tested to ensure their efficiency.
- The clinic room on Newington Court One ward was dirty with dust on appliances.

Child and adolescent mental health wards

Good

- The service provided safe care. The environment was clean, well equipped, and well maintained and staff informed us that they carried out a daily environment check. Medicines were safely managed and they followed good practice with respect to safeguarding.
- Staff ensured that patients' physical health was monitored, including after rapid tranquilisation and there was sufficient staff on the wards, including sufficient out of hours medical cover in place. All staff had received a performance appraisal.
- A comprehensive structured day of integrated education, therapy and psychology was provided for the patients from Monday to Friday.
- There was a range of staff in the multidisciplinary team and the ward had access to the full range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, occupational therapists, psychologist and social worker.
- We observed staff treating patients with compassion and kindness. Staff had an awareness of the individual needs of the patients and staff involved family and carers in patient's treatment.

Summary of findings

- Staff completed thorough risk assessments on each patient on arrival and that these risk assessments were regularly updated. Staff developed holistic, recovery-orientated care plans.
- Staff monitored the physical health of patients appropriately following administration of rapid tranquilisation and completed the necessary records. This was an issue at our previous focussed inspection.
- At our previous inspection we saw that only the first name of temporary workers was recorded on the rota, which could cause identification problems at a later date. On this inspection we saw that this was no longer a problem.
- At the last focussed inspection, we found that the provider failed to notify the CQC when required to do so around patients attending the emergency department. We reviewed a log of safeguarding incidents between August and November 2018, where patients had been taken to A&E and saw that the CQC had been notified on every occasion.

However:

- The provider failed to notify the CQC when required to do so where the police had been contacted following a serious incident. We viewed two incidents which the hospital had failed to notify the CQC of.
- On the child and adolescent mental health ward, some staff were unclear about what to do in the event of a fire.
- The medicine cabinet in the clinic room was in reach of patients waiting outside and there had been a number of incidents where patients had tried to reach the medications. The sharps bin in the clinic room was located above the sink, which could be hazardous.
- Whilst improvements were noted since the last inspection, not all agency health care assistants on the child and adolescent mental health wards had their induction checklists completed before working independently.

Summary of findings

- Whilst a comprehensive ligature point audit had been carried out, the remedial works action plan did not indicate whether the work had been completed where the anticipated completion date had passed.

Summary of findings

Contents

Good

The Priory Ticehurst House

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards.

Summary of this inspection

Background to The Priory Ticehurst House

The Priory Ticehurst House is situated in East Sussex. It provides inpatient mental health services for adults and young people. Since the last inspection, the service no longer provides long stay/rehabilitation mental health wards for working-age adults The child and adolescent mental health service at the hospital has two female wards; one ward with 13 beds and a high dependency unit with 13 beds for young people. On this inspection, we only visited the high dependency unit because there were no children and young people on the other ward. The hospital also has three acute psychiatric wards. One ward is a 16-bedded ward for female patients, another is a 9-bedded male ward and one 9 bedded mixed sex ward for private paying patients only.

The Priory Ticehurst House is registered for the following regulated activities: Assessment and medical treatment for persons detained under the Mental Health Act 1983; Treatment of disease, disorder or injury.

The child and adolescent mental health service received a focused inspection in June 2018. We told the provider it must make the following improvements:

- The provider must ensure that information about young people's risk are consistent across the different recording systems.
- The provider must ensure that young people are appropriately monitored following administration of rapid tranquilisation and records are completed.
- The provider must ensure that clear, accurate and up-to-date records are maintained including staff rotas. • The provider must ensure all staff receive an induction appropriate to their role before they undertake duties.
- The provider must ensure all staff have regular supervision.
- The provider must ensure that CQC are appropriately informed of all notifiable events (this was specifically about A&E admission).

We found that the provider had made these improvements at this inspection.

The adults acute psychiatric service was last inspected as a full comprehensive inspection of the location in April 2018. The service was rated as good overall and good in each domain.

Our inspection team

The team that inspected the hospital comprised of two CQC inspectors, one assistant inspector and three specialist advisors with experience of working within child and adolescent mental health services and adult acute mental health services. All three specialist advisors were nurses.

Why we carried out this inspection

We conducted a full comprehensive inspection of the service in response to risks highlighted by external agencies and to follow up on the improvements required from the last focussed inspection.

Summary of this inspection

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.

During the inspection visit, the inspection team:

- visited all four wards at the hospital with current admissions, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 10 patients, including two young people who were using the service and one family member of a patient;
- spoke with the hospital director and the ward managers for each ward;
- spoke with 25 other staff members; including doctors, nurses, occupational therapist, psychologist, social worker, student and housekeeping;
- attended and observed one hand-over meeting, one ward round and one learning from experience meeting;
- looked at 24 care and treatment records of patients:
- carried out a specific check of the medication management on all wards including 19 medicine charts; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients from all four wards were largely positive about their experiences at the hospital. Patients reported feeling safe and felt that the staff took a genuine interest in their care and wellbeing.

Patients felt supported through their treatment and took ownership of their care. Patients told us that the wards were clean, the quality of the food was good and that staff were always available. Patients reported that they felt safe on the wards and able to speak up to staff. Additionally, they felt their possessions were kept safe and that family were suitable involved in their care.

However, some patients felt there were not enough activities in the evenings and weekends.

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?

Good

We rated safe as good because:

- The service provided safe care. The ward environments were safe and clean and complied with mixed sex accommodation guidance. The wards had enough staff on shifts and whilst there was a reliance on agency staff, they were regular agency staff that ensured consistency and familiarity with the hospital. Out of hours medical cover was sufficient across the hospital.
- Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- All patients reviewed had a current risk assessment in place. Risk assessments were regularly updated. Staff demonstrated a good knowledge of their patients and the risks they posed. Risk management plans were in place for all identified risks in the patient care records.
- Patients' physical health was regularly monitored and managed well across all wards.
- Staff were confident in identifying and reporting abuse, as well as reporting incidents. Managers investigated incidents and shared lessons learned with the whole team and wider service.

However:

- Whilst a comprehensive ligature point audit had been carried out, the remedial works action plan did not indicate whether the work had been completed where the anticipated completion date had passed.
- The medicine cabinet in the child and adolescent ward clinic room was in reach of patients and there had been a number of incidents where patients attempted to reach the medications. The clinic room on Newington Court One was dirty with thick dust on appliances.
- On the child and adolescent mental health ward some staff provided inconsistent information during a fire alarm about which fire doors automatically opened when the alarm sounded and where visitors were evacuated to.
- Spare alarms were not consistently stored on the adult acute wards or accounted for on handover sheets. Staff alarms were not routinely tested to ensure their efficiency.

Summary of this inspection

Are services effective?

Good

We rated effective as good because:

- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment.
- Each service provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- A comprehensive structured day of integrated education, therapy and psychology was provided for the child and adolescent service Monday to Friday.
- Each service 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 appraisals. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- Most staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005 appropriately.

However,

- Patients that we spoke with did not feel that there were enough activities in the evenings or weekends.

Are services caring?

Good

We rated caring as good because:

- 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 and supported patients to understand and manage their care, treatment or condition.
- On admission, patients received a comprehensive welcome pack containing all the necessary information in to assist them in acclimatising to the ward environment.
- We saw evidence in care plans of patients views and documented where care plans had been offered to patients.
- An independent mental health advocate regularly visited the wards at the hospital.

Are services responsive?

Good

We rated responsive as good because:

- Each service had clear inclusion and exclusion criteria and there was a risk screening tool used by the central triage team. We saw appropriate discussions and referrals made for more intensive care units for patients requiring them.

Summary of this inspection

- Each ward had access to a full range of rooms and equipment to support treatment and care. Patients were permitted to personalise their bedrooms.
- On the child and adolescent ward, staff facilitated patient's access to high quality education. Education was integrated with psychology and occupational therapy and patients went on group trips into the community.
- The hospital managed concerns and complaints appropriately, investigating them and learning lessons that were shared with the wider service.

