Priory Healthcare Limited

The Priory Hospital Bristol

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Good
Are services safe?	Requires Improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Overall summary

The Priory Hospital Bristol is an independent hospital registered to provide care and treatment for up to 85 people with mental health conditions.

Our rating of this location stayed the same. We rated it as good because:

• All of the ward teams included or had access to a range of specialists. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

• Generally, the hospital provided a range of care and treatments suitable to the needs of the patients and in line with national guidance about best practice.

• The hospital generally provided safe care and patient areas in all wards were clean.

• Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

• Patients told us that staff explored their goals and they felt that staff were passionate about supporting them to achieve these.

• Staff said they felt valued by the organisation. They felt able to give feedback and senior managers were visible in wards.

• We found improvements in the management of safeguarding procedures. A safeguarding lead was appointed creating full oversight. Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

• Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

• Staff felt respected, supported and valued. They said the hospital promoted equality and diversity in daily work and provided opportunities for development and career progression.

However,

• Audits about the cleaning of the clinical rooms were not robust in identifying shortfalls. Clinic rooms needed cleaning

and were poorly organised. Checks on emergency equipment were not being completed and key items, such as defibrillations pads were missing for the emergency bags and some emergency medicine were missing.

• There were outstanding maintenance issues in the long stay and rehabilitation wards. For example, broken viewing panel in a bedroom, two bedrooms used for storage and broken automatic door stops.

Summary of findings

• Patients in all acute and long stay wards had limited opportunities for occupational therapies due to occupational therapist (OT) vacancies.

• Registered nurse vacancies were currently at 60% across the hospital. Although recruitment for substantive staff was ongoing this resulted in difficulties covering shifts of registered nurses. Despite attempts at securing bank and agency staff to cover vacancies the number of registered nurses on each ward could not always be maintained and addition health care assistants were used to cover gaps to support patient care. We were told agency staff didn't have access to patient's electronic care records.

• A range of patient records were not always comprehensive or updated regularly. This included risk assessments, care plans and mental capacity assessment records. Risk assessments or care plans in the psychiatric intensive care unit (PICU) lacked detail on how staff were to de-escalate or the least restrictive measures to take when patients behaviours placed them and others at risk of harm. Care plans in acute, PICU, long stay and rehabilitations wards did not always include meaningful discharge plans. In addition, they were not always personalised and in the rehabilitation wards goal setting was not always clear and in progress towards recovery was not always evident.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Specialist eating disorder services	Good 	• The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding • Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided. • The ward teams included or had access to a range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare. • Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. • Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions. • Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason. • The service worked to a recognised model of mental health rehabilitation. It was well led, and the governance processes ensured that ward procedures ran smoothly. However, • Audits about the cleaning of the clinical rooms were not robust in identifying shortfalls. Clinic rooms needed cleaning and were poorly organised. Checks on emergency equipment were not being completed and key items were missing for the emergency bags and some emergency medicine were missing.
Long stay or rehabilitation	Good 	Our rating of this service stayed the same. We rated it good:

Summary of findings

mental health wards for working age adults

- The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients cared for in a mental health rehabilitation ward and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to a range of specialists required to meet the needs of patients on the wards. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
- Staff planned and managed discharge well and liaised well with services that would provide aftercare. As a result, discharge was rarely delayed for other than a clinical reason.
- The service worked to a recognised model of mental health rehabilitation. It was well led, and the governance processes ensured that ward procedures ran smoothly.

However,

- Audits about the cleaning of the clinical rooms were not robust in identifying shortfalls. Clinic rooms needed cleaning and were poorly organised. Checks on emergency equipment were not being completed and key items were missing for the emergency bags and some emergency medicine were missing.

Summary of findings

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

Good 

Our rating of this service went up. We rated it as good

- The service provided safe care. The patient areas were safe and clean. Staff minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Generally, the hospital provided a range of care and treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff undertook robust risk assessments and assessments of needs.
- The ward teams included or had access to a range specialist. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decision.
- Staff felt respected, supported and valued. They knew and understood the provider's vision and values and how they applied to the work of their team.
- Our findings from this inspection demonstrated there were improvements in governance processes which generally operated effectively at team level.

However,

- Audits about the cleaning of the clinical rooms were not robust in identifying shortfalls. Clinic rooms needed cleaning and were poorly organised. Checks on emergency equipment were not being completed and key items, such as defibrillations pads, were missing for the emergency bags and some emergency medicine were missing.
- The recruitment for substantive registered staff was an ongoing challenge resulting in difficulties covering shifts of registered nurses. Resulted in the loss of a number of regular registered nurse agency staff meaning that health care supporter workers were often used to cover for registered nurses; wards that required two registered nurses were

Summary of findings

often left with only one registered nurse. This resulted in the registered nurse not having time to complete documentation robustly and the lack of therapeutic activities.

