The Priory Hospital Roehampton

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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 Hospital, Roehampton as **requires improvement** because:

- There had been a very high turnover of staff and high use of temporary staff. This impacted on the consistency of care provided to the patients.
- The layout of the hospital and the wards made it very hard for staff to observe patients who were at risk of self-harm. There were ligature risks throughout the hospital. There were a high number of incidents in the last year involving ligatures. Whilst the provider was taking steps to improve the safety of the physical environment there remained a high level of risk to patients' safety. Many of the patients were assessed as being at risk of self-harm and the hospital may not be able to meet their needs safely.
- Incident reports did not include a detailed description of the incident or information about the lessons learnt. This meant that it was hard to monitor the incidents and whether the lessons were being addressed. Whilst there were systems to ensure that learning from incidents took place within each ward, learning was not always shared across wards.
- On the wards for adults, informal patients were only allowed to leave the ward if they had leave authorised by their psychiatrist. We did not find evidence to show that patients were consenting to the restriction being placed on their freedom.
- On the acute wards, despite staff engagement arrangements being in place, there were significant numbers of staff with low morale, who had not felt that their concerns about staffing arrangements and safety for patients and staff had been listened to.
- There were insufficient facilities for physical examinations and nasogastric feeding on Upper Court.

However,

- Patients said that permanent staff were kind, caring and understanding. There were opportunities for patients and their relatives and carers to be involved in decisions about their care. There was a full range of therapies available. Care and treatment was delivered in line with best practice. The hospital was keen to make improvements and was working towards accreditation with the Royal College of Psychiatrists quality network for eating disorder services.

Summary of findings

Contents

Requires improvement

The Priory Hospital Roehampton

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Specialist eating disorders services

Summary of this inspection

Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides support and treatment for people with mental health needs, eating disorders and drug and alcohol addictions. It has 99 inpatient beds. The hospital provides care and treatment for adults and children experiencing acute episodes of mental illness, an in-patient detoxification and addiction therapy programme, and an in-patient care and treatment for adults and children with eating disorders.

Services are provided on the following wards:

- Lower Court is a mixed ward and provides care and treatment for up to 12 children and adolescents up to 18 years old experiencing an acute episode of mental illness.
- Priory Court is a mixed eating disorders service for up to 19 children and adolescents.
- East Wing provides care and treatment for up 12 female patients.
- Garden Wing is mixed adult ward for people experiencing acute mental illness. It provides services for up to 18 patients.
- West Wing is a mixed acute psychiatric admission ward and a ward for people participating in the addictions therapy programme.
- Upper Court provides an eating disorders services for up to 13 adult female patients.

The hospital was meeting all of the regulatory standards at a previous inspection in October 2014. The provider is registered to provide care for the following regulated activities:

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

There was a registered manager assigned to the hospital.

Our inspection team

The Priory Hospital, Roehampton was inspected by a team consisting of an inspection manager, four inspectors, an inspection assistant, a pharmacist, a Mental Health Act reviewer, three specialist advisors with professional backgrounds in nursing and an expert by experience. Experts by experience are people who have developed expertise in health services by using them.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, reviewed 15 submissions from staff and people who had used the services and received feedback from two commissioners.

Summary of this inspection

During the inspection visit the inspection team:

- Visited all six wards of the hospital and looked at the quality of the environment.
- Interviewed the ward manager on all six wards.
- Interviewed staff on the senior management team including the hospital director, deputy hospital director, medical director and lead for quality and assurance.
- Met with 39 members of staff including nurses, health care assistants, psychiatrists, dieticians, psychologists, compliance officer, lead for day therapies services, mental health act administrator, lead for safeguarding, the human resources advisor and the independent advocacy worker.
- Spoke with 30 people who used the service.
- Reviewed 18 comment cards.
- Reviewed 37 medication charts.
- Attended four ward rounds and one staff support meeting.
- Interviewed the independent advocate and their manager.
- Reviewed 24 patient electronic care records and 11 incident reports.
- Looked at a range of policies, audits procedures and other documents relating to the running of the service.

What people who use the service say

Throughout our interviews with patients, we were consistently told that permanent staff at the hospital were caring, respectful and understanding but patients were concerned about the high number of agency staff.

People told us high use of agency staff meant that was a lack of consistency in the staff on the ward and they felt reluctant to speak to agency staff because they did not know them. Some patient said that they did not feel safe when agency staff were working because they did not know the ward or the patients.

Patients knew who their keyworkers were and told us that they found their keyworking relationships supportive. If their keyworker was not working on a shift, they were aware of the back-up keyworker.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

- There had been a very high turnover of staff and high use of temporary staff. This impacted on the consistency of care provided to the patients.
- The layout of the hospital and the wards made it very hard for staff to observe patients who were at risk of self-harm. There were ligature risks throughout the hospital.There were a high number of incidents in the last year involving ligatures. Whilst the provider was taking steps to improve the safety of the physical environment there remained a high level of risk to patients' safety. Many of the patients were assessed as being at risk of self-harm and the hospital may not be able to meet their needs safely.
- Incident reports did not include a detailed description of the incident or information about the lessons learnt. This meant that it was hard to monitor the incidents and whether the lessons were being addressed.
- Learning from incidents took place within each ward, but learning was not always shared across wards.

However:

- Comprehensive risk assessments were completed on admission.
- All the equipment in clinic rooms was clean and well-maintained. Emergency medicines were all in date and stored appropriately. Systems were in place to ensure the safe management of medicines.
- There was an appropriate standard of hygiene and cleanliness at each of the wards. The wards had good quality furnishings, were well maintained and in a good state of repair.

Are services effective?

Requires improvement

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

- On the wards for adults informal patients were only allowed to leave the ward if they had leave authorised by their psychiatrist.We did not find evidence to show that patients were consenting to the restriction being placed on their freedom.

Summary of this inspection

- Health care assistants were completing documents such as risk assessments but had not all received training to undertake this task. The documents were reviewed by qualified staff.
- Independent Mental Health Advocacy services were not automatically provided for patients detained under the Mental Health Act. This service needs to be available in accordance with the Act and the Code of Practice.
- Agency staff and some bank staff did not have personal 'log-in' details for this system. This meant that agency and bank staff had to use the details of a permanent member of staff in order to access the details or complete records. This compromised the security of records

However:

- Comprehensive examinations of patients' physical health status and assessments of their mental health needs had been carried out by staff at or soon after admission to the hospital.
- Care plans and confidential records were stored securely and available for staff to use as appropriate.
- Wards worked within National Institute for Health and Care Excellence (NICE) guidelines in respect of the prescribing and management of medication and access to psychological therapies.
- A wide range of staff including medical, psychology, occupational therapy and pharmacist supported wards. Most permanent staff told us they received regular supervision and felt well supported.

Are services caring?

Good

We rated caring as **good** because:

- We observed that staff treated people in a caring and thoughtful manner . Staff engaged with patients in a respectful manner, and were discreet and respectful when discussing personal issues with them. The patients we spoke with in person were positive about staff who they said treated them with kindness, dignity and respect.
- Admission processes informed and orientated patients to the ward and service. Information packs were given to all new patients to inform them about their stay and the level of service they should expect.
- Most care plans included evidence of patient involvement. Care plans and risk management plans took account of individual

Summary of this inspection

approaches each patient had to managing their own risks. Patients told us they had received or been offered copies of their own care plans, and confirmed they were involved in their own care when they wanted to be.
- Information about how patients could access independent advocacy support was displayed clearly on notice boards and patients confirmed either an advocate supported them or they knew that support was available to them if ever they wanted it.
- Families and carers of patients were encouraged to be involved in the ongoing process of care planning and delivery. Patients, carers and family members were involved appropriately in decisions about care and treatment.
- Patients could give feedback on the service at regular ward community meetings. These meetings gave patients opportunities to speak up about any concerns they had and give their feedback as to how things were done on the wards.

However:

- Patients told us that they did not feel comfortable when there were high numbers of agency staff on duty. Patients felt less able to approach agency staff because they were not familiar with them.

Are services responsive?

Requires improvement

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

- There was no suitable environment available when patients require nutrition to be delivered through nasogastric tubes.
- There was not a suitable environment for the physical examination of patients on each ward.

However,

- Each of the wards had a range of different rooms and equipment to support treatment and care. Informal patients had free access to the extensive and attractive grounds surrounding the hospital.
- The feedback received from patients on each ward was that the food provided was of good quality.
- Patients had access to a wide range of therapeutic activities. However, on some wards patients said there was not enough to do in the evenings and at the weekend.
- Patients had information telling them how they could complain and staff used this to make improvements.

Are services well-led?

Requires improvement

We rated well led as **requires improvement** because:

Summary of this inspection

- On the acute wards, there were significant numbers of staff with low morale, who had not felt that their concerns about staffing arrangements and safety for patients and staff had been listened to.

However:

- Staff spoke positively about the recently appointed hospital manager.
- Staff were committed to providing high quality care in line with the visions of the organisation.
- Governance processes were in place which led to improvements.

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.

Use of the Mental Health Act was low. One patient was detained on West Wing and two patients were being admitted for assessment East Wing on the day of our visit.

The hospitals systems supported the appropriate implementation of the Mental Health Act and its Code of Practice. Detention paperwork was filled in correctly, was up to date and was stored appropriately. There was a Mental Health Act administrator based on site. Staff knew how to contact them for advice where necessary.

Training on the Mental Health Act and the Mental Capacity Act was covered as part of the mandatory training. People who used the services had their rights under the Mental Health Act explained to them routinely.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act 2005 (MCA) awareness training was delivered to all staff as part of the mandatory training programme, and the hospital had an identified member of staff who was the lead for Mental Capacity Act awareness. Eighty-seven percent of staff across the hospital had completed this mandatory training.