Are services well-led?

Good

We rated well-led as 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.
- The hospital demonstrated that governance processes operated effectively and that performance and risk were managed well.
- At the last focussed inspection of the child and adolescent service, we found that the provider failed to notify the CQC when required to do so regarding patients attending the emergency department. We reviewed a log of recent safeguarding incidents and saw that the CQC had been notified when this occurred.

However:

- The provider failed to notify the CQC of incidents, including those that involved the police, as required by regulations set out in the Health and Social Care Act. Please see 'Actions we have told the provider to take' for more information.

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.

Mental Health Act (MHA) paperwork was correctly filed, up to date and appropriately stored. Staff had access to administrative and legal advice and support and there was a MHA administrator for the hospital. Monthly audits were conducted to check paperwork was all in order and the act was being correctly applied.

Staff had access to a relevant and up to date MHA policy and procedures to ensure the code of practice was being followed. Staff demonstrated a good understanding of the implementation of the MHA and code of practice.

Patients had easy access to advocacy and information about the service was readily displayed and available.

Staff read patients their rights on admission and regularly thereafter. We saw evidence that this was delivered in such a way that patients could understand it, including bringing translators into the service.

Section 17 leave was facilitated and records contained clear information on conditions of leave and level of escort. Patients were not allowed to leave the hospital until they had read, understood and signed their Section 17 leave paperwork. We saw evidence that risk assessments were also reviewed before authorisation.

Consent to treatment documentation was in place for patients on all medicine records we reviewed. We found that both T2 and T3 certificates were reviewed in line with hospital policy. These certificates demonstrated that detained patients had the proper consent to treatment in place.

All wards displayed a notice by the ward door notifying informal patients of their right to leave. Staff could explain appropriate procedures they had in place should an informal patient ask to leave.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital delivered Mental Capacity Act (MCA) training as both face-to-face and online training. Staff had completed 100% of face to face training and 67% of online training. Staff demonstrated a good understanding of the act and the five statutory principles. Generally, staff we spoke with knew about Gillick competence but some staff were not confident in discussing it. Gillick competence is a test in medical law to describe whether a young person of 16 years or younger is competent to consent to treatment without the needs for parental permission or knowledge.

The service did not make any deprivation of liberty safeguards applications over the last six months.

Patient capacity was assessed by staff on admission to the service and revisited during ward rounds. We did not review any records where patients were assessed as having impaired capacity.

Staff we spoke with understood and worked within the MCA definition of restraint using least restriction and force wherever possible.

Staff could obtain advice regarding the MCA, including deprivation of liberty safeguards, from a central Priory office and from the hospitals MHA administrator.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Good	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good

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

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

Good

Safe and clean environment

- **Safety of the ward layout**
- All wards undertook daily environmental risk assessment checks. Each morning a staff member was allocated the security staff role and recorded their findings on a standard form that included each bedroom and room on each ward.
- All wards were within listed historical buildings and as such, the provider was unable to make any major changes to the building. As a result, there were multiple blind spots and ligature risks across the wards. However, the service undertook ligature risk audits and blind spot audits on each ward every six months. Each risk was mitigated by staff presence, individual risk assessments or building modifications where allowed. We saw regular staff observations of all ward areas whilst on inspection. Closed-circuit television was in place in all public areas of the wards to further support the management of any risks. Staff were aware of areas of risk within the wards and ligature cutters were readily available in the event of an emergency.
- All bedrooms had anti-ligature fixtures and furnishings and there was a programme of work to create 'safer rooms' with the installation of additional internal window frames that reduced the ligature risk, without impacting on the listed nature of the buildings. All ensuite bathrooms had recently installed Soft doors had been recently installed in all ensuite bathrooms to further reduce any ligature risks.
- Newington Court One and Two were single sex wards whilst Highlands ward accepted mixed-sex referrals. Highlands ward met the national mixed sex accommodation guidance. There was a separate female lounge, segregated sleeping areas and separate toilet and bathroom facilities.
- All rooms had nurse call systems and a new personal alarm system was in place for staff and visitors. Alarms triggered an audible sound whilst panels in or near to the nursing offices on all wards alerted responding staff to the location of the alarm. All ward staff additionally carried radios.
- All alarms in use were allocated to staff during handovers and recorded daily. However, spare alarms or those not currently in use were not consistently stored anywhere or accounted for on the alarms sheets. For example, we saw alarms in office drawers, hung up in nursing offices by tape or left on desks. Additionally, we did not see any recording of regular alarm testing to ensure their efficiency. We were told by senior staff that alarms were tested daily; however, we did not see any documented evidence that these occurred or actions taken if a fault was identified.

Maintenance, cleanliness and infection control

- All ward areas were clean and tidy with good furnishings. Highlands ward had only recently opened and contained all new furniture and benefited from a

full refurbishment. We saw cleaning rotas that demonstrated regular cleaning from the services housekeeping team and the estates team were responsive to any maintenance issues.

- However, the clinic room on Newington Court One had thick dust on many medical devices. Staff told us that housekeeping cleaned the room but this had not been raised with housekeeping, nor had any ward staff taken responsibility to maintain its cleanliness.

Clinic room and equipment

- Clinic rooms across the wards were fully equipped and had available emergency resuscitation equipment and emergency medicine. There was evidence that these were checked weekly and all equipment was calibrated annually and portable appliance tested.

Safe staffing

- All wards operated on a 3:1 patient to staff ratio on all day and night shifts to maintain safe staffing levels. The ward operated with two 12-hour shifts with an appropriate 30 minute handover period in-between.
- Ward managers could adjust staffing levels to account for the acuity on the wards. For example, if there were increases to patient observation levels required. Additionally, on Newington Court One ward, if patients were placed in bedrooms upstairs, an extra member of staff was deployed to work on the ward. Extra staff were also deployed during weekly ward rounds to ensure safe staffing levels on the wards.
- Each morning the hospital held what they called 'flash meetings' with the senior leadership team and ward managers of each ward that discussed staffing levels and acuity in order to appropriately redeploy staff across the hospital site.
- The service had an average staff vacancy rate of 3%. The service utilised bank and agency staff to ensure all shifts were filled. Agency usage was highest on Newington Court One ward which required higher staffing numbers due to a greater number of patient beds. Where bank and agency staff were used, the service ensured they were block booked or had at least worked with the hospital before to ensure familiarity with the wards and the hospital processes.
- All bank and agency staff received a thorough induction to the wards and competency checks were obtained every six months. Additionally, bank and agency staff had to undertake the hospitals own prevention and management of violence and aggression course before they were permitted to work independently on the wards.
- Patients received regular one-to-ones with their named nurse and ward activities or escorted leave was rarely cancelled due to staffing.

Medical staff

- The service had adequate medical cover across all wards during the day and night. Newington Court One and two each had a dedicated full-time consultant and Highlands had five visiting consultants who also worked at a neighbouring sister service. A visiting general practitioner (GP) visited the service once a week to support with patient physical healthcare. The service had a ward doctor available across the wards and a staff-grade doctor was available 24/7 on-site. There was also a duty system in place for an on-call manager and on-call consultant.

Mandatory training

- All substantive and bank staff were required to undertake mandatory training. Staff were up to date with appropriate mandatory training and overall 89% of staff had completed mandatory training. Mandatory training included basic life support, infection control, prevention and management of violence and aggression, Mental Health Act, Mental Capacity Act and safeguarding adults and children.
- Where staff were due training, we saw a monthly rolling programme of training courses with new and existing staff booked in to attend. There was a site learning administrator who reviewed training figures and liaised closely with ward managers to ensure ongoing compliance.

Assessing and managing risk to patients and staff

Assessment of patient risk

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

Good

- We reviewed 19 care records and found that every patient had a current and up to date risk assessment in place. Risk assessments considered a range of issues and these were regularly updated, including after any incidents.