- Some patients told us that there was a lack of therapeutic activities on the wards and they sometimes did not get their Section 17 leave. We saw that there was a lack of a structured programme of activities on a day to day basis.
- Patients' legal status was not always listed in their care records. A record of when patients were informed of their section 132 rights under the Mental Health Act (MHA) should be maintained.
- The service did not develop care plans which included meaningful discharge planning. Goal setting and documentation of progress made towards recovery was not documented or that patients had received a copy of their care plan.
- Risk assessments or care plans lacked detail on how staff were to de-escalate or the least restrictive measures to take when patients behaviours placed them and others at risk of harm.
- The records for patients assessed as lacking capacity did not demonstrate consultations, as part of best interest decisions, were reached with the patient, decision makers or professionals.
- Notices telling informal patients they were free to leave the ward were not on display in all acute wards.

Summary of findings

Contents

Summary of this inspection

Background to The Priory Hospital Bristol

The Priory Hospital Bristol is an independent hospital registered to provide care and treatment for up to 85 people with mental health conditions. The hospital is registered to provide the following regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury.

Patients detained under the Mental Health Act 1983 were admitted and were provided care and treatment in the following core services:

• Long stay/rehabilitation wards

• Acute inpatient units and a psychiatric intensive care unit (PICU)

• Eating disorder service

The long stay and rehabilitation wards for working age adults comprised:

• Hillside Ward: mixed gender ward for people who required mental health rehabilitative care.

• Oak Lodge Ward: Male ward for people with dementia or Huntington's disease and complex care needs. This ward accepted admissions for working age men as well as older men if the patient was appropriate for the care environment.

Acute inpatient units and a psychiatric intensive care unit (PICU): Acute wards comprise:

• Redcliffe Ward all male ward,

• Blackwell Ward

• Walter Ward (a mixed gender ward)

• Purdown (all male PICU) Acute mental health inpatient units.

Eating disorder service.

• Lotus ward:10-bed ward for men and women who required treatment for eating disorders.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Summary of this inspection

At the previous focussed inspection in September 2020 we took enforcement action under Section 31 of the Health and Social Care Act 2008 and placed conditions on the providers registration.

During the current inspection we saw that the provider had made enough improvements and so we invited the provider to apply to have the conditions removed. The provider was successful with their application to remove conditions on their registration. These were removed on 15 June 2021.

All requirement notices, which identify the improvements the provider must make to meet legal requirements, from the previous focussed inspection had been met and related to Regulation 9 (Person-centred care), 12 (Safe care and treatment), 15 (Premises and equipment), the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

What people who use the service say

Two of the three patients we spoke with in acute wards described the criteria for their admission and the conditions which referred to their detention. They praised staff that were working permanently at the hospital and told us the staff understood their conditions. They said the staff helped them make informed decisions. One patient gave us an example of the kindness from staff to support a smooth transition to the hospital.

Patients in long stay and rehabilitation wards said staff treated them well and behaved appropriately towards them.

Patients said staff treated them with dignity and respect and they listened to them. Patients said staff responded well to them with the right care at the right time. Patients said they 'couldn't fault staff' and that they were 'brilliant'. Patients said that staff explained things to them when they did not understand and helped them fill out forms. Patients said staff were always interested and involved in their care.

Patients in the eating disorder wards told us they felt safe and found it a supportive atmosphere. Patients said they were involved in their care planning and had a copy shared with them.

Patients in the eating disorder ward told us they received therapy which was effective and meaningful for them.

Patients in long stay and rehabilitation wards told us that there were regular staff, which improved consistency and patient experience. However, patients felt the night staff were not always familiar to them. All the patients we spoke with, told us the dietician that supports them is extremely personable, approachable and has had a profound effect on their recovery.

Patients told us that staff explored their goals and they felt the service was passionate about supporting them to achieve these

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?

Summary of this inspection

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the location,

During the inspection visit, the inspection team:

• spoke with the registered manager, clinical director, medical director and regional director

• spoke with three patients during the inspection and we received completed feedback cards from six patients

• spoke with 27 staff members, including ward managers and deputy managers, consultant psychiatrists, occupational therapists and physiotherapists, nurses and health care support workers

• looked at five staff records from across the hospital

• reviewed a number of accident and incident reports and the lessons learnt from these

• looked at quality assurance audits

• looked at a range of policies, procedures and other documents related to the running of the hospital and each of the core services

• visited each of the wards and looked at the quality of the environment including the clinic and treatment rooms

• looked at 54 care records of patients including medications records

• attended a patient group meeting, multidisciplinary team meetings, two therapy sessions and a staff handover session

• observed the care and support provided and interactions between patients, visitors and staff throughout the inspection

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

Areas for improvement

The provider should carry out the required maintenance on long stay and rehabilitation.