There were no applications for authorisation to deprive patients of liberty under schedule A1 of the MCA between 18 May 2015 and 18 November 2015, and there were no patients deprived of their liberty at the time of the inspection.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Inadequate	Requires improvement	Good	Good	Requires improvement	Requires improvement
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
Specialist eating disorder services	Requires improvement	Good	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

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

Requires improvement

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

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

Inadequate

Safe and clean environment

- The building in which the hospital was based and the layout of the acute wards made it very hard for staff to observe patients. The hospital was situated in a listed, historical building which restricted the changes that could be made. There were blind spots on the acute wards. West Wing was laid out on four different levels. On West Wing, a corridor with bedrooms for male patients was situated up a small flight of stairs from the main nursing station. Two bedrooms were particularly difficult to see as they were down a small staircase off the corridor and a further bedroom could not be seen due to a bend at the end of the corridor. A further four bedrooms on West Wing were in a separate area and a long way from the nurses station. East Wing was laid out on three floors. During our visit, one patient was being supported by a staff member carrying out one-to-one observations. The staff member was sitting outside the patient's bedroom which was two flights of stairs away from the nursing office. This member of staff was a long way from colleagues and it would have been difficult for them to receive assistance quickly. During our visit in the evening, patients' on West Wing had unrestricted access to a staircase that led to a corridor of offices and therapy rooms. This corridor was very isolated from the ward and many of the rooms were unlocked. Patients could also access a further isolated staircase that led to the staff room. These areas had potential ligature anchors and were not included in the ligature risk assessment. Patients also had unrestricted access to a poorly lit garden that had blind spots and ligature points.
- We looked at the management of risks associated with ligature anchor points. Across the three wards there had been 10 ligature related serious incidents of self-harm in the three months prior to the inspection. This included one death. Following the serious untoward incident in December 2015, West Wing had been closed to new admissions for two weeks to enable improvements to the safety of the environment to be made which included work to reduce ligature points. However, on West Wing there were still ligature points classified by the hospital as category 3 (high risk). These were found throughout the ward including bedroom doors, door handles, window handles and sink taps. Four bedrooms next to the nurses station had been designated for higher risk patients. These rooms had observation panels on the bedroom doors although anyone looking through these panels would not be able to see the patient if they were lying on the bed. Anti-ligature features had been fitted in the en-suite facilities and piano hinges were fitted to the doors. Ligature anchor points on the windows had not been removed, although work had been commissioned to change the windows to address this risk. On East Wing the bedrooms were fitted with anti-ligature features and anti-barricade doors. On Garden Wing there were ligature points in an unsupervised lounge area. Environmental risk assessments considering the risk from ligature points had been completed. Risk to patients was largely mitigated through additional levels of staff observation when required. Further work on West Wing to replace windows was taking place in May 2016.

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

Requires improvement

- East Wing was for female patients only. On Garden Wing and West Wing, male and female patients were accommodated on separate corridors. All bedrooms had en-suite facilities. However, male patients had to walk along the female corridor to access to the therapy department, clinic room and garden. On West Wing we noted that a male patient was staying in lower risk room on a female corridor and a female patient was staying in a lower risk room on a male corridor. The deputy ward said that these rooms would be swapped later that day. This meant that occasional breaches in same-sex accommodation were occurring.
- The clinic rooms looked clean and well kept. There were sinks available for handwashing, as well as adequate space available for preparing medication. Facilities and processes were in place for the disposal of medicines and satisfactory records were kept. There were two sealed emergency boxes available (one in each building of the hospital). Each ward had a separate adrenaline pre-filled syringe available for immediate use. We saw evidence that emergency equipment was being checked regularly each weekend. They said that these problems had been addressed by appointing agency staff on two month contracts.
- There were no seclusion facilities at the hospital. Patients presenting a heightened level of risk were placed under an increased level of observation. If this was insufficient to manage the risk, patients would be transferred to a psychiatric intensive care unit (PICU). Very exceptionally, if there was an incident of violence and aggression that hospital staff could not manage safely the police would be called. Of the 27 statutory notifications of police involvement in the twelve months before the inspection, none related to incidents of violence on the wards.
- There was an appropriate standard of hygiene and cleanliness at each of the three wards. The wards had good quality furnishings, had been well maintained and were in a good state of repair. There were dedicated housekeeping staff for each ward, and patients confirmed that the wards were generally kept clean and tidy. There was a cleaning schedule and cleaning records were maintained.
- There were appropriate call systems in all the bedrooms with a call alarm button situation by the bed and in the bathroom. Staff were issued with personal alarms.

Safe staffing

- The service provider used a tool to calculate the numbers of staff required on each shift for each ward. This enabled extra staff to be requested if the number of patients increased on the ward. The system also allowed for the numbers of staff to be decreased if there were empty beds. There were two nurses allocated to each ward at all times and between one and four HCAs depending on the number of patients.
- The hospital provided data on staffing levels for the three months prior to the inspection, from 16 November 2015 to 21 February 2016. During this period the correct numbers of staff had been working on the Garden Wing for 86% of day shifts, 93% of day shifts on West Wing and 92% on East Wing. The figures were slightly higher on night shifts, when the full quota was achieved on 94% of shifts on Garden Wing, 99% on West Wing and 97% on East Wing. This showed that on most shifts the numbers of staff who were working was in line with the staffing tool used by the hospital.
- On East Wing there were six vacancies for qualified nurses amounting to 55% of the qualified allocation to the ward, and two vacancies for HCAs. On Garden Wing there were five vacancies for qualified nurses, amounting to 54% of the allocation, and vacancies for two HCAs. On West Wing there was just one vacancy for a qualified nurse, although one nurse was on a period of long term absence and one nurse was leaving. There were three vacancies for HCAs.
- The use of temporary staff was high, both during the day and at night. Temporary staff were used on 41% of day shifts on Garden Wing and 36% of day shifts on East Wing. The figure for West Wing was lower at 15%. At night, temporary staff were used on 33% of shifts on Garden Wing and 51% of shifts on East Wing. Again, the figure was lower for West Wing at 21%.
- The impact of the high use of temporary staff was expressed by staff and patients. Patients said that the use of temporary staff meant there was a lack of consistency and they much preferred being cared for by permanent staff as they knew them more. One patient said that temporary staff tended to be more restrictive as they did not know peoples individual needs. Comment cards completed by patients said that they did not always feel safe on the wards.

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

Requires improvement

- We heard from staff before and during the inspection who were concerned about the high use of temporary staff especially qualified nurses. There were particular concerns about the use of temporary staff at night. Staff said that at times they felt unsafe and that a lack of permanent staff was particularly a problem when there were a number of admissions on the same day.
- During an unannounced visit in the evening as part of the inspection, we found there was one permanent HCA on duty and three agency staff, two of whom were qualified nurses. In this situation, the HCA took responsibility for leading the shift as they were familiar with patients and the layout and routines of the ward. This included writing the shift co-ordinating plan, ensuring the required levels of observation were carried out and directing the agency staff to areas of the ward where they needed to be. We also observed that staff did not know each other's names. Temporary staff were unfamiliar with the layout of the ward and did not know the names of patients. An agency nurse told us that they were required to complete an induction folder which took about one hour and that they were shown around the ward. They said that this was the third time they had worked at the hospital.
- The hospital management team were very aware of the staff vacancies and high use of temporary staff. There was an active programme of recruitment including visits to recruitment fairs at local universities and holding interviews and assessments for applicants once a month. There were some initiatives to ensure that agency staff were more familiar with the wards. For example on Garden Wing, agency staff were given a two month contracts to promote some improved consistency.
- Staff were spending time with patients and ensuring that one-to-one sessions were facilitated. Patients said that staff made time to support them and that one-to-one sessions were kept and not cancelled. Feedback in relation to individual sessions with nurses was very good. On West Wing patients said that leave was not cancelled. A patient on Garden Wing said that escorted leave was an issue and that they would like there to be more staff available to facilitate this. Another patient said that there was not much to do after 5.00 and at weekends.
- There was a doctor on duty on site 24 hours each day who could attend the wards quickly in emergencies. One doctor we spoke with said there could be difficulties in responding to requests for assistance if there were a number of admissions on the same shift.
- There was an effective system for monitoring mandatory training which covered 21 essential areas of staff competency. Training was carried out online and in class based sessions. Compliance with mandatory training for permanent staff was 78% on West Wing, 86% on Garden Wing and 80% on East Wing.

Assessing and managing risk to patients and staff

- During the six months from mid-May 2015 to mid-November 2015 there were nine incidents of restraint on Garden Wing and four on West Wing. The figure for East Wing was higher, with 46 incidents of restraint involving 16 patients. None of these restraints were in the prone position.
- The referral forms for NHS admissions all included a thorough risk assessment completed by the referring agency. For patients admitted privately, their consultant completed a risk assessment. Patients were not admitted if they had a history of offences, fire setting, arson or sexual offences. The decision to admit was made by the consultant psychiatrist based on a recommendation by the ward manager. When a referral for admission was not accepted a report was sent to the head office.
- We looked at the risk assessments in nine patient records. The risk assessment tool included the information on the patient's psychiatric history, a list of presenting risk and a plan for managing risk. The plan for managing risks included the level of observation the patient required and other information such as restricting access to sharp objects and ligature points. Risk assessments were completed on admission and frequently updated throughout the patient's stay in hospital. On East Wing, eight out of 12 patients had a risk rating of 'high'. The presenting risks on the records we viewed for East Wing patients included suicide, absconding and deliberate self-harm. On West Wing, patients admitted for acute psychiatric care presented risks of suicide, deliberate self-harm and neglect. For patients admitted to the addictions treatment programme, risks were more likely to be associated with

non-adherence to the programme, supply of drugs and absconding. On East Wing, all four of the risk assessments we reviewed were completed by an HCA and authorised by qualified nurses.