Management of patient risk

- Staff demonstrated a good knowledge of their patients and the risks they posed. Management plans were in place for all of the identified risks in the patient care records we reviewed.
- The service had an observation policy in place that staff were aware of and adhered to. We saw good discussions around risk and mitigating actions to take, including details of the required observation levels for each patient.
- Staff applied blanket restrictions on patient's freedom only when justified on the basis of risk. For example, patients were allowed mobile phones and laptops on the ward but were not allowed chargers on the ward and had to charge devices in the ward offices. The rationale for this was that as patient bedroom doors were routinely left open throughout the day other patients at risk could easily obtain items that could pose a potential risk.
- All ward entrance doors were locked. The doors had clear signs explaining the rights of informal patients to leave. Ward staff told us that if an informal patient wanted to leave the ward they would unlock the doors for them. Where concerns regarding the patient's wellbeing or safety were identified, staff would use their holding powers under the Mental Health Act 1983 and inform a doctor to undertake an immediate mental health assessment for the patient.

Use of restrictive interventions

- The hospital did not have any seclusion facilities available and therefore there were no episodes of seclusion or long-term segregation within this service.
- For the six months prior to 31 July 2018, there were 59 episodes of restraint within the service. The data submitted by the service did not break this figure down by wards. No episodes of restraint resulted in prone restraints being used or any rapid tranquilisation.
- The service regularly reviewed restrictive interventions during monthly clinical governance meetings. The director of clinical services took a lead on reviewing restrictive interventions.
- Staff reported using restraint as the final option in dealing with challenging behaviours on the wards and only ever after de-escalation techniques had failed. All staff were trained in appropriate restraint techniques and much of this training focussed on calming and de-escalation.
- We saw staff had followed National Institute for Care and Health Excellence guidance when using rapid tranquilisation. Patients received appropriate physical health monitoring following its use.

Safeguarding

- Safeguarding adults and children formed part of staff mandatory training and 88% and 85% (respectively) of staff had completed training. Additionally, we saw other staff members booked onto future courses and the safeguarding modules were run once a month for new and existing staff.
- All staff we spoke with were knowledgeable of the safeguarding procedure. The service had a clear safeguarding flowchart in all staff offices and staff were given a small personal safeguarding factsheet for reference. There was a designated safeguarding officer within the hospital.
- Safeguarding concerns were logged and tracked regularly in monthly clinical governance meetings and any learning from closed safeguarding from around the hospital were shared and disseminated to all staff.
- The service demonstrated a good working relationship with patient's local authorities who also phoned into ward rounds and clinical governance meetings where necessary.
- Staff could give examples of how to protect patients from discrimination, including those with protected characteristics. There was an appropriate equality policy in place for staff to adhere to and we saw evidence of the service constantly learning and updating this to align with modern issues and practices.

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

Good

- There were safe procedures for children visiting all wards. There was a separate family room away from the wards where children could visit patients.

Staff access to essential information

- The service utilised an electronic patient record system that most staff had secure access to. Substantive staff, long term bank and agency staff all had their own secure login for the system.
- The service also held up to date patient paper records with print outs of risk assessments, management plans and care plans. This was due to poor connectivity across the hospital and acted as a contingency plan in the event that the electronic patient records were unavailable. Paper copies of patient files were kept appropriately locked within cupboards in the ward offices.

Medicines management

- Medicines were appropriately stored, administered and reconciled on all wards. All medicine was in date and appropriately labelled.
- However, Newington Court One ward held a large quantity of 'stock' medicines. Both the nursing and pharmacy staff regularly checked the stock medicine. We checked the stock medicines on inspection and it was all in date and correctly stored. The other adult wards used the additional stock medicine from Newington Court One ward from time to time if their stock medicine was running low. This meant checks of the stock medication took nursing and pharmacy staff an excessive amount of time. We interviewed the nursing staff and pharmacist who agreed the amount of stock medicine held on the ward needed to be reduced. This was noted as an issue by the pharmacist and director for clinical services for the hospital and we saw plans to implement a more robust system and development of an appropriate, smaller stock list.
- We reviewed 18 medicine charts that were all accurate and without any errors, including 'as and when' medicines.
- An allocated staff member appropriately recorded daily clinic room temperatures and clinic fridge temperatures and detailed actions when this feel out of acceptable ranges.
- There was a service line agreement in place with a local pharmacy service to provide comprehensive pharmacy support. A pharmacist visited the service once a week to dispense named-patient medicine, provide stock medicine and review the medicine management charts to undertake regular audits. All queries, errors, advice and audits were recorded on an electronic reporting system and the relevant hospital staff received notifications. The visiting pharmacist also ran medicine training sessions for staff.
- The service appropriately monitored and recorded patients' physical health following administration of high dose antipsychotic medicine in line with National Institute of Health and Care Excellence guidance (QS80/S6).

Track record on safety

- There were no serious incidents reported by the service during the same period. However, there were robust process in place should a serious incident occur.

Reporting incidents and learning from when things go wrong

- The service implemented an electronic incident reporting system that all staff had access to and could use to raise an alert. All alerts raised were sent through to ward managers for review and senior leadership the day following their completion. A daily incident report was compiled and monitored by the quality improvement lead with discussions around incidents occurring at monthly clinical governance meetings. We saw evidence of managers returning incident forms to staff to enter extra details or clarify issues for staff to learn and improve on their incident reporting skills. The director of clinical services then reviewed all incidents.
- Staff understood what incidents needed reporting and we saw evidence that a range of incidents had been submitted onto the system and appropriately investigated.
- The service had a duty of candour policy in place that staff were aware of. The service was open and transparent with patients, family members and carers if things went wrong. As part of the investigation process and incident reporting system at the service, duty of candour was included and monitored by senior leaders.

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

Good

- We were told that during monthly reflective practice sessions, staff could bring any concerns regarding reporting incidents or the process to the meeting and discussions would be had to understand the next steps to take and to extract any previous learning.
- Weekly team meetings were used to ensure any updates, change of practice or learning from incidents was disseminated to all ward staff. A monthly 'learning from experiences' group comprised of senior hospital staff looked any learning to take forward following previous incidents around the hospital and inform all staff of these via electronic newsletters and physical posters on the wards.
- Staff told us that the service held debriefing sessions to support staff and patients on the ward following serious incidents.

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 reviewed 19 care records and each contained a detailed initial patient assessment. A full range of assessments were undertaken on admission to the service including mental health and physical health examinations. Physical health screening included basic body statistics, blood testing and an electrocardiogram. An electrocardiogram is a test which measures the electrical activity of the heart to show whether it is working normally.
- We saw evidence of ongoing physical health monitoring by both internal and external professionals for patients who required it. The service developed their own physical health screening tool that was undertaken weekly for all patients as a minimum.
- Staff at the service also sought patient consent to receive medical summaries from their GP's. The service had a visiting GP once a week in which there was an appropriate referral process in place to continue physical health screening and monitoring for patients and to refer elsewhere when necessary.
- All patients had a current and up to date care plan. We found care plans to be holistic in nature, personalised and recovery-orientated. Care plans were updated when necessary.

Best practice in treatment and care

- The service provided a range of care and treatment interventions through psychological intervention, occupational therapy and fitness programmes. These included mindfulness, anxiety groups and anger management.
- All patients had access to physical healthcare both in the hospital and in the community, seeing specialist professionals when required. We saw evidence in the care plans that we reviewed that patients on anti-psychotic medicine received an electrocardiogram test on admission and this was monitored ongoing throughout their stay to monitor their cardiac health.
- The service supported patients to live healthier lives. A full-time fitness instructor worked across the service and worked in partnership with a dietician who visited once a week to implement food and fitness programmes for clients. Attached to Newington Court One and Two wards was a small hall with an array of equipment for games and fitness sessions in addition to a new gym being installed into another building on the grounds.
- The service also employed an activity coordinator for evening and weekends when the occupational therapist team weren't at the service.
- We were told that the service was set to go smoke-free in the new year and that plans were in place to offer appropriate support to patients to facilitate this.
- All wards used Health of the Nation Outcome Scales to indicate if patients' health and wellbeing improved during their admission to the wards. Additionally, staff told us that they used the Glasgow antipsychotic side-effect scale (GASS). This was an easy to use self-reporting questionnaire aimed at identifying the side effects of antipsychotic medication in patients.