• The provider should continue to review their staffing levels to ensure sufficient numbers of skilled and competent staff are deployed to fulfil the staffing requirements.

Summary of this inspection

• The provider should ensure that all patient documentation is comprehensive, personalised, reflects all patients needs and goals and is regularly updated.

• The provider should ensure that care plans for patients in active rehabilitation are recovery-orientated and include meaningful discharge planning.

• The provider should ensure that all patients detained under the Mental Health Act have their rights explained on a regular basis and this should be documented.

• The provider should ensure that patients lacking capacity to make decisions are involved in the assessment and decision making process and this should be documented.

• The provider should ensure that risk assessments or care plans in PICU detail how staff were to de-escalate or the least restrictive measures to take when patients behaviours placed them and others at risk of harm.

• The provider should ensure it can clearly articulate its model of care for rehabilitation and long stay patients and ensure this is effectively implemented.

• The provider should ensure that patients have access to the outdoor garden in long stay and rehabilitation wards.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Specialist eating disorder services	Requires Improvement	Good	Good	Good	Good	Good
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Good	Good
Long stay or rehabilitation mental health wards for working age adults	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Specialist eating disorder services

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

Are Specialist eating disorder services safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement:

Safe and clean ward environment

- The clinic room and treatment room were not clean. We found a clinical waste disposal bin with no bag fitted in it, with stale blood stains on the lid and the inside of the bin. We raised this with the management team and the bin had been removed the next day and replaced with a clean bin with a waste disposal bag loosely inserted inside.
- There were no cleaning records available for either the clinic room or treatment rooms. We were told by staff that the cleaning of the clinic and treatment rooms was done as routine but there was no way of verifying that regular cleaning of the clinic room or treatment room took place. We raised this with staff, who said a specific cleaning rota for both rooms would be implemented imminently.
- Staff did regular risk assessments of the care environment. A ligature risk assessment had been completed, using a rating score.
- Ward layout allowed staff to observe all parts of ward. The ward is shaped in a square with four corridors and a courtyard in the middle. There are windows throughout the inner side of the building so staff could see across the ward. The service manages observation by staff presence and convex mirrors.
- There were no potential ligature anchor points – or staff had mitigated the risks adequately. All bedrooms were fitted with ligature-free furniture and fittings. Where ligature points had been identified in communal areas, staff had mitigated the risks appropriately.
- The ward complied with guidance on eliminating mixed-sex accommodation. The service is a 10-bedded unit with individual bedrooms for patients. The majority of patients were female and were allocated rooms on two adjoining corridors. There is one room at the start of the third corridor of the square shaped ward, which was reserved for male patients.

Maintenance, cleanliness and infection control

- Staff had not maintained clinic equipment well or kept it clean. Emergency resuscitation equipment and a suction machine were available, but we were not assured that staff checked these regularly as we found the emergency suction machine to be very dusty and the suction tube was stored on the floor. Records showed that the defibrillator had been checked monthly, however we found the pads had expired 10 months prior to the inspection. We raised both these issues with staff at the time of inspection.

- The clinic room was equipped with drugs but was not checked regularly. We found that the drugs cupboards were overstocked, and some blood collection bottles (vacutainers) had expired and were still being used.
- General equipment such as wheelchairs and weighing scales had been well maintained and kept clean.
- Most of the ward area was clean, had good furnishings and was well-maintained. The living space, bedrooms, corridors and therapy rooms were all clean and well kept.
- Most areas had cleaning records that were up to date and demonstrated that the ward areas were cleaned regularly.
- Staff adhered to infection control principles, including handwashing. There were antibacterial hand gel dispensers and face masks available throughout the ward. We saw that staff were cleaning wheelchairs after each use and there was a poster reminding staff to do this.

Safe Staffing

- Managers had calculated the number and grade of nurses and healthcare assistants required. During the day there were two qualified nurses and a minimum of four healthcare assistants (HCA's) on shift, and during the night this reduced to one nurse and a minimum of two HCA's. At the time of inspection there were two vacancies for qualified nurses.
- Staff rotas showed that the ward staffing matched the calculated staffing requirements.
- The ward manager could adjust staffing levels daily to take account of case mix. Extra staff had been sought in a timely manner when this was required.
- When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. The service rarely used agency healthcare assistants.
- When agency and bank nurses were used those staff received an induction and were familiar with the ward.
- A registered nurse was always present in communal areas of the ward. The ward had at least one qualified nurse on shift throughout the day and night.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients we spoke with told us they were regularly having one-to-one time with their named nurse and felt these sessions were invaluable.
- Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. The staff delayed escorted leave for 10-15mins if the ward was busy.
- There were enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely (and staff had been trained to do so).