- Safeguarding formed part of the mandatory training and had been completed by 90% of permanent staff. When we asked staff what they would do if they thought a patient was being abused, staff told us that they would escalate the matter to the ward manager or the safeguarding lead for the hospital.
- Medicines were stored securely in designated cupboards and medicines trolleys. The medicine storage areas were clearly labelled in the locked clinic rooms on all wards that we visited. The keys to all the clinic rooms and medicines cupboards were held by one of the nurses on duty. Each of the medicines trolleys were attached to the walls of the clinic rooms where they were stored and were used to store medicines being taken by current patients. The physical health medicines were stored separately from the psychiatric medicines. All the medicines were neatly laid out in alphabetical order and were also separated by formulation. Controlled drugs (CDs) were stored and managed appropriately. The CDs were checked each day by two registered nurses. The pharmacy service was provided by an external organisation. A regular pharmacist visited the hospital twice a week, reviewed all the drug charts and conducted regular audits of the clinic rooms.
- Arrangements were made for children to visit in parts of the hospital away from the ward.

Track record on safety

- Between 1 January 2015 and 31 January 2016 there were 365 incidents recorded on the adult acute wards. East Wing had an exceptionally high level of incidents, totalling 224. On Garden Wing there were 81 and on West Wing there were 60.
- There were 105 incident of self-harm, including attempted suicide and self-inflicted injury. There were forty incidents of patients actually absconding, and a further 19 records of patients attempting to abscond. There were 23 incidents of actual physical violence involving person to person contact with intent to harm and 45 incidents of aggression that involved threatening behaviour, verbal abuse or harassment.

Reporting incidents and learning from when things go wrong

- Incidents were reported using an electronic reporting system. Staff were aware of how to report incidents. The incidents were collated and reviewed by a compliance manager and were discussed at a weekly learning and outcomes group meeting. The discussion and actions at the learning and outcomes group fed into the overall clinical governance meeting in the hospital.
- Between 1 March 2015 and 29 February 2016 there were 31 incidents of patients self-harming using a ligature and a further 12 incidents of patients attempting to use a ligature. Ligature cutters were kept in a clearly labelled, designated place on the wall of the nursing office.
- We reviewed a sample of eight incident forms completed on West Wing during the period March 2015–March 2016. The quality of the information being recorded was very variable. Three of the incident forms involved incidents of deliberate self-harm and one of these involved a suicide attempt. The incident involving a suicide attempt was graded as moderate risk but there were no details recorded in the lessons learnt section of the form explaining the learning that would be shared with team. The forms for two incidents which involved self-harm included no description of the incident. The quality and detail of incident reporting was poor. This made it hard to monitor incidents and be sure that lessons were learnt.
- We reviewed a sample of four incidents reported on Garden Wing during March 2015 – March 2016. One incident which involved high risk incidents following a period of leave from the hospital was not recorded on the electronic reporting system but only on a sheet of paper. We reviewed the minutes for the learning and outcomes group meeting which corresponded to this incident and there was no record of this incident being discussed. The process for recording and reviewing incidents was not being followed and this compromised the learning and improvements which could be made to ensure patent safety.
- During discussions with staff about recording incidents we found two incidents that had occurred that were not recorded. One incident involved a complaint made by the parent of a patient about scissors being left on an

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

Requires improvement

unstaffed nursing station that were easily accessible to patients who self-harm. The complaint was recorded but the incident was not. The other incident involved a patient complaining that a member of staff assaulted her whilst untying a ligature. Whilst the allegation of assault was recorded as an incident, the ligature incident was not.

- Some changes had been made across the acute services in response to serious incidents. On West Wing, the ward was closed to new admissions for two weeks after a serious untoward incident. Four bedrooms on West Wing were designated as safer rooms for patients assessed as presenting a higher level of risk. These rooms had anti-ligature features in the bathroom and an observation panel in the door. However, there were still ligature anchors within these rooms and the observation window enabled the person looking through the window to see the patient if they were lying in bed. Safer rooms are also planned for East Wing. In total there were plans for 17 safe rooms across the site. The hospital insisted that a full risk assessment was provided by the commissioning authority before the patient was admitted. All patients were placed on four observations per hour until they had been assessed by a consultant psychiatrist. Permanent staff had received training on completing risk assessments.
- Following a serious incident on West Wing, the therapy team provided support to staff and facilitated a de-brief session. Senior managers attended the ward and spoke with staff about how they were getting on after the incident. One member of staff had been off work since the incident.

Duty of Candour.

- Staff we spoke with understood the principles of duty of candour and were aware of what steps to take to speak with a service users if a mistake or incident occurred. We reviewed two letters sent to families of patients who had died whilst receiving care and treatment with Priory Roehampton hospital. These letters were supportive, open and transparent and showed a good display of duty of candour.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- A full assessment of the patient was carried out by a doctor on admission. This included details of the patient's mental health history, physical health history, current presentation and assessment of risks.
- Physical examinations were routinely carried out on admission to the ward. Ongoing monitoring of patients' physical health and physical health checks were being completed routinely.
- We looked in-depth at 13 patient records and at the care plans in another five records. Care plans were being completed and were person centred and comprehensive. Almost all the records showed a holistic approach to patient care. Patients' records were all up-to-date. Daily entries in the notes used a standard template covering drinking, eating, toileting, interactions and family contact.
- Most care plans were person centred showing evidence of patient involvement. For example, the records stated the patient's preferred way of managing urges to self-harm involving distraction techniques that were very specific to the patient. On other care plans, patient's views and comments were recorded. However, some care plans were generic. Care plans did not include any consideration of discharge planning and involvement of community based services.
- Patient records were all kept securely in an electronic patient record system. Agency staff and some bank staff did not have personal 'log-in' details for this system. This meant that agency and bank staff had to use the details of a permanent member of staff in order to access the details or complete records. This compromised the security of records. Records of observations were kept in a paper file.

Best practice in treatment and care

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

Requires improvement

- On West Wing we looked at 12 drug charts and they all recorded the allergy status of the patient. There were no unexplained missed doses. Any doses that had not been given had the reason clearly stated on the relevant section of the drug chart. All of the medicines taken when required had the reason for use annotated on the drug chart. If a patient refused their medicines, this was discussed with the multidisciplinary team members at the ward round and an action plan was put into place. This was also discussed in the daily handover.
- On Garden Wing we looked at 10 drug charts and they all had a record of the allergy status of the patient. Four of the drug charts had a picture of the patient attached. There were no unexplained missed doses. Any doses that had not been given had the reason clearly stated on the relevant section of the drug chart. All of the medicines taken when required had the reason for use annotated on the drug chart. One patient had been allowed to keep one medication to self-medicate. A risk assessment had taken place prior to the patient being allowed to self-medicate.
- A wide range of therapies were provided for patients on the wards and these were facilitated by staff from the therapies department. Patients were able to access art therapy, drama therapy, cognitive behavioural therapy and solution focussed therapy. The therapies provided were varied, and met standards for good practice in line with the National Institute for Health and Care Excellence (NICE) guidance.
- Patients had access to physical healthcare. A doctor was on-call 24 hours a day. Patients requiring specialist healthcare were transferred to a local hospital for care and treatment. A full-time escort for transferred patients was provided if necessary.
- The hospital carried out a range of management and clinical audits across the site. This included an audit of clinical effectiveness and compliance with NICE guidance in the treatment of depression. The themes of other audits included reducing restrictive practice, infection control, safeguarding, risk assessments and ligature points.

Skilled staff to deliver care

- There was a full range of mental health professionals supporting the patients' care and treatment. An occupational therapist was based on each ward. Psychologists, family therapists, addiction therapist and dialectical behavioural therapists were based within the therapy department. A dietician was also available.
- An induction programme for new permanent staff was taking place every month. The induction programme took place over two weeks and included a corporate induction, clinical induction, Mental Capacity Act training, Mental Health Act training and basic life support. Agency staff were required to completed an induction checklist which took about one hour. At the start of each shift, a permanent member of staff will also go through a list of patients with any agency workers and advise them of the level of observation for each patient.
- Permanent staff were expected to receive monthly supervision, appraisals and attend team meetings. We reviewed 22 supervision records for staff across the hospital. There was a clear process followed in supervision with information about updates and developments being given by the supervisee to the supervisor. Follow up actions from each supervision session agreed and documented. Supervision records stored securely and kept confidential
- Nurses told us that team meetings took place each week and that their supervision was up to date. One health care assistant (HCA) said he had not had supervision for two months and that team meetings were often cancelled due to a lack of staff. Supervision notes were brief but covered the key points that were discussed in the meeting. Temporary staff did not receive supervision and did not routinely attend team meetings.
- The hospital operated a 'foundation for growth' training programme enabling staff to develop their skills through an e-learning programme.
- The hospital had disciplinary and capability policies to address poor performance. Where there were concerns about agency staff they were not offered further shifts at the hospital.

Multi-disciplinary and inter-agency team work

- Multidisciplinary meetings took place on each of the wards. We observed a multi-disciplinary team meeting on East Wing that was attended by the consultant psychiatrist, psychology assistant, social worker, ward

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

Requires improvement

doctor and charge nurse. The team discussed each patient, including a review of the level of risk they presented. Each member of the team contributed throughout the meeting.

- Handover meetings took place twice each day when the shifts changed. Notes were recorded of these meetings. These notes included a list of the observation status for every patient.
- There were good relationships across the wards. Staff from the therapy department attended multi-disciplinary team meetings.
- Relationships with teams outside the organisation appeared limited. There was little discharge planning in the care plans. NHS patients were often recalled to their home areas very suddenly which could be disruptive to patient care.