Skilled staff to deliver care

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

Good

- Teams were well staffed by a variety of experienced and qualified mental health workers including consultant psychiatrists, speciality doctors, nurses, psychologists, occupational therapists, healthcare assistants and students or trainees. A visiting pharmacist come to the service once a week. All staff members reported that they felt well integrated and utilised within the teams. Multidisciplinary team meetings were well attended by a range of health professionals.
- Ward managers ensured that all staff, including agency staff, received an appropriate induction before they were permitted to work on the wards.
- We saw appropriate one-to-one supervision provided to staff members on a monthly basis. The service also delivered a 'rolling programme' once a month in which a reflective practice group was part of to act as group clinical supervision.
- Managers had oversight of supervision and kept a log of up to date records. The human resources department also pulled reports on supervision statistics to inform managers of and provide assurances of regular supervision. Newer members of staff and students or trainees received more regular supervision.
- Seventy three percent of staff had accessed supervision in October 2018. This was lower than previous months and included staff on sick leave and maternity/paternity. Additionally, there had been recent ward manager changes and therefore there was a crossover of staff supervision at this time leading to a lowered completion rate for October. We saw regular clinical group supervision offered on the wards.
- All staff had received an appraisal in the past 12 months.
- Within the rolling programme in the service, teaching and learning sets were delivered by qualified staff on a monthly basis to further skill ward staff.
- Additionally, staff could search and apply for appropriate external training courses on the services internal electronic system. The service told us of previous healthcare assistants who were currently completing undergraduate nursing degrees. These courses were fully funded by the service and a learning contract was set and agreed by the service and staff member to ensure the newly gained skills would be utilised within the service for a certain period of time.
- There were no staff performance issues during our visit but ward managers stated they would be happy to approach and receive support from the human resources team if a situation arose.

Multi-disciplinary and inter-agency team work

- The wards held daily 'flash' meetings between senior staff and ward managers to appropriately plan for the day in addition to daily handover meetings, twice weekly ward rounds and weekly multidisciplinary team meetings. These meetings were well attended and ensured clinical risk was discussed and managed appropriately on the wards.
- There were effective handovers between shifts to ensure any risk or changes were communicated well. The shift patterns allowed for a full 30-minute handover between shifts.
- The service had effective working relationships with patient's care coordinators, community mental health teams and crisis teams. Whilst the majority of patients were placed at the service some distance from their home, staff explained they had minimal issues trying to contact patient's local services. We saw collaborative working between the teams when discharge planning and patients care coordinators attended or dialled into ward round meetings.

Adherence to the MHA and the MHA Code of Practice

- All paperwork relating to the Mental Health Act (MHA) was correctly filed, up to date and appropriately stored. Staff had access to administrative and legal advice and support and there was a MHA administrator for the hospital. Monthly audits were conducted to check paperwork was all in order and the MHA was being correctly applied.
- Staff had access to a relevant and up to date MHA policy and procedures to ensure the code of practice was being followed. Staff demonstrated a good understanding of the implementation of the MHA and code of practice. The service delivered two modules of training for the mental health act. Face-to-face Mental Health Act training was delivered by the service and 100% of staff had completed this training. There was an additional online Mental Health Act training course that 67% of staff had completed.

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

Good

- Patients had easy access to information about independent mental health advocacy. Each ward displayed posters on the wards in addition to information being verbally given and written in ward welcome packs. An advocate also visited the wards once a week.
- Staff read patients their rights under the MHA on admission and regularly thereafter. We saw evidence that this was delivered in such a way that patients could understand it, including bringing translators into the service.
- Section 17 leave was supported when this had been agreed and records contained clear information on conditions of leave and level of escort. Patients were not allowed to leave the hospital until they had read, understood and signed their Section 17 leave paperwork. We saw evidence that risk assessments were also reviewed before authorisation.
- Consent to treatment documentation was in place for patients on all medicine records we reviewed. We found that both T2 and T3 certificates were reviewed in line with hospital policy. These certificates demonstrated that patients detained under the MHA had the proper consent to treatment in place.
- All wards displayed a notice by the ward door notifying informal patients of their right to leave. Staff could explain the appropriate procedures they had in place should an informal patient ask to leave.

Good practice in applying the Mental Capacity Act

- All staff had completed face to face Mental Capacity Act (MCA) training, with 62% of staff completing online MCA training. Staff demonstrated a good understanding of the Act and the five statutory principles.
- The service did not make any deprivation of liberty safeguards applications over the last six months.
- Patient capacity was assessed by staff on admission to the service and revisited during ward rounds. We did not review any records where patients were assessed as having impaired capacity.
- Staff we spoke with understood and worked within the MCA definition of restraint using least restriction and force wherever possible.
- Staff could obtain advice regarding the MCA, including deprivation of liberty safeguards, from a central Priory office and from the hospitals MHA administrator.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- We observed many positive and respectful interactions between staff and patients. Staff spoke with patients in a kind and caring manner, demonstrating respect and compassion and were always available to support patients with their needs. During reviews and meetings, staff spoke of patients in a dignified manner.
- Staff supported patients to better understand and manage their care and treatment. Staff spoke clearly and concisely to patients to help them understand their treatment and therapeutic activities.
- There was a culture of empowering patients and giving them ownership over their treatment.
- All clinicians demonstrated a real understanding of the patients on the wards and were knowledgeable of patient risks and treatment plans. Staff were sensitive towards patients' cultural, religious and social needs.
- In the most recent satisfaction survey supplied by the hospital, 80% of patients reported that they would recommend the hospital to friends and family members and 89% felt the hospital was caring and supportive of their needs and recovery journey.

Involvement in care

Involvement of patients

- On admission all patients were orientated to the ward by staff, given information about their care and treatment and read their rights. Patients were also given a comprehensive welcome pack and staff explained the processes and timings on the ward.
- Care plans were holistic and considered a range of aspects. Patient views were sought to devise their care

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

Good

plans, during ward round reviews and during one-to-one sessions to empower them in their treatment. It was also clear that patients were given, or offered, a copy of their care plan.

- Staff discussed ward round meetings with patients a day before they occurred. The preparation before the ward round ensured that patients were supported to list issues they wanted to bring to the meeting on the following day.
- We saw boards displaying key workers allocated to each patient for each shift on all wards, so that patients were kept informed of who would be supporting them. The wards also had staff pictures on ward boards with names of staff members to help patients understanding of staff roles. This was one aspect of the safe wards programme that the wards participated in.
- All wards held weekly community meetings that patients could attend. These meetings gave a space for patients to raise issues with staff, give compliments, feedback and have a choice of the structured activities offered on the wards. The consultants for each ward attended the community meeting fortnightly and community boards on the wards had 'you said, we did' posters explaining the actions taken as a result of issues raised.
- Patients were given an evaluation survey on discharge to give feedback on the service they had received.
- Advocacy was available and there were posters on the wards detailing the advocacy support. This information was repeated in the patient welcome pack and staff told us they supported patients to approach the advocacy services. Advocacy services visited the wards at least once a week.

Involvement of families and carers

- Family members and carers were updated and involved in patients care when consent had been given by the patient. Family members and carers were invited to attend ward rounds or phone into the meetings where this was not possible.
- The consultants of the service held family sessions each week and offered one to one time or to contacted by telephone to review their family member's 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

Access and discharge

Bed management

- Newington Court One had 16 female patient beds, Newington Court Two had nine male patient beds and Highlands ward had nine mixed sex patient beds. Referrals were received and triaged by a central single point of contact within the Priory group. The service did not hold any waiting lists and had a target time of one hour to accept or reject referrals made.
- The service had clear inclusion and exclusion criteria and there was a risk screening tool used by the central triage team. Ward managers told us they were able to have discussions regarding refusing admissions if they felt the acuity on the ward was high and another patient would become unsettling for patients.
- The service submitted information reporting average bed occupancy levels of 89% for the 6-month period prior to 31 July 2018. This was slightly above the recommended minimum threshold of 85%.
- The average length of stay before discharge for patients over the same period was 17 days.
- Patients going out on overnight leave always had a bed to return to; the service never accepted any referrals into a bed occupied by someone on leave.
- We saw appropriate discussions and referrals made for more intensive care units for patients requiring them. Transfers were always discussed as a multidisciplinary team and every effort was made to do so at an appropriate time of the day, whilst managing any present risks.