Medical Staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training. Staff we spoke with told us they had received mandatory training and had refresher training when required.
- Overall, staff in this service had undertaken 82.3% of the various elements of training that the provider had set as mandatory. This included basic life skills, Prevention and Management of Violence and Aggression (PMVA), safeguarding adults and children, infection control and safe handling of medications.

Assessing and managing risk to patients and staff

Assessment of patient Risk

- Staff did a risk assessment of every patient on admission and updated it regularly, including after every incident. Risk assessments were clearly visible in care records and regularly updated.

- Staff use a recognised risk assessment tool.

Management of patient risk

- Staff were aware of and dealt with any specific risk issues, such as malnutrition and skin integrity.
- Staff identified and responded to changing risks to, or by, patients.
- Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.
- Staff applied blanket restrictions on patients' freedom only when justified.
- Staff adhered to best practice in implementing a smoke-free policy.
- The service displayed a notice to tell informal patients that they could leave the ward freely. Patients who were informal knew their right to leave the ward at their will.

Use of restrictive interventions

- Staff used restraint in a planned way where this was clinically assessed.
- Staff used restraint only after de-escalation had failed and used correct techniques. Staff were able to explain how they used verbal de-escalation techniques to avoid restraint as much as safely possible.
- Staff understood and where appropriate worked within the Mental Capacity Act (MCA) definition of restraint.
- Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Rapid tranquilisation had not been used at the service since August 2020.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.
- Staff followed safe procedures for children visiting the ward.

Staff access to essential information

- The service used a combination of paper and electronic patient records.
- All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in as accessible form. This included when patients moved between teams.
- If staff were expected to record information in more than one system (paper or electronic), this did not cause them any difficulty in entering or accessing information.

Medicines Management

- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

- There was one serious incident in the last 12 months.

Reporting incidents and learning from when things go wrong

Good

Specialist eating disorder services

- All staff knew what incidents to report and how to report them.
- Staff reported all incidents that they should report.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.
- Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss this feedback. There is evidence that changes had been made as a result of feedback.
- Staff were debriefed and received support after a serious incident. However, some staff we spoke with told us that these were very brief and were not as beneficial as they could be.

Are Specialist eating disorder services effective?

Good

Our rating of effective stayed the same. We rated it as good :

Assessment of needs and planning of Care

- Staff completed a comprehensive mental health assessment of the patient in a timely manner, at, or soon after, admission. This was regularly reviewed and documented in patient's care records.
- Staff assessed patients' physical health needs in a timely manner during and after admission.
- Staff developed care plans that met the needs identified during assessment. Care plans in all records we reviewed were comprehensive and addressed the needs identified during the patients' assessment.
- Care plans were personalised, holistic, recovery orientated. Care plans were very detailed and showed that they had been individually personalised for each patient. Care plans included patients' views, encompassed all their needs and clearly described patients' strengths and goals.
- Care plans were regularly updated and clearly documented in patients' care records.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from NICE. Patients care and treatment was supported with medication and psychological therapies and, activities, training and exposure work intended to help patients acquire skills. Therapies included trauma-based therapy, family therapy and Eye Movement Desensitisation and Reprocessing (EMDR). EMDR is psychotherapy that enables patients to heal from the symptoms and emotional distress that are the result of disturbing life experiences.
- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Patients' had access to a dietician who supported them with meal plans and understanding why certain foods are offered and encouraged. Care records showed that physical healthcare of patients was being monitored regularly and appropriate support was in place to manage this.
- Staff had assessed and met patients' needs for food and drink and for specialist nutrition and hydration. We saw evidence of careful assessment of the patient's diet and supervision of the refeeding programme. Staff were trained in, and supported patients with enteral feeding for the duration this was clinically indicated as the most appropriate method for nutritional intake.
- Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, and dealing with issues relating to substance misuse.
- Staff used recognised rating scales to assess and record severity and outcomes (for example, Health of the Nation Outcomes Scales).

Good

Specialist eating disorder services

- Staff used technology to support patients effectively (for example, for prompt access to blood test results and online access to self-help tools).
- Staff participated in clinical audits, benchmarking and quality improvement initiatives.

Skilled staff to deliver care

- The team included or had access to the full range of specialists required to meet the needs of the patients on the ward. The ward team included clinical psychiatrists, an assistant clinical psychologist, integrative therapists, a dietician, a speciality doctor, occupational therapist, nurses and health care assistants. The ward was visited weekly by a pharmacist and social worker weekly.
- Staff were experienced and had the right skills and knowledge to meet the needs of the patient group.
- Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings.
- The percentage of staff that have had an appraisal in the last 12 months was 87%.
- The percentage of staff that received regular supervision was 86%.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.
- Managers ensured that staff received the necessary specialist training for their roles. Staff had received specific training to support their role in an eating disorder unit, such as nasogastric intubation (theory and practical), eating disorders, personality disorders and FFP3 mask fitting.
- Managers dealt with poor staff performance promptly and effectively. The management team had dealt with sub-standard staff performance appropriately, in a supportive and meaningful way.