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

- Use of the Mental Health Act was low. One patient was detained on West Wing and two patients were being admitted for assessment East Wing on the day of our visit. There were no detained patients on Garden Wing.
- Training on the Mental Health Act formed part of the induction and mandatory training. Staff could contact the Mental Health Act office if they had any queries.
- Leave from the hospital had to be authorised by the consultant. There were frequently entries on the records of informal patients stating that they did not have authorised leave. One record of an informal patient stated that the patient was frustrated with restrictions and with not being allowed leave. Only one record included a statement confirming that the patient had capacity and was consenting to the restriction being imposed.
- Although patients had access to an advocacy service, this service did not include the provision of Independent Mental Health Advocacy (IMHA) as defined by the Mental Health Act. The local authority commissioned an IMHA service for patients detained under the Mental Health Act in the local area. The hospital had met with the local authority to formalise a referral process to this service. There had been no visits to the hospital by an IMHA service since the new contract began on 1 February 2016.

Good practice in applying the MCA

- Training on the Mental Capacity Act formed part of the induction and mandatory training. Eighty-seven percent of staff across the hospital had completed this mandatory training.
- There were no applications for authorisation to deprive patients of liberty under schedule A1 of the MCA between 18 May 2015 and 18 November 2015, and there were no patients deprived of their liberty at the time of the inspection.

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

Good

Kindness, dignity, respect and support

- We observed positive staff attitudes and behaviours when they were interacting with patients.
- Comment cards said that staff very helpful and friendly staff, they were caring and considerate, and that patients felt listened to. Other comments said that patients found staff to be approachable and overall, that they were treated well.
- We interviewed 15 patients in groups of between three and six. Comments were very positive across all three adult acute wards. Patients said that staff were nice and took time to get to know them and that this made it easier to discuss their problems.
- We observed staff engaging with patient in a manner that was responsive to their specific needs. For example, we saw a member of staff talking to a patient about the specific triggers that were causing cravings for alcohol and discussing the coping mechanisms that the patient could use. One patient told us that staff were compassionate, they did not judge patients and they were skilled in being able to pick up on changes in patients moods.

The involvement of people in the care they receive

- We reviewed 20 care plans and most showed that the patient had been involved. One patient told us that they

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

Requires improvement

had a copy of their care plan and that they found regular, informal meetings with their nurse to be productive. Patients met with their consultant once a week, either in a multi-disciplinary meeting or as an individual consultation.

- Most patients told us that they were aware of the advocacy service. The advocate said that they supported patients with meetings with their consultant, understanding how care and treatment was provided, discharge planning, benefits, housing and relationships with staff. The contract for the provision of advocacy had recently changed and there were concerns from the manager of the advocacy service about whether the hours were sufficient to meet the needs of patients.
- Families and carers were involved in care planning and decisions about treatment and care. Electronic care records showed that patients frequently had leave with their family or friends. The hospital organised family days when family and friends were encouraged to visit the hospital. A family programme involved weekly sessions with the patient and their family facilitated by a therapist.
- Community meetings were taking place on each ward once a week. These meetings provided the opportunity for patients to give feedback about the service. Meetings typically involved discussions about ward maintenance, food, access to gym and planning activities.

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

- Referrals to the adult acute wards were made both privately and through NHS commissioners. Patients on East Wing were all NHS patients who had been placed at the hospital because there were not beds available in their area. These patients could be from anywhere in England. On West Wing, patients on the addictions therapy programme were all privately funded, either through paying directly or through private medical insurance. The acute psychiatric patients were more likely to be NHS patients. Garden Wing was predominantly for privately funded patients. At the time of our visit there were two NHS patients on Garden Wing.
- The hospital did not admit patients with a forensic history, a history of violence or fire setting or a history of sexual offences.
- Bed occupancy between 1 May 2015 and 31 October 2015 was 62% on East Wing, 76% on Garden Wing and 70% on West Wing.
- Patients were not admitted into beds that were allocated to patients who were on leave.
- Patients were not moved between wards during an in-patient episode. However, NHS patients could be returned to their local area at short notice.
- The hospital accepted admissions 24 hours a day.
- There were no delayed discharges between 18 May 2015 and 18 November 2015.

The facilities promote recovery, comfort, dignity and confidentiality

- On each of the wards, patients had their own bedroom. Bedrooms were well furnished, comfortable and had en-suite facilities. Each ward had a communal lounge. West Wing had a small lounge for female patients and a separate lounge for patients on the additions treatment programme. Therapeutic activities took place off the ward in the therapy department. There was a clinic room on each ward, although the clinic room on Garden Wing was not big enough to accommodate an examination couch, meaning that physical examinations had to take place on another ward. Patients on Garden Wing and West Wing had their meals in a restaurant that was also used by staff. Patients on East Wing had meals in a dining area on the ward.
- Most patients had their own mobile telephone and could make telephone calls in their rooms.
- A selection of food was provided on the hospital menu and patients were able to select meals on a daily basis. Most patients told us that the food was good, there was lots of choice, and there was good selection of vegetarian meals Patients were able to make hot drinks and snacks at any time on the wards.

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

Requires improvement

- Patients were able to personalise their bedrooms. Patients could lock their bedroom doors. Bedrooms were also fitted with a personal safe.
- Patients spoke positively about the activities available at the hospital. These activities included dance and movement, art therapy and assertiveness training. Patients on Garden Wing told us that there was little to do at weekends and after 5pm. Some patients said they would like to have more access to the gym.

Meeting the needs of all people who use the service

- West Wing and East Wing were unable to admit patients with mobility difficulties due to stairs throughout the ward. There were no lifts. Garden Wing was set out on one level but was not able to accommodate wheelchair users.
- Information leaflets could be translated into languages spoken by patients. Interpreters and signers could also be provided if they were required.
- On admission, patients are provided with a comprehensive information pack giving details of both the hospital and the local area.
- We interviewed the catering manager who had a good understanding of how to ensure that patients who required a particular diet such as kosher or halal food, had this provided appropriately.
- There was a chapel on site run by the hospital chaplain. People of any faith could request to use the chapel. Information was available for patients on the location of local places of worship.

Listening to and learning from concerns and complaints

- There were a total of 28 complaints across the three wards between 30 October 2014 and 3 November 2015. Eleven of these complaints were upheld.
- Regular learning and outcomes meetings were held monthly. Incidents and complaints were shared and discussed during this meeting. Actions and follow up plans were initiated following this meeting and followed up by each responsible ward manager.

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

Requires improvement

Vision and values

- Staff we spoke with told us that they were proud to work for the hospital and the organisation. They were able to reflect the values of The Priory Group.
- Staff were very positive about the hospital director and the senior management team within the hospital. They told us that they were very visible and approachable. Staff on the ward told us that they felt supported by their managers.
- Ward managers and nursing staff spoke positively about the values of the hospital including a commitment to provide high quality person-centred care within an open and fair culture that enables learning and innovation. Other staff spoke about the importance of treating patients with dignity, compassion, kindness and respect.
- The objective of the teams generally reflected the organisations values.

Good governance

- A governance system was in place in the hospital. There were a number of meetings across the hospital where information was shared and discussed and these fed into overarching clinical governance committee led by the provider. We reviewed the minutes for these meetings, which showed that, overall information sharing took place well within the hospital and the wider organisation.
- A new supervision process had recently been introduced in the hospital and staff were receiving regular supervision which was being recorded and documented. A set process for supervision was in place which supported staff, shared information about recent incidents and provided actions to be taken forward from the supervision session

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

Requires improvement

- Audits were being carried out regularly and action plans developed following completion of audits. We reviewed recently completed audits of risk assessments, observations and care planning. These identified areas for improvement action plans had been developed.
- The hospital had a 'quality walk round' process in place which had a standardised template to review the quality of services for service users. Ward managers and the senior management team were responsible for ensuring the action plans following these checks were implemented.
- The views and experiences of people who used the service were captured in a patient forum meetings and a community meeting. The minutes of these meetings were shared and discussed
- The ward managers had sufficient authority to complete their job and were supported by the senior management team.

Leadership, morale and staff engagement

- A staff survey was carried out in 2015. Questions that scored highly were about knowing what was expected of staff, how staff work helps to achieve the objectives of the hospital and being proud to work for the Priory Group. Questions that received low scores were about health and safety, training and development and having adequate materials and equipment.
- The staff vacancy and turnover rates for each ward indicate that there were only a small proportion of staff with more than one year's experience of working on the wards. Turnover rates from 1 November 2014 to 1 November 2015 were 76% on Garden Wing, 81% on East Wing and 40% on West Wing.
- The hospital held a 'your say' forum for staff to provide feedback to senior managers. Each ward nominated representatives. There was also a forum across the Priory group to which the hospital sent representatives.
- The senior hospital managers held a weekly open door 'coffee and catch up' whereby any member of staff could meet with them to discuss any matter relating to the management of the hospital.
- Despite these engagement initiatives a number of staff on these wards said they had low morale and were very anxious about the safety of the patients and their safety. Nine staff contacted the CQC before the inspection to share their concerns and had not felt that the senior managers in the organisation were acknowledging and responding to their concerns. The main concerns related to the staff vacancies and high numbers of temporary staff.

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

- Lower Court provided care and treatment for up to 12 children and adolescents experiencing an acute episode of mental illness. The ward was set out across two floors. There were seven bedrooms on lower floor and five bedrooms on the upper floor. There were some blind spots on the ward. There were no convex mirrors to address this.
- One communal bathroom had anti-ligature features. Two bedrooms close to the nursing office were in the process of being refurbished. This included the installation of anti-ligature features, installing collapsible curtain rails, changes to light fittings, and changing the bathroom doors. A full ligature audit had been completed but needed to be updated following these changes.
- Lower court was a mixed ward. Male patients were accommodated on the ground floor in bedrooms with en-suite facilities. The main lounge was used by both male and female patients. Female patients said they felt uncomfortable when there were mostly male staff on duty. They told us that on shift at the end of January 2016 there was only one female member of staff on duty which meant that male staff were assigned to carry out close observations of female patients.
- The clinic room was clean, spacious, tidy and free from clutter. Checks of medical equipment had been carried out and documented for the two months prior to the inspection. A defibrillator was available and in working order. An emergency bag was stocked with visible expiry dates. A report had been made that the lock on the emergency bag was broken. Emergency medicines were managed by a pharmacy contractor who visited the hospital twice each week. An adrenaline auto-injector was available for the emergency treatment of severe allergic reactions (anaphylaxis).
- There was no seclusion room at the hospital. There was no evidence of patients being secluded in bedrooms.
- The ward was clean, well maintained and the furniture was in good condition. In one lounge area new paintings were being fitted.
- An infection control audit had been carried out in September 2015. Two bedrooms were in the process of being fitted with laminate flooring for high risk patients to improve infection control.
- An emergency response system had been installed allowing staff and patients to request different levels of assistance. Activation panels were placed throughout the ward. An incident had occurred when staff were not aware of the alarm being activated. At that time no-one had been in the nursing office so no-one heard the alarm. This led to a delay in staff responding to a patient's request for assistance. As a result of this incident a second alarm panel was fitted outside the nursing office.