Discharge and transfers of care

- The service had one delayed discharged during the past six months. All delayed discharges were due to an

inability to find an appropriate placement where patients who needed could continue their care. The service worked closely with NHS commissioners to address this.

- The service effectively planned for patient discharge from admission. There was appropriate liaison with patient care coordinators and community mental health teams. The service implemented a discharge and transfer checklist to ensure all appropriate parties were informed of discharge and the appropriate package of care was in place. The discharge checklist included care records supplied to the community mental health teams and summaries of recent ward rounds, observations levels, risk and incidents whilst in the service.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own bedrooms and there was a mixture of ensuite rooms and rooms with shared bathroom facilities. Patients did not have keys to their rooms, with rooms being left routinely open unless patients specifically asked them to be locked.
- Patients were allowed to personalise their rooms but this rarely happened due to the short length of stay for the majority of patients.
- Each bedroom had lockable storage units for patients to use to store any valuable belongings. The wards had a secure cupboard with prohibited patient items where items were appropriate signed in and out when required.
- Each ward had access to a full range of rooms and equipment to support treatment and care. This included appropriately equipped clinic rooms, therapy rooms, additional quiet lounges, hall and gymnasium with a variety of equipment.
- Each ward had rooms and lounges available for patients to meet with visitors. Additionally, there was a quiet family room off the ward where patients could meet visitors including child visitors.
- Patients were allowed mobile phones on the ward in order to make private phone calls. Additionally, the wards had cordless ward phones that patients were also entitled to use.
- Each ward had two secure outside spaces. These were routinely locked but access was allowed at all times of the day when requested by patients. One space was an outside secure courtyard that was always supervised due to the risks presented in the space and one was a secure outside garden for general access.
- Patients had access to hot drinks and obtain snacks at all hours on the ward.

Meeting the needs of all people who use the service

- All wards were accessible to patients with wide corridors and room doors. Newington Court One had an adapted bedroom a lift in place to transfer patients between floors. The service could not accept patients with severe physical support needs as there were no specialist adaptions, hoists and accessible bathrooms, toilets or shower facilities provided. This was clearly documented on the central triage risk screening profile for this service.
- The service ensured patients were well informed on treatments, medication, local services, patient rights and the complaints process in a variety of ways. Patients were given welcome packs detailing this information on admission, there were multiple notice boards around the wards and we saw staff enabling patients to make informal complaints whilst trying to resolve them locally.
- Information leaflets on the ward were only available in English text. However, staff explained that they could order alternatives if required.
- The service had easy access to interpreters and gave examples of when this had been used previously.
- Patients had a choice of foods available that met their dietary requirements relating to religious or ethnic group food choices.
- Patients had access to spiritual support and the wards had religious books available. Staff informed us that they additionally supported patients to attend their religious worship outside of the hospital.

Listening to and learning from concerns and complaints

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

Good

- In the 12 months prior to 31 July 2018, the service received 14 complaints. Of these, seven were upheld or partially upheld, one was ongoing and none had been referred to the complaints ombudsman.
- Patients reported that they knew how to raise a complaint with the service. We saw evidence of staff accepting informal complaints about the service and attempting to resolve them locally. Managers reported complaints, their outcomes and any learning to all staff members.
- Staff knew how to handle complaints appropriately. This included both formal and informal complaints. Informal complaints were dealt with immediately and locally on the ward and formal complaints were logged and tracked in line with policy.
- Senior management regularly reviewed formal complaints and sent weekly newsletters to staff informing them of lessons learnt and practices changed as a result of previous complaints that occurred hospital wide.

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

Good

Leadership

- Leaders within the service had a variety of experience, skills and knowledge required to ensure an efficient running of the service. Local leaders worked shifts on the wards as and when required.
- Leaders could clearly explain their roles and demonstrated a high understanding of the services they managed. They clearly explained how the teams worked to provide high quality care. Team leaders and senior management had daily meetings to discuss the days running of wards and clinical governance meeting monthly to discuss clinical risk.
- Leaders were visible on the wards and around the hospital with senior leaders having open door policies. Staff told us that senior leaders were approachable and supportive to their needs and concerns.
- As part of the ongoing overall hospital retention plan, we saw development pathways in place for both qualified and unqualified members of staff, including leadership and management training.

Vision and strategy

- Staff understood the values of the provider and told us they strived to work within these to ensure safe and positive patient care.
- Staff were aware of the leadership teams locally and centrally to the Priory Group. Staff stated local leadership teams were highly visible and always approachable. When discussing trust wide senior leadership, all staff were aware of who they were, how to contact them and stated that they had previously visited the wards

Culture

- Staff reported feeling respected, supported and valued as part of their teams. Most staff felt positive about the service and proud to work there. Staff told us that whilst at times their jobs could become stressful, the teams all worked together to get through difficult periods.
- Staff felt able to raise issues and escalate concerns without fear of retribution. Staff were aware of the whistleblowing process and would be happy to follow it if required.
- There were no performance issues at the time of our inspection but ward managers reported that they knew the process to take and would receive sufficient support if they did encounter issues.
- Staff appraisals included discussions about career development and the opportunities and training available to staff members.

Governance

- The service had efficient systems in place to ensure that managers had access to information pertinent to their roles. The service had oversight of supervision and appraisals, beds were managed well and incidents, safeguarding's and complaints were appropriately logged, investigated and learned from.
- There was an appropriate clinical governance structure in place to ensure information and risk was escalated and managed in a timely manner. Monthly learning from

experience meetings ensured that change in practice was identified based upon previous learning from incidents hospital wide and disseminated to ward level staff.

- Senior staff undertook monthly clinical walk rounds of all wards to monitor service delivery, clinical standards and to talk with ward staff.
- The service had allocated lead staff to undertake varying auditing processes to provide assurances on practices and develop action plans to address or improve issues that arose. This included monthly care planning audits, medicine audits and emergency equipment audits.

Management of risk, issues and performance

- Ward managers had access to electronic local risk registers and could add entries onto it. Staff reported that they could easily escalate any issues to service leads if required which could then be put onto the hospital wide risk register.
- The risk register contained entries relating to staff concerns and the areas of risk described by senior staff.
- The service had a contingency plan in place to ensure continuity of service if there was an emergency effecting service delivery.

Information management

- The service had systems in place that could collect data for the quality assurance team automatically, so not burdening frontline staff with analytical data collection tasks.
- Staff had access to sufficient equipment and information technology in order to do their work. The secure record keeping system was easily available to staff to update patient care records and review during ward rounds and other team meetings. Closed-circuit television was available on all wards in public areas which ensured that patient monitoring was made safer and aided in the process of incident investigations.
- The care records system was shared hospital wide and held confidentially on systems that only staff had access to with a secure username and password. This eased information sharing between wards and teams.
- Team managers had systems and dashboards in place to support them in their role. This included information on staffing, supervision and appraisals, training and service performance data.

Engagement

- Staff and patients were kept up to date with service information through weekly bulletins, newsletters, staff intranet, team meetings and community meetings in addition to the service website.
- Patients had opportunities to offer feedback on the service they received both during an admission period or after. We saw feedback being discussed and changes being considered with regular patient forums and feedback sessions. All patients were given an exit questionnaire on discharge to review the service they had received.