Multidisciplinary and interagency team work

- Staff held regular and effective multidisciplinary team (MDT) meetings. Staff from all disciplines met once a week to review any patients waiting to be admitted and to plan discharges. Ward rounds were held twice a week to discuss all patients in detail.
- Staff shared information about patients at effective handover meetings within the team. Staff completed handover meetings before each shift change. These meetings were informative and covered all aspects of patients care and treatment.
- The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation.
- The ward teams had effective working relationships with teams outside the organisation. Staff had good working relationships with the local authority social services, community mental health teams and GPs. Care records showed that staff had regular contact with patients' care coordinators to inform them of patient progress and involve them in discharge planning.

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

- Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who their MHA administrators were.
- The provider had relevant policies and procedures that reflected the most recent guidance.
- Staff had easy access to local MHA policies and procedures and to the Code of Practice.
- Patients had easy access to information about independent mental health advocacy. Information was clearly displayed around the ward and patients were aware of the advocacy service.

Good

Specialist eating disorder services

- Staff explained to patients their rights under the MHA in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.
- The service displayed a notice to tell informal patients that they could leave the ward freely.
- Staff did regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

- Staff had a good understanding of the Mental Capacity Act (MCA), in particular the five statutory principles.
- The provider had a policy on the MCA, including Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the MCA.
- Staff took all practical steps to enable patients to make their own decisions. Care records clearly documented patients' mental capacity to make decisions and it was evident that patients had been supported to make their own decisions.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions.
- When patients lacked capacity, staff were aware of making decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. However, they rarely admitted patients who lacked capacity to make decisions in relation to their care and treatment.
- The service had arrangements to monitor adherence to the MCA.
- Staff audited the application of the MCA and acted on any learning that resulted from it.

Are Specialist eating disorder services caring?

Good

Our rating of caring stayed the same. We rated it as good :

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.
- Staff supported patients to understand and manage their care, treatment or condition. Patients we spoke with told us their care and treatment were individualised and staff always showed extra effort to help them achieve their recovery goals.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services. Patients had access to dentists, opticians and other physical health services in the community for routine appointments.
- Patients said staff treated them well and behaved appropriately towards them. All the patients we spoke with, or received feedback from, were highly complementary of the staff. Patients said staff were caring, respectful and the 'help and support had been faultless'.

Good

Specialist eating disorder services

- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Patients were assessed individually and there were examples of the service providing support for patients where a need was identified.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Patients we spoke with felt they could raise concerns and patients were encouraged to participate in improvement of the service. We saw one patient attended and provided valuable input into a clinical governance meeting during this inspection.
- Staff maintained the confidentiality of information about patients.

Involvement in Care

- Staff used the admission process to inform and orient patients to the ward and to the service. All patients were given a welcome pack which included information about the hospital, ward, staff, therapy, a typical weekly timetable and restricted items.
- Staff involved patients in care planning and risk assessment. This was evidenced in care plans, participation in multidisciplinary team reviews and access to a copy of their care plan. Patients told us they had an hour's session with the ward doctor in person before the weekly ward round, which gave them the opportunity to discuss their progress and treatment.
- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.
- Staff enabled patients to give feedback on the service they received. The service had various ways for patients and families to provide feedback including surveys, complaints and compliments procedures, community meetings and a letterbox.
- Staff ensured that patients could access advocacy. Patients we spoke with knew there was an advocacy service available but had not needed to access it during their care and treatment.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. Staff had involved families where they had consent to do this, and family visits were facilitated when this was assessed as safe and appropriate for patient recovery.
- Staff enabled families and carers to give feedback on the service they received. This was facilitated through surveys, complaints and compliments procedures and a letterbox.
- Staff provided carers with information about how to access a carer's assessment.

Are Specialist eating disorder services responsive?

Good

Our rating of responsive stayed the same. We rated it as good :

Access and discharge

- There was always a bed available when patients returned from leave. Patients bedrooms were assigned to them for the whole duration of their stay.

- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interest of the patient. This had happened on one occasion in a 12-month period prior to inspection and was clinically justified by the multidisciplinary team.
- When patients were moved or discharged, this happened at an appropriate time of day. Patients were made aware of any moves or discharges and were supported to plan for this and make arrangements where required.
- A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and this was sufficiently close for the person to maintain contact with family and friends. The hospital had a PICU unit on the same premises which could be accessed easily, in a timely manner with little disruption for the person.