Safe staffing

Good

Child and adolescent mental health wards

- A tool was used to calculate staffing levels across the organisation to establish appropriate staffing levels. The standard allocation was one member of staff for every three patients with additional staff allocated for one-to-one observations.
- Data provided by the hospital showed that there was a full allocation of nursing staff on the ward for 87% of the shifts between 16 November 2015 and 21 February 2016.
- During the same period, temporary staff were used for 32% of all shifts. The ward manager acknowledged that patients do not always like being cared for by temporary staff. When we visited the ward during a night shift the staffing allocation was one permanent qualified nurse, one agency nurse, three permanent health care assistants (HCAs), two bank HCAs and one agency HCA. The agency HCA had not worked on the ward in the previous six months. Patients said that they felt unsafe when bank and agency staff were working. They gave examples of a bank nurse being rude to a patient and told us about an incident involving an agency nurse restraining a patient in a painful and inappropriate manner.
- The ward manager could increase the number of staff on duty when one or more patient required one-to-one observations.
- One member of staff was always available in the communal areas.
- Patients all had regular one-to-one sessions with their named nurse and said that they found these sessions helpful.
- Patients said that the activities co-ordinator made sure that there were things to do in the evening and at weekends. One patient said that leave groups and regular outings had not been taking place since the occupational therapist left. Managers at the hospital said that trips had been cancelled as there had been no contingency plan for the occupational therapist's departure. However, they a said that other staff had subsequently been deployed to this role to ensure that the impact of there being no occupational therapist was minimal.
- Medical cover was provided 24 hours per day by an on-site responsible medical officer. They could be supported by an on-call CAMHS consultant.
- Staff had received appropriate mandatory training. On the 18 November 2015, the average mandatory training rate for staff was 84%.

Assessing and managing risk to patients and staff

- There were no incidents of seclusion or long-term segregation on this ward.
- There were 47 uses of restraint between 13 May and 13 November 2015, involving 13 patients. One incident resulted in prone restraint and rapid tranquilisation. Every restraint was classified as an incident. Staff attempted to verbally de-escalate situations before restraint was used. Training had been provided in conflict resolution to help staff manage situations involving conflict and aggression. This training covered the setting of thresholds for physical interventions.
- We read through one patient record. There was an up-to-date care plan completed with multi-disciplinary input. The risk assessment included a list of known risks, details of recent incidents and details early warning signs of factors that may increase the level of risk.
- During our visit, patients were not allowed unsupervised access to the second floor. When patients were allowed to access this floor, a member of staff was present on the corridor at all times.
- Safeguarding was included in the mandatory training for all permanent staff. Staff told us that if they were aware of any safeguarding concerns they would escalate this to the ward manager or the safeguarding lead for the hospital..
- We reviewed medicines management across the hospital. We found that medicines were stored securely in designated cupboards. A pharmacist visited the hospital twice a week, reviewed all the drug charts and conducted regular audits of the clinic rooms.

Track record on safety

- There was one serious incident requiring investigation (SIRI). This involved an allegation of inappropriate comments made by a staff member when restraining a young person.
- Between the 1 January 2015 and 31 January 2016 there were 228 incidents recorded. There were 109 incidents of self-harm, including attempted suicide and

Good

Child and adolescent mental health wards

self-inflicted injury, 19 incidents of patients absconding, 15 incidents of aggression and three incidents of violence. The use of ligatures occurred in 30 of these self-harm incidents

- An audit of ligature risks highlighted many ligatures points including door hinges, door handles, bathroom taps and curtain rails. Plans were in place to ensure that all pipes were boxed in and drawer handles and sink taps were being replaced. This work was due to be completed in March 2016. The audit also recommended that risks were reviewed in weekly nurses meetings.

Reporting incidents and learning from when things go wrong

- Incidents were recorded on an electronic patient record. This system generated a weekly incident report that was emailed to ward managers.
- The ward manager told us that staff met for reflective practice sessions after incidents to look at what can be learned from incidents. After every incident the multi-disciplinary team analysed the triggers to the incident. A 'learning outcomes' group met once a month to review incidents and complaints across the hospital. However, some staff said that team meetings did not discuss learning from incidents on other wards.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed eight patient records. Records showed that patients were assessed on admission. A level of observation was set on the basis of this assessment. Observation levels could be increased by nursing staff but could only be decreased with the agreement of the consultant.
- Records included evidence of physical health checks being carried out on admission and ongoing monitoring of physical health conditions.
- Care plans were completed for each patient. There was a record of patients being involved in developing the plan. Risk assessments were completed on admission and updated after incidents occurred. Patients had a number of care plans covering specific aspects of their care. For example, one patient had specific care plans for sleep hygiene, safeguarding, leave and restraint. The restraint care plan said that restraint should be used as a last resort and included a list of early warning signs.
- Assessments, plans and progress notes were all kept securely on an electronic patient record.

Best practice in treatment and care

- Medicines were stored securely in designated cupboards and medicines trolleys. The medicines storage areas were clearly labelled in the locked clinic rooms on all wards. The keys to all the clinic rooms and medicines cupboards were held by one of the nurses on duty. Each of the medicines trolleys were attached to the walls of the clinic rooms where they were stored and were used to store medicines being taken by current inpatients. The physical health medicines were stored separately from the psychiatric medicines. All the medicines were neatly laid out in alphabetical order, and were also separated by formulation.
- Recommended therapies were provided by the multi-disciplinary team including cognitive behavioural therapy, dialectical behavioural therapy, cognitive analytical therapy, psychotherapy, art therapy, music therapy, drama therapy, art therapy, music therapy, dance therapy, dance and movement therapy which were provided by qualified therapists. Support for patients with day-to-day coping skills was based in on dialectical behavioural therapy.
- Assistance with physical healthcare was provided by nurses and the duty doctor when required. When patient required a specialist treatment for their physical health, patients were taken to a local acute hospital.
- Staff used the children's global assessment scale and the health of the nation outcome scales for children and adolescents to measure the progress that young people have made. Outcome measures were completed on admission and discharge. The ward manager was planning to introduce further assessments during admission.

Skilled staff to deliver care

Good

Child and adolescent mental health wards

- In addition to nurses and health care assistants (HCAs), the multi-disciplinary team included a consultant psychiatrist, a ward doctor, a lead therapist, a family therapist, an occupational therapist, a psychology assistant and activity co-ordinators. A dietician was allocated to the ward. The clinical psychology post was vacant.
- New staff attended the induction programme. The ward had introduced a 'buddy' system in which an established member of staff provided support to a new employee.
- Staff were scheduled to received supervision once a month. We reviewed 22 supervision records for staff across the hospital. There was a clear process followed in supervision with information about updates and developments being given by the supervisee to the supervisor. Follow up actions from each supervision session were agreed and documented. Supervision records were stored securely and kept confidential.
- Two HCAs said that supervision sessions were good. Another HCA said that they had only had two supervision sessions in the previous five months, but that these sessions were helpful.
- CAMHS specific training was being introduced. This included sessions on working with young people, communication skills, working with families and understanding the Children's Act.

Multi-disciplinary and inter-agency team work

- Two multidisciplinary ward rounds took place each week. These meetings provided an opportunity for patients to meet with their psychiatrist and other members of the team providing care. The progress of each patient was reviewed.
- Handover meetings took place when shifts changed twice a day. In these meetings staff discussed any admissions, discharges and incidents that had taken place during the previous shift. Levels of risk and the observation status for each patient were updated and written up on a white board in the nurses office. There was a meeting once a week for nurses. Staff said that attendance at these meetings was inconsistent and depended on who was on duty.
- Working relationships with healthcare teams and agencies outside the hospital tended to be limited. Most patients did not live in the local area. When patients were discharged, a letter was sent to their GP.

Adherence to the MHA and the MHA Code of Practice

- Staff had accessed Mental Health Act training. They knew how to seek advice if they had any questions.
- We saw that patients who were not detained formally under the Mental Health Act (1983) were given information about their status as 'informal' patients.

Good practice in applying the MCA

- Capacity was discussed and recorded regularly in ward rounds. Medical staff recorded and updated capacity assessments clearly in patient records.
- Staff were aware of how to access support or advice relating to the Mental Capacity Act, if they needed it.
- All permanent staff received training in the Mental Capacity Act. Additional training on assessing Gillick competency was provided on a specific CAMHS training course.

Are child and adolescent mental health wards caring?

Good

Kindness, dignity, respect and support

- We spoke with five patients. Their comments about the permanent staff were all positive. One patient commented that staff never talk down to patients. Another patient said that staff treated young people with respect.
- Patients told us that they found staff to be understanding and that nurses treated them well.

The involvement of people in the care they receive

- On admission, patients received a handbook. This included information about the staff team, access to therapy, weekly meetings and a list of things that patients should bring with them to hospital. There was

Good

Child and adolescent mental health wards

an accompanying handbook for parents and carers that included more details about care and treatment during the first weeks of admission, observation levels and visiting times.