Learning, continuous improvement and innovation

- Staff were given the support and encouragement to raise ideas for service improvements and projects. For example, a new gym was being installed into a small unused building on-site after a staff member suggested the space be transformed for staff and patient leisure activities. Additionally, the staff member sourced funding and donations to equip the space.
- The wards participated in the safe wards scheme and were working towards implementing all aspects of the programme.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

Safety of the ward layout

- Upper Court ward was made up of three corridors in a horseshoe shape, located on the first floor of the building. Bedrooms were split across the three corridors with the most acutely unwell patients located closer to the nurse's office.
- Staff in the nurse's office were able to view closed circuit television of the communal areas on the ward.
- The main access to the ward was via a steep and narrow spiral stair case. There were two other entrances to the ward that were through the adult wards but these were only used in emergencies.
- Patients had access to a secure garden by staff escort, through the hospital via the main reception door. Staff mitigated the risks by calling ahead to the reception and requesting the front door stays locked.
- Staff were aware of the blind spots on the ward and mitigated them by using observations. A new remote monitoring system was being installed, which would allow an offsite company to remotely view all rooms and communal areas on the ward 24 hours a day and alert ward staff if there were concerns. Staff were obtaining consent from the patients and their families to turn on the cameras in the bedrooms.
- A comprehensive ligature point audit identified potential risks on the ward and there was a mitigating action plan in place, which mitigated these risks and staff were aware of. However, on the ligature works action plan, it did not show whether actions had been completed or not.
- Staff informed us they carried out a daily ward environment check for safety.
- During our visit staff pointed out an area on the ward where there were exposed nails which a patient had used to hurt themselves with. By the end of our visit the hospital carried out work to make this area safe.
- Ward staff carried alarms on the ward and we observed a good staff response to these when they were used. Non-ward staff reported that they did not carry alarms and some stated that they felt they would feel safer if they did.
- The ward was clean, well equipped, and well maintained.
- The clinic room was small, but fully equipped with appropriate resuscitation equipment which staff checked regularly. However, the medication cabinet was within reach of the clinic room door, which could allow patients to reach into the medication cabinet. We saw that there had been seven incidents over the last three months where patients had either tried to access the clinic room or reach the medications.
- Staff maintained the equipment in the clinic rooms, staff checked it all regularly and it was kept clean. However, we did see that the sharps bin was located above the sink, which could be a potential hazard as the sink was a clean area.

Safe staffing

Good

Child and adolescent mental health wards

- The hospital provided figures that showed that Upper Court ward had two qualified nurse vacancies and four health care vacancies. The hospital reported that the ward depended on high levels of agency staff, but that these agency staff were booked as long-term locums who received support and supervision and were able to access training from the Priory.
- The ward used agency staff to cover shifts. The ward manager was able to book agency cover in advance, ensuring they could use the same staff who were familiar with the ward practices and policy.
- Each morning the hospital held 'flash' meetings with the senior leadership team and ward managers of each ward that discussed staffing levels and acuity in order to appropriately redeploy staff across the hospital site.
- There were two qualified nurses and four health care assistants on each shift. There was an additional health care assistant who commenced their shift at 5pm. They were based on Upper Court ward but could be deployed across the whole hospital, depending on where they were needed. Staffing numbers could be adjusted depending on the acuity to the patients on the ward. If there was more than one person on one-to-one observations then an additional health care assistant could be requested to provide cover to ensure the observations could take place.
- A resident medical officer, who was based across the whole hospital, provided emergency and out-of-hours cover.
- The hospital informed us that the ward was staffed at a ratio of one staff per two patients, which is in accordance with the quality network for inpatient child and adolescent mental health standards.
- We reviewed staffing rota's and noted that there were sufficient staff to carry out physical interventions such as restraint.
- We checked five agency health care assistant staff files. Whilst we found some improvements since the last inspection with regards to staff inductions, two induction checklists were partially completed with one incomplete checklist. The ward manager informed us that the agency induction list that was incomplete was a staff member that completed only one shift and that all the staff files would be audited.
- During our inspection we observed staff responding to a physical health care emergency, and saw that they responded quickly and efficiently.
- All staff had completed their mandatory training in prevention and management of violence, breakaway and basic life support training. However, in other areas not all staff had completed their mandatory training. Sixty-six percent of staff had completed e-learning for Mental Health Act and 62% for e-learning Mental Capacity Training and DOLS, but all staff had completed their face to face Mental Health act and Mental Capacity Act training. Seventy-three per cent had completed people handling and 82% safeguarding children and 76% safeguarding adults. Clinical risk assessment training was completed by 74% of staff. The hospital provided a copy of an action plan they had put in place to address the non-compliance to ensure all staff are appropriately trained.

Assessing and managing risk to patients and staff

- We reviewed five care records. Staff had completed a thorough risk assessment of each young person at the point of admission. Staff reviewed and updated these regularly, at each ward round and routinely following an incident. We saw in one of the notes that a young person made an allegation against a staff member and the hospital took immediate action to safeguard the patient.
- Staff used a Priory risk assessment form, appropriate for the age of the patients on the ward.
- Staff supervised the patients on the wards to use the ward kitchen to make drinks during the day.
- Staff were aware of and dealt with any specific risk issues, such as self-harm. We observed that staff used personalised and specific techniques to care for patients, which were recorded in their care plans.
- Staff applied blanket restrictions on patients' freedoms only when justified. Patients could not access their bedrooms during the day until the school day finished at 3:30pm. However, staff could individually risk assess patient to give them access to their bedrooms prior to this if required.
- There were signs around the ward notifying informal patients of their right to leave the ward at their will.
- Staff developed holistic, recovery-orientated care plans informed by a comprehensive assessment.

Good

Child and adolescent mental health wards

- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multi-disciplinary team and with those outside the ward who would have a role in providing aftercare.
- The ward had a soft room off the main corridor which staff confirmed was not used as a seclusion room. The soft room had padded cushions on the walls and floor, with weighted cushions and no door. Patients could take themselves to or be escorted by staff. During our inspection we observed staff using this room to restrain patients to prevent them from harming themselves. The room was visible to other patients who were in the corridor or lounge nearest it, which may compromise patient dignity.
- The hospital reported that from February 2018 to July 2018 there were 357 episodes of restraint on Upper Court ward. During our visit there were three incidents of patients being restrained. We saw evidence that an assistant psychologist had carried out a debrief with one of the patients and we were told that staff had also had a de-brief following at least one of the incidents. However, staff informed us that de-briefs were not always done due to time constraints.
- The ward was using two safety pods, which were large bean bags designed to enhance the safety of physical interventions such as restraint. The bags were portable and could be transported by staff to where needed on the ward. Staff spoke highly of the safety pods as they felt that they provided more dignity for patients when being restrained. All staff on the ward were trained in the prevention and management of violence and aggression model.
- During our inspection we observed the evacuation of the ward for an un-planned fire alarm. Some staff provided inconsistent information about which fire doors would automatically open when the alarm went off and where visitors should be evacuated to. Patients on the ward who were distressed by the fire alarm were provided with ear defenders. After the fire alarm, we reviewed two personal emergency evacuation plans for two patients and saw that they were individual and adequately took into account the patients risk and needs. All patients on Upper Court ward had personal emergency evacuation plans in place.
- Fire evacuations had most recently happened on Upper Court ward in April, June, July and September. In September, during a real fire situation on Garden Court ward, a full evacuation of all 62 staff and patients from Ticehurst house took place in under six minutes. The hospital had a three-year rolling programme assessing the fire risk across the whole site.

Safeguarding

- Staff that we spoke with knew how to make a safeguarding alert to the safeguarding lead and the hospital social worker. We viewed the last three months of safeguarding referrals. Staff understood how to protect patients from abuse and/or exploitation and the service worked well with other agencies to do so. There was an identified named staff member for child protection.
- A weekly meeting was held hospital wide to discuss any current safeguarding referrals.
- We saw a log of the safeguarding alerts for the last three months and the CQC had been notified of all them.
- There were safe procedures for children visiting all wards. There was a separate family room away from the wards where children could visit patients.

Staff access to essential information

- The staff were using both an electronic recording system, as well as paper files containing copies of the patient's care plan and risk assessment in the office. Of the paper files we checked they were all up to date with the electronic recording system.