Discharge and transfers of care

- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. We saw care coordinators were kept informed of patient's progress and they were involved in discharge planning. This was documented well within patient care records.
- Staff supported patients during referrals and transfers between services - for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. We saw an example of how staff had provided extensive support for a person transferring from Lotus ward to a PICU, following a rapid deterioration in their mental state.

Facilities that promote comfort, dignity and privacy

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Bedrooms were clean, bright and promoted dignity and comfort. Patients had unrestricted access to their rooms throughout the day and night. All bedrooms had en-suite toileting and showering facilities.
- Patients could personalise bedrooms. We saw patients had personalised their rooms with things that were meaningful to them, such as photographs and artwork.
- Patients had somewhere secure to store their possessions. Patients could store possessions in their rooms and had the option to store valuables in a locked box in the ward office.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. The service had a clinic room, treatment room, female lounge, therapy rooms and a living room. The living room was well equipped with things for meaningful activity and self-care, for example games, books, arts and crafts, skincare face masks and hand masks.
- There were quiet areas on the ward and a room where patients could meet visitors.
- Patients could make a phone call in private. Patients were able to use their personal mobile phone/ technology devices outside of therapy sessions to maintain contact with friends and family in private.
- Patients had access to ample outside space. Patients could access a courtyard in the middle of the ward and the main grounds of the hospital.
- The food was of a good quality. All patients had an individual meal plan written collaboratively by the patient and dietician. This allowed for the patients' preference whilst maintaining nutritional intake. Patients we spoke with told us that food was tasteful and of high quality.
- Patients could make hot drinks and snacks 24/7. Staff would provide access to the kitchen area based on individual patient risk. Patients' whose nutritional intake was being monitored were supported by staff to access the kitchen, to ensure food and fluid charts were completed accurately.

Patient engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities. We saw examples of patients being able to continue their work remotely from the hospital, which promoted their integrity and dignity.

Good

Specialist eating disorder services

- Staff supported patients to maintain contact with their families and carers. Patients we spoke with felt that they had good contact with their families and carers, and staff had facilitated family visits when safely possible during the Covid-19 pandemic.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients, for example, by ensuring disabled patients had access to premises and by meeting patients' specific communication needs. The ward was all on one level and easily accessible by someone using a wheelchair. Where a patient had specific communication needs, staff would access support from the local authority or within the Priory hospital for support with translators, sign language specialists and Makaton (a language programme that uses signs together with speech and symbols, to enable patients to communicate).
- Staff ensured that patients could obtain information on treatment, local services, patients' rights and how to complain. Throughout the ward there were several information boards with information for patients, including advocacy, safeguarding, complaints, eating disorder leaflets and chaplaincy. The information provided was in a form accessible to the patient group, and easy-read versions were available when this was required.
- Staff made information leaflets available in languages spoken by patients. Staff knew who to contact to access leaflets in languages other than English.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Patients were individually assessed, and meals were prepared on-site to ensure dietary requirements of religious and ethnic groups could be facilitated. Managers knew who to contact to access specific ingredients for a variety of diets; such as kosher, halal and gluten-free.
- Staff ensured that patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

- Patients knew how to complain or raise concerns. The ward had no formal complaints in the 12-month period before the inspection.
- When patients complained or raised concerns, they received feedback.
- Staff protected patients who raised concerns or complaints from discrimination and harassment.
- Staff knew how to handle complaints appropriately.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Are Specialist eating disorder services well-led?

Good

Our rating of well-led has stayed the same. We rated it as good

Management of risk, issues and performance

- Senior Managers maintained and had access to the risk register at hospital level. Qualified staffing vacancies were currently at 60% across the site. A recent addition we saw was the negative impact of the Governments change to tax for agency staff (IR35 regulations). As a consequence, significant locum agency staff have left. The provider was

undertaking a high level meeting that week to identify remedial actions. We also reviewed the site improvement plan (SIP) which the senior management team used to identify all personnel and environmental issues affecting the hospital. Staff at a ward level could escalate concerns when required. The wards had a shared drive folder to record governance checks and processes, such as their audits and risk register.

- Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.
- Staff concerns matched those on the risk register.
- The service had plans for emergencies, for example, adverse weather or a flu outbreak.
- Where cost improvements were taking place, they did not compromise patient care.

Information management

- Locum staff were not all given access to ward information, such as patient records. We were told agency staff didn't have access to patient's electronic care records.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. There was an ongoing issue with wireless internet connectivity, which management had tried to resolve but due to the location remained an issue.
- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.
- Information governance systems included confidentiality of patient records.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- Information was in an accessible format, and was timely, accurate and identified areas for improvement.
- Staff made notifications to external bodies as needed.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.
- Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

- Staff felt respected, supported and valued.
- Staff felt positive and proud about working for the provider and their team.
- Staff felt able to raise concerns without fear of retribution.
- Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.
- Managers dealt with poor staff performance when needed.
- Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Staff appraisals included conversations about career development and how it could be supported. Leaders had supported healthcare assistants who expressed interest in phlebotomy and electrocardiography (ECG), to access this specific training.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.