- Patients consistently told us that they felt involved in their care and treatment. This included weekly meetings with their named nurse, developing their care plan in one-to-one sessions with their named nurse and attending the multi-disciplinary meetings once a week. One patient told us about discussions they had about medication and possible side-effects. Most patients felt that staff listened to them. One patient said they did not always feel listened to and another said they wished staff would listen to them more.
- Patients had access to an advocate with experience of working with children and young people provided by the national youth advocacy service.
- A support group for families or close friends of inpatients was run every Monday. The group aimed to provide information and facilitate discussion about the challenges of helping to support a young person in treatment.
- Community meetings were due to take place every Monday. These meetings had been cancelled five times in the previous 17 weeks. The meetings usually involved discussions about issues such as fire procedures, complaints, advocacy visits, the reasons for doors being locked and the rights of informal patients.

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

Good

Access and discharge

- Most patients were admitted to the ward in crisis. When a referral was received, the ward manager liaised with referring agency to agree a realistic timescale for admission. Members of the multidisciplinary team would also speak to the referrer to ascertain the patients' needs and the purpose of admission. The majority of patients were funded by NHS England.
- The bed occupancy rate between 1 May and 31 October 2015 was 83%
- Patients were discharged from hospital at an appropriate time of day.
- The ward did not admit patients to beds that are allocated to patients who are on leave. One patient told us that periods of leave were limited to three nights. She said she would have liked longer periods of leave to help her adjust to being out of the hospital.
- The ward manager told us that there had been some difficulties in arranging a bed in a psychiatric intensive care unit (PICU). If a patient was waiting for a PICU they would be placed on 2:1 observations.
- There had been one delayed discharge in 2015 caused by difficulties in finding accommodation for the patient. Data provided by the hospital showed that there were no delayed discharges between 18 May and 18 November 2015

The facilities promote recovery, comfort, dignity and confidentiality

- There was a full range of rooms including bedrooms, bathrooms, a lounge area and a clinic room with an examination couch.
- There was no room specifically set aside for visitors, but visitors could use the group therapy room. Some patients saw visitors in their bedroom. Patients had some choice in how they would like observations to be carried out when they were with their visitors. One patient had asked for their time with visitors to be monitored using CCTV equipment. Visitors under the age of 18 were required to be accompanied by an adult.
- The use of mobile phones on the ward was restricted at meal times, during therapy time and during education sessions. Phones were handed in to staff when patients went to bed.
- Patients had access to a secure garden.
- Patients told us that they thought the food was good. They said that food was always freshly cooked and that alternative meal was available if they wished. Patients could ask to use the kitchen to make themselves a snack at any time.

Good

Child and adolescent mental health wards

- The patient handbook encouraged patients to decorate their own rooms with photos, posters and anything that would help them to feel at home. Patients could also bring their own pillow and duvet covers if they wanted to.
- There was a school on site that patients attended during the week. The school liaised with each patient's own school to facilitate continuing education. Activities took place in the evening and at weekends. These were arranged by the activities co-ordinator and included a music group, arts and crafts group and a gardening group. One patient told us that activities were led by the interests of the patients.

Meeting the needs of all people who use the service

- Admission to the ward would be based on assessment of the patient's condition. Other sites in the Priory Group offered full disability access.
- The ward had a contract with an interpreting service and bought in translators for CPA meetings. Interpreters were used when assessing a patient and reading the patient's rights to them.
- Patients were asked about their dietary requirements on admission. Vegetarian options were available at all meals. Meals could also be prepared in accordance with religious and cultural needs. A dietician was allocated to the ward.
- A chaplain visited the ward to provide spiritual support. The chaplain was able to organise visits from other religious representatives. A chaplaincy leaflet was displayed on the notice board giving details of monthly visits.

Listening to and learning from concerns and complaints

- There had been three complaints between 30 October 2014 and 9 November 2015. All three complaints had been upheld.
- Information about how to complain was included in the handbook for parents and carers. Patients told us that if they had a complaint they would speak to the ward manager. One patient said they did not feel listened to when they raised concerns about staff.
- The ward manager provided two examples of changes that had been made following complaints. One complaint was about a member of staff falling asleep on the night shift. This led to checks to ensure that all staff understood the importance of observations and constant assessments of patients and the importance of engagement with patients. Another patient complained that there was not enough room to store their property. As a result, additional storage was being fitted in all of the bedrooms.

Are child and adolescent mental health wards well-led?

Good

Vision and values

- Information produced by the hospital about this service highlighted the values of listening to young people, understanding their goals, involving young people and their families in treatment decisions, developing trust and building a safe framework for recovery. We found these values were shared by the staff and demonstrated in the delivery of services.
- The senior management team were described as friendly and approachable. Staff said they were visible and frequently visited the ward.

Good governance

- The ward manager was assisted by a ward clerk and felt supported by their manager, the deputy hospital director.

Leadership, morale and staff engagement

- The sickness rate for the ward was 2.3% and the staff turnover rate was 46%
- Staff said they were aware of the procedure for whistle blowing
- Staff provided mixed views on levels of morale within the staff team. One HCA said that a lot of staff had left because morale was generally poor, that the managers were unapproachable and that the approach to taking leave and swapping shifts was unnecessarily inflexible. Another HCA said the immediate management was supportive and they had always been able to swap shifts when they needed to.

Requires improvement

Specialist eating disorder services

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

Are specialist eating disorder services safe?

Requires improvement

Safe and clean environment

- Upper Court was a ward for up to 13 women with eating disorders. It was on the first floor of the main hospital building. There were two rooms identified for patients at higher risk of self-harm which were located near to the nurses' office. There was good visibility in the main ward area although there were some blind spots due to the layout of the building.
- The ward had an up to date ligature risk assessment completed in November 2015. Ligature risks were identified in the bedrooms. When patients were admitted the risks were checked and the room assessment was linked to their notes so that staff providing care to patients could have an understanding of the specific risks in the room. However, these ligature risk assessments did not state how identified risks would be addressed. Staff mitigated risks from ligatures through agreeing levels of staff observation based on the individual needs of the patients.
- Priory Court was a ward for children and young people up to 18 years old. The ward had accommodation for up 19 patients arranged over two floors. There were comprehensive ligature risk assessments available on the ward. These assessments said how the risks would be mitigated.
- Priory Court was a mixed ward with both male and female young people. It was designed to meet the Department of Health guidance relating to same sex accommodation. There were separate lounge areas for male and female patients. The rooms had en-suite facilities and there were separate bath and toilet facilities in the ward for males and females.
- Upper Court and Priory Court had access to clinic rooms with emergency medicines. There was a defibrillator on Upper Court. This was regularly checked. The weighing scales which patients used to check their weight regularly had not been calibrated for over a year.
- Due to the small size of the clinic room, a clinic room in an adjoining ward was occasionally used to administer medicines. This meant that patients moved from one ward into another ward on occasion. The clinic room on Upper Court was not large enough to have an examination couch so examinations and blood tests were taken in patients' bedrooms. When nasogastric feeding took place, this was done in the therapy room.
- There was a hospital-wide infection control lead and regular infection control audits which were completed. Upper Court had a nurse designated as the infection control lead whose role was to ensure that actions from the audit were implemented.
- The wards had an alarm system which activated through the hospital. This was functioning and ensured that immediate support was available in an emergency.

Safe staffing

- The hospital managers used an established tool to determine the staffing levels on the wards we visited. This ensured that there was a minimum of three

members of staff to one patient. This equated to a minimum of two nurses on both day and night shifts. Additional staff were brought in to cover one to one observations.

- The hospital provided data on staffing levels for the three months prior to the inspection, from the 16 November 2015 to 21 February 2016. During this period the correct numbers of staff had been working on Upper Court for only 77% of day shifts and 55% of day shifts on Priory Court. On night shifts, the full quota was only achieved on 68% of shifts on Upper Court and 68% on Priory Court. Agency staff were used on 37% of day shifts at Upper Court and 38% of day shifts on Priory Court. The figure for night shifts was 51% on Priory Court and 42% on Upper Court.
- Ward managers told us that when they book temporary staff, they try to ensure that regular staff are provided who are familiar with the ward. However, on Priory Court, two patients told us that patients groups were sometimes cancelled when staff were busy and four patients said that the patients' escorted walks were sometimes late when nurses were busy. Two health care assistants on Priory Court told us that they were sometimes left alone on shifts with agency nursing staff who were not familiar with the ward. We saw that agency staff had an induction checklist which ensured that they had basic information about the ward and hospital policies.
- The hospital had medical cover, including an onsite out-of-hours doctor. During working hours, each of the wards had consultants and a junior doctor allocated to the wards. At the weekend and overnight, there was a doctor allocated to cover the hospital site in its entirety.
- Staff we spoke with confirmed that they had accessed mandatory training. On 18 November 2015, the mandatory training compliance rate was 90% on Upper Court and 87% on Priory Court. There were also sessions where an emergency was simulated, so that staff could practice their learning, such as the use of skills in resuscitating patients.