Medicines management

- Staff followed best practice when storing, dispensing and recording the use of medicines. Staff regularly reviewed the effects of medication on each patient's physical health.
- During the inspection we saw staff administer a rapid tranquilisation injection, we checked the electronic record for the young person and saw that staff had monitored and recorded the physical health and well-being of the young person following the administration of the injection. Further we saw that the patient was offered a de-brief with the assistant psychologist and her feedback on the incident was recorded. We viewed records where staff recorded if they were unable to obtain vital observations such as blood pressure or pulse as the young person had not consented.

Good

Child and adolescent mental health wards

- There was a service line agreement in place with a local pharmacy service to provide comprehensive pharmacy support

Track record on safety

- From December 2017 to June 2018 Upper Court ward reported eight serious incidents. These included patients absconding from the wards, aggression towards staff, physical ill health and episodes of self-harm. Any serious incidents that occurred were subject to an SBAR (situation, background, assessment, recommendations) investigation process and reported centrally to The Priory Group to ensure all aspects were captured and learned from.
- The hospital provided us with a list of lessons learnt from physical interventions with patients on Upper Court ward. The lessons learnt were for specific patients and ranged from updating/amending care plans with particular information, to ensuring that risk assessments were updated, to specific techniques to de-escalate patients and prevent situations from escalating.

Reporting incidents and learning from when things go wrong

- The provider operated an electronic system for staff to report incidents. All staff had access to this system. Details of all incidents are sent to the senior management team, as well as being monitored for quality assurance. We saw that staff were reporting incidents through the system, but that not all incidents which were notifiable to the CQC were being sent when the police had been contacted.
- The provider had a duty of candour policy which clearly laid out staff responsibilities to the patients on the ward in the case that something went wrong or mistakes were made.
- Staff received feedback from incidents at team meetings and through individual supervision and one to one sessions. Staff met monthly as a team to discuss incidents and any learning from incidents.
- Staff reported that they had de-briefs, when there was time, following any serious incidents and could access additional support.
- A monthly lessons learnt meeting was held and any lessons learnt and actions taken were reviewed. These lessons learnt were then circulated to all staff.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed five care records. Staff assessed the physical and mental health of all patients on admission. Individual care plans were developed and regularly reviewed through multi-disciplinary discussion and updated as needed.
- Care plans reflected the assessed patient needs, were personalised, holistic and recovery-orientated. However, we noted that there was no designated space for families or carers input. The care plans that we viewed were created shortly after the patient was admitted to the ward.

Best practice in treatment and care

- We reviewed six medication charts and found no concerns with the prescribing of medications, we also saw that consent to treatment forms were attached to medicine cards for all patients. However, some of the medication charts did not have photo identification, which would have provided an additional layer of safety, especially for new or agency staff..
- Staff provided a range of care and treatment interventions suitable for the patient group, such as psychology.
- A comprehensive, structured integrated timetable of education, therapy and psychology was provided for the patients at the on-site school Monday to Friday between 9:30am and 3:30pm. This integration was new, having the day previously separated out into therapy and education. Staff we spoke to thought this was a positive change and reduced the number of incidents that happened. Staff also reported better communication between education and therapy and that staff from different disciplines worked together as a team to benefit patients.
- On weekends there was not a structured timetable, but ward staff told us that they organised walks and outings, allowed the patients to have free time and the patients

could attend the function hall and play badminton. Staff had a weekend budget to arrange activities and outings for the patients and staff ran informal groups such as beauty therapy.
- We were told that the service was set to go smoke-free in the new year and that plans were in place to offer appropriate support to patients to facilitate this.
- Patients that we spoke with did not feel that there were sufficient activities in the evenings or weekends.

Skilled staff to deliver care

- All staff members had received a performance appraisal.
- Sixty-one percent of staff had received supervision for the most recent month. Staff informed us that they found their supervision useful when they had it. Staff received both individual and group supervision. The service informed us that the supervision rates were low due to staff being moved from the other ward which closed, onto Upper Court ward and that an action plan is in place to increase the amount of staff who can provide supervision to other staff through training and using other managers from other wards. Additionally, we saw regular opportunities for group clinical supervision sessions for staff.
- The ward had one dedicated locum consultant and one speciality doctor, who was section 12 approved. A section 12 approved doctor is a doctor trained and qualified in the use of the Mental Health Act. Both had received training in using tools for assessing patients with an autistic spectrum disorder (ASD) diagnosis. However, other staff on the ward had not had specific training on ASD disorders and thought it would be helpful to do so.
- The hospital had an arrangement whereby a local NHS GP came to the hospital every Friday morning to assist patients with any physical health problems. GP appointments could also be arranged on other days of the week.

Multi-disciplinary and inter-agency team work

- The multidisciplinary team carried out a weekly ward round, which patients attended.
- There was a range of staff in the multidisciplinary team and the ward had access to the full range of specialists required to meet the needs of patients on the ward. This included doctors, nurses, occupational therapists, psychologist and psychologist assistant and a social worker. An education department supported the ward and the patients attended school every weekday. We were informed that a drama and art therapist had been hired and were to start shortly.
- The ward teams had effective working relationships with teams outside the organisation and appropriate staff such as the social worker to facilitate this relationship. Staff informed us that they liaised with local authorities, community mental health teams and other services in the patient's local area.

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

- All staff had completed their mandatory face to face Mental Health Act (MHA) training, however only 62% of staff had completed their MHA E-learning. Staff we spoke with had a good understanding of their roles and responsibilities under the MHA and the MHA code of practice and discharged these well.
- Staff had easy access to administrative support and legal advice on the implementation of the MHA and its code of practice. Staff knew who their MHA administrators were and reported that they had a good relationship. Papers related to detention under the MHA were stored with the MHA administrator.
- Staff ensured that patients were aware of their rights and patients had easy access to information about independent mental health advocacy. Patients we spoke with reported that they could easily access an advocate. Information about advocacy and the patients' rights under the MHA was also provided in the welcome pack.
- The service displayed multiple notices on the ward telling informal patients that they could leave the ward freely.

Good practice in applying the Mental Capacity Act

- All staff had completed their mandatory face to face Mental Capacity Act (MCA) and Deprivation of Liberty safeguard training, however only 66% of staff had completed their Mental Capacity Act E-learning.
- All staff that we spoke with had a good understanding of the MCA and the guiding principles. Staff were confident in discussing issues around capacity to consent to treatment and the majority were confident in discussing Gillick competence. Gillick competence is a test in

Good

Child and adolescent mental health wards

medical law to describe whether a young person of 16 years or younger is competent to consent to treatment without the needs for parental permission or knowledge.

- All patients on the ward were either detained under the MHA or informal patients. Deprivation of liberty safeguard applications would not be appropriate as the patients were all under the age of 18.

Are child and adolescent mental health wards caring?

Good

Kindness, privacy, dignity, respect, compassion and support

- We saw staff treating patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients through personalised ways. Staff expressed a caring approach when they were talking about patient needs.
- We spoke with two patients, who were mostly positive about the staff and the support they provided. One young patient did not feel that all the staff understood their needs. The hospital was providing additional training and awareness to support staff to understand patient needs better.
- Staff we spoke with described the wide range of topics that they spent time talking to the patients about including issues such as safety and awareness of social media.
- Staff provided patients and families with a laminated card containing key information and contact details of the hospital and crisis services for families and carers whilst the patients were on leave and when they were discharged.