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

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services. This was available through the intranet, bulletins and community meetings.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.
- Patients and carers were involved in decision-making about changes to the service.
- Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Learning, continuous improvement and innovation

- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.
- Staff used quality improvement methods and knew how to apply them. Staff participated in national audits relevant to the service and learned from them.
- Staff were in the process of applying for a Quality Network for Eating Disorders (QED) accreditation.

Leadership

- At the time of inspection, the ward manager was on extended leave and the deputy manager was due to leave the following week. The staff were unaware of the plans in place to cover the leadership of the ward. The registered manager told us contingency plans to cover leadership on the wards was in place.
- Ward leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Leaders were visible in the service and approachable for patients and staff.

Governance

- Ward managers were not always able to make decisions about referrals for placements. We were told the agreements on placements came through the "referrals" team and not from the ward managers.
- Clinical audits, were not always accurate. For example, audits had taken place to show that the emergency equipment such as defibrillator had been checked although the pads were out of date. This meant that audits were not picking up issues in compliance.
- There was a clear framework of what must be discussed at a ward, team or directorate level team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service had monthly team meetings to share information around health and safety, concerns, training compliance, updates/ changes etc. The service also held regular quality improvement meetings to review their quality improvement plan.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. There was a strong culture of staff supporting other wards when required.

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

Good

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

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

Requires Improvement

Our rating of this service has stayed the same. We rated it as requires improvement

Safe staffing

- Staff vacancies were across all wards and in the psychiatric intensive care unit (PICU). Daily flash meetings were held to discuss the allocation of staff. Ward managers told us there was a shortage in booking agency nurses. They said that where there was a shortage of nursing staff throughout the day, they increased the number of healthcare assistants to ensure there were enough staff on the ward to support patients.
- Staff in Purdown (PICU) told us the skill mix was not suitable to meet the complex needs of patients. Staff said there were no permanent nursing staff on duty twice per week and the agency staff were "unfamiliar" to patients. They said there were only two permanent nurses and when they returned on shift any “duties” missed would have to be covered by them.
- The staff on, Walter Ward, said they did not have enough one-to-one time with the patients to support their individual needs, facilitate activities and ensure they had breaks. We saw staff’s time was limited with completing administrative tasks, for example, completing daily notes. All staff agreed this did not result in cancelled escorted leave.
- Medical cover was adequate day and night. Wards had access to a consultant psychiatrist who provided medical cover for the wards. A resident medical officer was available seven days a week and was able to provide medical advice and assistance out of hours.

Medicine management

- Clinic rooms in two acute wards and the PICU were not clean. The clinic room checks for Blackwell was dated 2020. Medicines cupboards were overstocked in Purdown and there were no regular checks of medicines held in stock or for equipment such as emergency bags.
- Emergency bags were not routinely checked, equipment was missing from the emergency bags and medicines were out of date. For example, the emergency bag in Blackwell had out of date pain medicines, blue blood bottles and dressings for minor injuries. Adult defibrillation pads were missing from the emergency bag in Purdown. In Walter ward there were out of date swabs, blood bottles and safety needles.
- The service used effective systems and overall processes to prescribe and administer medicines. Staff regularly reviewed the effects of medicines on each patient’s mental and physical health.

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

Good

Use of restrictive interventions

- Risk assessments or care plans did not identify clearly how staff should manage or the prevent risks re-occurring. Care plans were not detailed to show how the levels of risk identified were to be reduced.
- The seclusion policy stated that detailed care plans were to be developed where behaviours that challenged escalated beyond eight hours. However, care plans were not detailed. Reports of seclusion for one patient lacked the detail to evidence the staff had followed the care plan regarding the least restrictive measures and de-escalation prior to seclusion. This meant the staff were making decisions on seclusion due to lack of detailed guidance. A member of staff told us they terminated a seclusion period early for one patient as it was not "warranted".
- Staff used restraint only after de-escalation had been unsuccessful and the comments from staff confirmed they only used recognised techniques. Staff in acute wards explained the processes they would use which included distraction techniques.
- Records on the acute wards and PICU showed that restraint had not been used over the last two months. The restraint audit identified no restrictive practice having been undertaken in Walter ward and the staff on Purdown, the PICU, told us restraint had not been used in a while. We saw de-escalation seating and bean bags in Purdown for the purpose of supporting patients to regain control over their behaviour.
- Staff followed the National Institute of Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Staff informed us they had not used rapid tranquilisation over the past two months which was reflected in the records and audit seen for all wards.