Assessing and managing risk to patients and staff

- Between May 2015 and October 2015 there were 47 incidents of restraint on Priory Court which involved nine patients. None of these restraints were in the prone position. On Upper Court there were 29 incidents of restraint involving three patients. None of these restraints were in the prone position.
- Staff on the wards undertook training in safe restraint as well as an additional training course in de-escalation techniques which included verbal de-escalation. Staff we spoke with told us that they found this training useful.
- We checked the records of eleven patients. Risk assessments had been completed on admission, were thorough and regularly updated. The risk assessment section on the electronic record system had a pro-forma set of questions which established risk domains. Risks specific to eating disorder services where not part of the pro-forma so staff completed a free text section to highlight these.
- Some information, including physical observation records, was held on both the electronic record and in paper files. On Upper Court, the physical observations completed when the patient was admitted had a paper record that had not been electronically stored.
- There were some blanket restrictions in place on the ward which reflected the patients' needs. For example, bedrooms doors were locked during the day. On Upper Court, we saw that despite these blanket restrictions being in place, there were circumstances when these restrictions were not imposed due to the individual needs of patients. For example, one patient who needed time in their room to study was able to have their room unlocked as an exception.
- Staff we spoke with had received safeguarding training relating to both children and adults as a part of their mandatory training and induction. There was a safeguarding lead for the hospital who was a social worker, as well as a lead doctor and a lead nurse. This meant that staff were aware of someone who they could contact with safeguarding queries.
- Medicines were stored securely in designated cupboards and medicines trolleys. The medicines storage areas were clearly labelled in the locked clinic rooms. The clinic rooms were clean and well kept. There were sinks available for handwashing, as well as adequate space available for preparing medication. Processes were in place for the disposal of medicines

and satisfactory records were kept. The pharmacy service was provided by an external organisation. A regular pharmacist visited the hospital twice a week, reviewed all the drug charts and conducted regular audits of the clinic rooms. All the nurses said that the support from the pharmacist was very valuable.

Track record on safety

- In the six months prior to the inspection, there were no incidents in the eating disorders services that were classified as serious incidents. However, in the 13 months prior to the inspection there were 391 other incidents across the two wards. On Priory Court there were 95 incidents of self-harm, including attempted suicide and self-inflicted injury, 21 incidents of inappropriate behaviour and 14 incidents of patients absconding. On Upper Court there were 35 incidents of absconding and a further 28 attempts to abscond. There were 23 incidents of inappropriate behaviour and 25 incidents of self-harm.

Reporting incidents and learning from when things go wrong

- Staff we spoke with on the eating disorders wards were aware of the process to report incidents. There was an online incident reporting system in place throughout the hospital.
- Staff were aware that there was a different procedure to report incidents of restraint which took place as a result of planned naso-gastric feeding. We saw that these incidents were comprehensively recorded.
- Ward managers were sent a weekly summary of all the incidents which were reported across the hospital. We saw these summaries on the ward and ward managers used them to ensure that information was shared with the staff team, including learning from incidents.
- Staff and patients told us that debriefing sessions took place when there were incidents on the ward. The hospital had introduced a peripatetic debrief team which consisted of five members of staff from the therapy team. They were available to assist with debriefing and provide additional support to patients and staff after incidents on the wards.
- Changes had taken place on the wards following incidents. For example, there was a review of searching policies and additional training for staff related to carrying out searches of patients following an incident where contraband items were brought onto Priory Court.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- Patients were assessed on admission and initial care plans were completed within 72 hours. Where admissions were planned, assessment visits to patients took place before admission. For emergency admissions, information, including a risk assessment, was completed by referring organisations.
- We looked at eleven patient records across the two wards. Comprehensive care plans were completed. Patient's views were incorporated into the care plans. Patients were aware of their care plans, and either had copies or had been offered copies.
- Care planning included specific areas such as dietetic needs and physical health care needs as well as psychosocial needs. We saw that these were determined by individual patient need. For example, we saw that a specific care plan about the use of social media was in place based on the needs of an individual. We also saw that there were specific care plans related to patients who were reliant on naso-gastric feeding including the circumstances in which restraint should be used which had been discussed with patients.

Best practice in treatment and care

- The hospital offered a wide range of therapeutic interventions, including cognitive behavioural therapy, dialectical behavioural therapy and other group and individual work including food behavioural groups and contemplating change groups. Some group work took place in the therapy department but each ward also had a group room where some group work and therapy took place, particularly for patients who were too unwell to leave the ward.

Requires improvement

Specialist eating disorder services

- Patients on both wards had access to family therapy support in line with National Institute for Health and Care Excellence (NICE) guidance for eating disorders services.
- Staff used a number of outcome measures to determine the effectiveness of the care and treatment. This included health of the nation outcome scales and a specifically adapted version for children and young people. On Priory Court, the staff used the children's global assessment score as an additional measure. Across both wards, the hospital used the recognised eating disorder examination questionnaire to measure people's progress towards recovery.
- Each ward used these outcome measures on admission and discharge as well as through the admission period, and the results were compared to similar wards across the Priory Hospital Group. These measures were also considered by clinicians individually and used to develop effective care plans.
- Staff were familiar with the guidance set out in the managing really sick patients with anorexia nervosa (Marsipan) documentation and the junior version of this. The service linked with a local Marsipan group based at St George's Hospital, a local acute trust to ensure that information was shared between the organisations.
- The service had two dieticians who worked across the wards. Patients were offered support from a dietician on admission. Dieticians offered both group and individual support.
- Patients had access to support from clinical psychologists who were attached to the wards. They provided individual and group sessions.
- Clinical staff carried out local audits. For example, one of the ward doctors was undertaking an audit of the recording of physical health checks on admission. This meant that staff were engaged in using audits processes to improve the quality of care on the wards.

Skilled staff to deliver care

- Each ward had a multidisciplinary team which included nursing and medical staff, clinical psychologists, family therapists, dieticians and therapists. The hospital had a social worker and a pharmacist. Priory Court had a ward occupational therapist and activity coordinators.
- There was no occupational therapist assigned to Upper Court at the time of our visit. This was identified as a concern from some of the staff. Patients could access support from an occupational therapist based on a different ward, but some areas of support, such cookery sessions were not being provided.
- Health care assistants provided key working sessions for patients on both the wards. As part of these sessions, they updated risk assessments and care plans. One health care assistant on Upper Court told us that they completed risk assessments but had not received specific training related to how to do this. This meant that there was a risk that staff were not provided with sufficient training to complete all the tasks which they were asked to do.
- The hospital has a comprehensive induction. We spoke with four members of staff who had completed the induction over the previous year. They told us that it consisted of classroom learning and shadowing experienced staff. They felt that it prepared from for their role on the wards. Upper Court had an induction file in the nursing office containing a summary of important information and policies. This was readily accessible for all staff. There was also a checklist for temporary members of staff who were new to the ward to complete on their first shifts. On Priory Court, we saw that new staff completed a competency checklist relating to observations and medications to ensure that they had an understanding when they were on the unit.
- We reviewed 22 supervision records for staff across the hospital. There was a clear process followed in supervision with information about updates and developments being given by the supervisee to the supervisor. Follow up actions from each supervision session were agreed and documented. Supervision records were stored securely and kept confidential
- Compliance rates for mandatory training were 90% on Upper Court and 87% on Priory Court.
- Staff told us that they had opportunities to access additional training. We saw that supervision took place regularly and staff had both clinical and management supervision. This was more consistent on Upper Court. On Priory Court there were some members of staff who

had not had monthly management supervision recorded. However, staff told us that they were able to access their managers for support as necessary. Staff had completed annual appraisals.

- The hospital had initiated a specific training programme which ran over six months specifically supporting staff who worked in eating disorders services. This was accredited by the University of Brighton. Staff who had completed this course spoke very positively about it and the impact that it had on their work, particularly nursing staff.
- Upper Court undertook ward-specific training. There was a rolling schedule of meetings and training slots over a four week period so one week there was a business meeting, one week there as a case discussion, one week training on a specific issue and one week a team meeting. This meant that training could be tailored to meet the needs of the ward staff.

Multi-disciplinary and inter-agency team work

- We observed multidisciplinary meetings on both wards. We saw that the teams were effective in using the different professional skills and knowledge within the meetings. Staff showed a thorough understanding of individual patients' needs.
- The hospital had close working relationships with services in Surrey as a number of referrals came from that part of the country. They also told us that they worked very well with some of the local London mental health trusts. The ward staff invited staff from local community teams to ward rounds and care programme approach (CPA) review meetings. They also ensured that local teams were provided with updated information.
- On Upper Court, the organisation of staff teams had changed in the months prior to our inspection. Separate ward rounds and management rounds had been introduced to distinguish between the day to day management of needs and concerns of patients and the longer term planning. Staff were positive about this change.
- Handovers took place between staff on each shift. These were recorded on the ward with information shared about current risk levels and observations levels of all the patients on the ward to ensure that current information was shared between shifts.

Adherence to the MHA and the MHA Code of Practice

- As part of this inspection we conducted a Mental Health Act (MHA) review of Upper Court. Three patients were detained under the MHA. They all spoke positively about the service. Medication charts showed that all treatment was being given under an appropriate legal authority. The responsible clinician had recorded their assessment of patients' capacity to consent at (or near to) the first administration of treatment for mental disorder. However in the ward round notes where there were records of ongoing capacity assessments it was not clearly stated what the capacity assessments were for.
- Staff had accessed Mental Health Act training. They knew how to seek advice if they had any questions.
- We saw that patients who were not detained formally under the Mental Health Act (1983) were given information about their status as 'informal' patients. The specialist registrar said that the competency and capacity of informal patients was assessed on admission and reviewed in relation to specific decisions. If informal patients wanted to leave the ward this would be discussed with the patient and their family.
- We saw that an error had been made on Mental Health Act documents, meaning that the patient was not lawfully detained. These documents had not been properly scrutinised. When the ward became aware of this, they used the doctor's holding powers under section 5(2) immediately and a Mental Health Act assessment was arranged. We saw that staff had informed the patient and their family as soon as they had become aware of this error.

Good practice in applying the MCA

- Staff on the ward had a good understanding of the day to day use of the Mental Capacity Act. The consultant psychiatrist showed a very clear understanding of Gillick competency and this was also reflected across the staff team. Two health care assistants said that would speak to doctor or nurse if an informal patient asked to leave. However, there were no evidence of competency being assessed in the records that we reviewed
- Staff were aware of how to access support or advice relating to the Mental Capacity Act if needed.

Requires improvement

Specialist eating disorder services

Are specialist eating disorder services caring?