Involvement in care

- On admission patients received a welcome pack. The pack contained all the information necessary to support someone new to the ward environment including: Information about the ward, treatment, activities, the daily routine, the name of their key worker and treating team, the mutual behavioural expectations and how to complain. On arrival the patients were paired up with a staff member to support them all day and help them to become orientated to the ward.
- We saw evidence in the care plans that we viewed of patient feedback. Patients were invited to attend their weekly ward rounds and participate in the planning of the care and treatment. Patients who chose not to attend their weekly ward round were able to provide written feedback.
- A weekly community meeting was held on the ward for the patients to attend and provide their feedback. We saw a summary of this meeting and the actions taken on the notice board on the ward.
- Staff informed and involved families and carers where appropriate to do so. Staff told us that with the patient's consent they call the families and carers every evening to update them and more often if there was an incident.
- Families and carers were provided with feedback forms to complete.
- We spoke to one family member who had concerns about the lack activities during the evenings and weekends. However, they were generally positive about staff.
- An independent mental health advocate attended the ward weekly to assist the patients explaining and exercising their rights, raising concerns or complaints and provide information and support.

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

Good

Access and discharge

- In the six months to July 2018 the average bed occupancy for Upper Court was 83%. Bed occupancy levels are the rate of available bed capacity. It demonstrates the percentage of beds occupied by patients.
- The hospital had recently temporarily closed its other child and adolescent ward, Garden Court, due to a lack of referrals.

- The average lengthy stay of patients who had been discharged from August 2017 to July 2018 was 74 days. Beds were kept available for patients returning from weekend leave and patients were moved on to other services based on their assessed clinical needs.
- Admissions to the ward were always planned, although the admission could still happen within a day or so from the referral.
- The hospital provided us with figures which demonstrated that they currently had seven patients whose discharge was delayed.
- Staff supported patients during referrals and transfers between services, by liaising with the community teams.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had their own bedrooms, which they could personalise if they wished. The bedrooms were spread across three corridors. There were four bathrooms shared between the bedrooms. The patients were only able to shower as the baths had been put out of use due to a previous risk issue.
- There was a kitchen attached to a dining room but only the staff had access to. The staff could make hot drinks for the patients 24 hours a day. There was also a second smaller and quieter dining room.
- There was secure storage on the ward for patients to store their possessions. Each young person had three lockers allocated, one for storing their toiletries, one for their clothing and one which contained their contraband or restricted items, based on a risk assessment. Staff supervised patients accessing their belongings.
- Staff had access to a locked staff room, which was adjacent to the nurses' station. However, staff did not have access to a locker for their personal possessions.
- The ward had a full range of rooms and equipment. There were three lounges for patients to use, a well-equipped but small clinic room, therapy rooms, a sensory room and activity areas.
- The ward was located on the first floor of the building. Whilst the patients did have access to a secure garden, this was only by escort as it was a short walk through the rest of the hospital.
- Two of the lounges were situated away from the main office and provided the patients with a quiet place to go. There were rooms to see visitors in both on and off the ward.
- The patients had access to a phone on the ward, they were also allowed to have their mobile phones on the ward. Patients were discouraged from using them during the school day. Some patients could take them with them but encouraged to remove their SIM cards for the duration of the school day.

Patients' engagement with the wider community

- Patients were expected to attend the school located on site, where they received integrated therapy, psychology and education between 9:30am and 3:30pm Monday to Friday. School subjects covered included science, English, citizenship and personal, social, health and economic education, maths, careers, arts and craft, horticulture, music, physical education, and food technology.
- Every young person had an occupational therapy assessment shortly after their admission to the ward. Subject to an individual risk assessment, patients went on group trips into the community to the shops, cinema, or cafes. Occupational therapy could also offer individual therapy.
- Staff encouraged the patients to maintain contact with their families. Staff routinely invited family members to attend ward reviews and care programme approach meetings.
- Staff told us that there were opportunities for patients to volunteer and previous patients had volunteered at local charity shops or at some local stables.

Meeting the needs of all people who use the service

- The building was not purpose built, so adjustments to the ward were made where possible. There was a lift on the ward for those unable to use the stairs, however, it was accessed through the adult acute ward.
- A quiet lounge could be provided as a multi-faith room if a patient needed.
- A dietician visited the ward every week and could liaise with the kitchen regarding any dietary needs.
- Interpreters were used if necessary and the staff were aware of the process of arranging this service.

Listening to and learning from concerns and complaints

- In the 12-month period up to July 2018 the service had received six complaints. These ranged from personal

belongings going missing or being damaged on the ward to concerns about communication with families. Three of the complaints were upheld and one was partially upheld.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.
- Patients were provided with verbal information from staff about how to complain and in the welcome pack they received on arrival. Patients also had opportunity to raise any concerns at the weekly community meeting.

Are child and adolescent mental health wards well-led?

Good

Leadership

- The ward manager, who was new to post, had previously been the deputy manager and had the necessary skills, experience and knowledge to perform their role competently. They had a clear understanding of the service and was visible on the ward.
- Staff stated that the hospital director and other members of the senior management team were visible and the hospital director operated an open-door policy.
- The staff were aware of the local senior management structure and knew who to contact if there was a particular issue with safeguarding, facilities or HR issues.

Vision and strategy

- Staff we spoke to said that they had been consulted regarding the new wards that might open and knew the direction that the service was moving in.
- Staff informed us that there is a weekly newsletter to all staff keeping them updated of any developments in the service.

Culture

- Staff we spoke to said that they felt valued by their senior colleagues. Staff also said that they felt valued and respected by other members of the multi-disciplinary team and ward staff and that there was effective communication.
- Staff reported that the team worked well together in what could be a pressured environment.
- Staff we spoke to were aware of the whistle-blowing process.

Governance

- The provider failed to notify the CQC when required to do so where the police had been contacted following a serious incident. We viewed two incidents which the hospital had failed to notify the CQC.
- At the last focussed inspection, we found that the provider failed to notify the CQC when required to do so around patients attending the emergency department. We reviewed a log of safeguarding incidents between August and November 2018, where patients had been taken to A&E and saw that the CQC had been notified on every occasion.
- At our previous inspection we saw that only the first name of temporary workers was recorded on the rota, which could cause identification problems at a later date. On this inspection we saw that this was no longer a problem.

Management of risk, issues and performance

- The hospital maintains a risk register which is updated every month at the senior management team meeting. Staff are able to add items to the risk register. The register rated the level of risk, stated controls identified and mitigating factors and no risks remained high after the control measures and action plans. Entries on the register included temporary staff use, information technology issues, high number of incidents of self-harm and restraint, identified issues from ligature audit.

Information management

- Staff had access to appropriate technology systems to complete their work without this being over burdensome. Staff had access to incident reporting systems, risk registers, patient's care records and Mental Health Act paperwork. Agency staff did not have the same access, but the wards had good systems in place to ensure agency staff could access vital care plans and risk assessments and incident reporting.

Engagement

Good

Child and adolescent mental health wards

- Patients completed a discharge satisfaction survey on discharge. Over the past 12 months. Eighty per cent of patients across the entire hospital recommend the service to family and friends.
- Community meetings were held weekly on all units to allow patients the opportunity to provide feedback on the service. Patients are asked to complete a discharge feedback form.
- The ward had access to feedback from families and patients.
- The service made appropriate notifications to external agencies, such as local safeguarding teams.

Learning, continuous improvement and innovation

- The service was accredited with the quality network for inpatient CAMHS. The most recent visit was in November 2017.
- The service had recently introduced safety pods on the ward, which are large bean bags designed to enhance the safety of physical interventions such as restraint.
- The service had recently moved to an integrated school, therapy and psychology day. This enabled the patients more time off the ward, saw a reduction in incidents and had promoted better communication in the unit between different disciplines of staff.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that CQC are appropriately informed of all notifiable events.

Action the provider SHOULD take to improve

- The provider should ensure all staff alarms are consistently stored, accounted for on handover sheets and routinely tested to ensure their efficiency.
- The provider should ensure that clinic rooms are clean and tidy and that medicine cabinets and sharps bin are located in safe places in clinic rooms.
- The provider should ensure that all staff are reminded of the fire evacuation procedure for staff, visitors and patients.
- The provider should ensure that all agency induction checklists are completed.
- The provider should ensure that all ligature risk action plans clearly identify their progress of completion.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **Failure to notify the CQC of incidents that were reported to the police.** **This was a breach of regulation 18(2)(f)**

This section is primarily information for the provider

Enforcement actions

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.