Good

Kindness, dignity, respect and support

- We observed staff on both wards providing care and assistance to patients with kindness and compassion. Staff spoke about patients with respect. Patients we spoke with reported that staff were respectful towards them and caring.
- Patients knew who their keyworkers were and told us that they found their keyworking relationships supportive. If their keyworker was not working on a shift, they were aware of who the back-up keyworker was.
- Two patients on Priory Court told us that found it more difficult to speak with some of the unfamiliar agency staff who worked during night shifts.
- Upper Court had an anonymous feedback box which ensured that patients who felt less comfortable speaking up in a community meeting were able to provide feedback.

The involvement of people in the care they receive

- Each ward had a weekly community meeting. Minutes of these meetings were available to patients. We reviewed the minutes from these meetings over the previous six months. Patients were given the opportunity to raise concerns regularly. On Upper Court, there was a monthly summary of actions arising from the community meetings with a 'You said, We did' format so that patients on the ward could track through changes as a result of the meetings. We saw an example of ordering more cutlery when it was raised on the ward that this was running low.
- Patients had the opportunity to complete a form before their ward round setting out the matters that they would like discussed in the meeting.
- Patients were also involved in assessment centres to recruit new staff. When patients did not wish to be actively involved in interviews, staff asked them to identify lists of questions for potential new staff, ensuring that there was still a patient voice in the recruitment of staff.
- There was a weekly families/carers group which ran across both wards. This provided opportunities to give feedback the service. Training was also provided in these sessions. For example, before Christmas, there had been a pre-Christmas support group to look specifically at supporting people over the holiday period.

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Are specialist eating disorder services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- There were no delayed discharges at the hospital between 18 May 2015 and 18 November 2015.
- On Upper Court, admissions were planned to take place at 10am and 2pm, allowing sufficient time to admit a patient. There was also scope for emergency admissions which could happen at any time. In these circumstances an out-of-hours doctor was available on site to admit the patient.
- Discharges from the service were planned with community teams in the patient's local area. We saw that discharge was planned from admission and patients on Upper Court had discharge care plans when possible.

The facilities promote recovery, comfort, dignity and confidentiality

- Priory Court was located in a purpose built building within the hospital grounds. It was spread over two levels with a lounge area on both levels. There was a treatment room and two therapy rooms. The building had a lift so that people with limited mobility could access the ward. There were also rooms which could be used for individual therapy.

Requires improvement

Specialist eating disorder services

- Upper Court was located in an older part of the hospital on the first floor. There was no lift access and there were steps within the ward which meant that it was not accessible for someone who relied on a wheelchair.
- Both wards had dining rooms. The dining room on Upper Court did not have cooking facilities. However, patients progressed to the main dining room in the hospital as they moved through their recovery programme. Patients from Upper Court used the assisted kitchen on Priory Court as a part of their therapeutic programme.
- The clinic room on Upper Court was very small. This meant that there was no examination couch in the clinic area and there was no space to administer nasogastric feeding tubes.
- Patients who needed nutrition delivered through nasogastric tubes were treated in the group therapy room in Upper Court. This was not a suitable environment as patients may have been restrained to have this treatment at times and therefore the therapeutic environment may be jeopardised. As there was no examination couch in the clinic room, some medical examinations took place either in patients' bedrooms or in the clinic room for the adjoining ward.
- Staff on Upper Court told us that there were plans to change the configuration of the ward so that a therapy room near the nursing office would become a safer room to accommodate high risk patients.
- There was a broad activity programme across the two wards with therapy sessions and leisure activities as well as a school for young people. This programme ran over six days a week from Monday to Saturday.
- There was a school on site with three teachers and two teaching assistants. This school liaised with young person's own school to ensure that education objectives were consistent. Young people were positive in their feedback about the education services.
- There was a chaplaincy service available on site. The chaplain could access spiritual support for a number of religions as necessary.

Meeting the needs of all people who use the service

- Information was available on the wards regarding advocacy services, complaints and people had access to a welcome pack with relevant information when they were admitted to the ward.
- Patients were able to choose menus which were appropriate to their religious and cultural needs. For example, halal food was available.
- Staff on Upper Court were sensitive to the sexual orientation of patients and were able to give examples of how patients who identified as lesbian or bisexual were supported.
- Staff had access to interpreters including British sign language interpreters.

Listening to and learning from concerns and complaints

- On Upper Court there had been eight complaints in the year from 30 October 2014 to 9 November 2015. Six of these complaints had been upheld. On Priory Court there had been six complaints in the same period, of which one was upheld.
- Staff on the wards told us that they were familiar with the procedures for formal and informal complaints. They told us that they received feedback about informal complaints and learnt from them. We were told about examples on Priory Court where there had been a discussion about boundaries which had led to learning within the team following an informal complaint. On Upper Court we were told about a complaint about the catering service. This had led to changes and a meeting taking place regularly with the catering staff to ensure that there was a better understanding of the needs of the patient group.
- Patients were aware of how to make complaints and told us that they would feel confident a making a complaint about the service.

Are specialist eating disorder services well-led?

Good

Vision and values

Requires improvement

Specialist eating disorder services

- Upper Court had a ward specific philosophy of care. This was set out in the information given to staff, patients and families when they first arrived on the ward.
- Staff spoke positively about the leadership team at the hospital. There had been a recent change in hospital director. Staff spoke positively about the visibility and the availability of the new director. There was less knowledge of leadership across the Priory Group.

Good governance

- Ward managers had a good understanding of the strengths of their wards and where there was additional work that needed to be done. Information about staffing numbers, including training needs of staff was collected centrally and shared with ward managers.
- Feedback from incidents, complaints and audits were discussed at team meetings and used to improve services.
- The hospital had a daily flash meeting in the morning where all the ward managers met to discuss immediate issues and concerns. This ensured that information relevant to the provision of care was shared promptly and that there was regular communication between ward managers.

Leadership, morale and staff engagement

- On Upper Court, the sickness rate for permanent staff was 1.7%. On Priory Court this figure was 1%. The percentage of permanent staff who had left between 1 November 2014 and 1 November 2015 was 78% on Upper Court and 74% on Priory Court.
- Staff were very positive about the local support they received from their immediate line managers. Staff told us that the management in the hospital were very responsive. For example, on Upper Court the ward manager told the hospital director that there needed to be additional capacity for clinical supervision for staff and this was addressed immediately.
- The hospital offered specific leadership development training for ward managers. Ward managers who accessed this told us that they found this helpful
- The hospital held a 'your say' forum for staff to provide feedback to senior managers. Each ward nominated representatives. There was also a forum across the Priory group to which the hospital sent representatives.
- The hospital had a weekly open door 'coffee and catch up' whereby any member of staff could meet with the senior hospital management.

Commitment to quality improvement and innovation

- The eating disorders service took part in peer reviews and was working towards being accredited with the Royal College of Psychiatrists quality network for eating disorder services. In February 2016, both wards had received accreditation visits but had not yet received feedback. Both the ward managers told us about changes they had been able to make as a result of being part of this peer network.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff turnover is reduced and more permanent staff are employed to provide consistency of care.
- The provider must progress work to improve the safety of the physical environment.
- The provider must consider if patients with a high risk of self-harm should be admitted to an environment where it is hard for staff to observe patients.
- The provider must ensure that incidents are recorded correctly so the information can be used to monitor and improve the service.
- The provider must ensure that informal patients are able to leave the hospital in line with their legal status.
- The provider must review staff engagement to ensure that staff working in the acute wards are able to raise concerns
- The provider must ensure that a suitable environment is available when patients require nutrition to be delivered through nasogastric tubes and that there is a suitable environment for the physical examination of patients on each ward
- The provider must ensure that personal log-in details of permanent staff are not shared with agency staff.

Action the provider SHOULD take to improve

- The provider should ensure that same sex accommodation is provided at all times on the mixed gender acute wards.
- The provider should ensure patients detained under the Mental Health Act have access to an independent mental health advocate.
- The provider should ensure that health care assistants have training on completing documents such as care plans and risk assessments.
- The provider should ensure that female patients can where possible have their close observation carried out by staff of the same gender to preserve their privacy and dignity.
- The provider should ensure that learning from incidents is shared across wards.
- The provider should ensure that community meetings on the CAMHS unit happen each week as planned.

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
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent Care and treatment of service users must only be provided with the consent of the relevant person. Informal patients were only able to leave the ward if this was authorised by their psychiatrist. We did not find evidence to show that patients were consenting to this restriction on their liberty. This was a breach of regulation 11(1).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for the patients. There had been two inpatient deaths and many other incidents involving self-harm. Many patients admitted to the hospital had complex needs and high risks of self-harm and the provider was not keeping them safe. This was a breach of regulation 12(1).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment All premises must be suitable for the purposes for which they are being used.

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	We found that there were ligature points throughout the hospital. Further work needed to take place to improve the safety of the physical environment. Patients who needed nutrition delivered through nasogastric tubes were treated in the group therapy room in Upper Court. This was not a suitable environment as patients may have been restrained to have this treatment at times and therefore the therapeutic environment may be jeopardised. This was a breach of regulation 15(1).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to ensure compliance. This includes systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients. Incidents were not being recorded correctly so the information was not complete to monitor and improve the service. Systems for staff engagement were not working effectively as staff did not feel able to raise concerns knowing they would be supported and improvements made. Personal log-in details of permanent staff were routinely shared with agency staff which could compromise the security of patient records. This was a breach of regulation 17(1)(2).

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing There must be sufficient numbers of suitably qualified, competent, skilled and experienced persons.

This section is primarily information for the provider

Requirement notices

Diagnostic and screening procedures

Treatment of disease, disorder or injury

There were high numbers of staff vacancies, especially qualified nurses. There was a high use of temporary staff. There was a significant staff turnover. This meant that there were not always sufficient staff or consistent staff who knew the service and the patients.

This was a breach of regulation 18(1).