Assessing and managing risk to patients and staff

- Staff assessed and managed risks to patients and others. Nursing staff completed and updated risk assessments for each patient.
- Staff completed a risk assessment for each patient on admission.

Management of patient risk

- Staff knew about the risks to each patient and acted to prevent or to reduce the risk. Staff aimed to minimise the risk where they could not easily observe patients.
- Staff followed policies and procedures using observation which minimised the risk from potential ligature points. The review and update of policies and procedures were included in the quality improvement meeting minutes.
- Staff monitored the risk of potential harm to patients and dealt with any specific risk issues. Safety performance was monitored and reported via the incident reporting and complaints processes.
- Staff discussed and reviewed each patient during weekly ward rounds. Risks were identified and documented accordingly. The manager on one acute ward confirmed an administrator had been appointed and would be supporting the ward in their clerical duties.

Safety of the ward layout

- All patient areas were safe, well equipped and furnished. The layouts of the wards allowed all parts to be observed and where appropriate mirrors were used in corridors to remove blind spots. Staff had access to personal alarms**.**
- Potential ligature points were assessed, and action taken to mitigate the risk.
- Mixed-sex accommodation was in line with the Department of Health guidance. There were female only lounges in mixed wards.
- The ward manager in Redcliffe, an acute ward, told us the ward was to be reconfigured to ensure patients have more space. We were told that reducing occupancy levels was being considered to maximise patient space.

Maintenance, cleanliness and infection control

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

Good

- There was suitable furnishing**.** However, in two bedrooms (on Purdown and Redcliffe) there were unpleasant smells. Ward managers told us that the issues had been reported to the maintenance team and were not currently in use.
- We observed staff following preventative procedures for COVID-19. Staff explained how they followed infection control principles including the use of personal protective equipment (PPE) as required. We saw the availability of cleaning wipes and hand cleansing gels within meeting rooms.

Mandatory training

- Staff said they completed and kept up-to-date with their mandatory training. The training records seen on wards confirmed staff had completed all relevant mandatory training which included health and safety and immediate and basic life support. We saw in Walter ward that most staff had completed their prevention and management of violence and aggression (PMVA) training on 11 April 2021. Additional training dates were being allocated to those who could not attend.

Safeguarding

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff received training specific for their role on how to recognise and report abuse.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- There were systems in place to ensure staff felt supported with safeguarding procedures. Staff worked well with the safeguarding lead and said they could contact them with any concerns. Their comments showed they knew the signs of abuse and were clear on reporting abuse.

Staff access to essential information

- Staff had access to clinical information, and they maintained clinical records electronically.

Track record on safety

- The acute and PICU had a good track record on safety**.** Ward managers reviewed the safety on the wards. Examples included oversight of all the rotas and observation charts.

Reporting incidents and learning from when things go wrong

- The service managed patient safety incidents well. Staff recognised incidents and knew how to report them**.**
- Staff reported serious incidents clearly and in line with the hospital's policy.
- Staff understood the duty of candour. They were open and transparent and gave patients and families where applicable a full explanation when things went wrong.

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

Good

Our rating of this service stayed the same. We rated it as good:

Best practice in treatment and care

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

Good

- Care plans for eight patients were not personalised. The patients voice or the progress made with the goals and needs identified were not included in their care plans. The goals identified lacked the measures to ensure successful outcomes. The ward manager in Purdown, the PICU, agreed that care plans lacked guidance to staff on how to meet their identified needs. We noted in the 'keeping safe' care plans that "calm cards" were meant to be used for two patients to prevent behaviours from escalating. However, staff we spoke with had no knowledge of the calm cards or where to find them.
- Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare.
- Staff participated in clinical audits such as records and health and safety. Staff followed up-to-date policies and delivered high quality care according to best practice and national guidance.
- Care records reviewed in acute wards and the PICU demonstrated that staff provided a range of care and treatment interventions suitable for the patient group. The interventions were delivered in line with NICE guidance.

Skilled staff to deliver care

- The ward team included or had access to some specialists such as consultants and therapists.
- Staff said they had attended the required training and supervision was taking place although we were told it was intermittent in Purdown. Staff we spoke with said their induction programme was tailored to their role and was started before they went onto the wards.

Multidisciplinary and interagency teamwork

- Staff from different disciplines worked together as a team to benefit patients. The ward team had a good working relationship with other relevant teams within the organisation and with relevant services outside the organisation.
- A new post of occupational therapy assistant (OTA) had been created to support patients in acute wards. The manager on Walter ward had created champions within the ward which included an occupational therapy champion. The role of the champion was to support the OTA with on-going activities for patients. However, patients had limited opportunities for therapy programmes due to occupational therapist (OT) vacancies.

Supporting people to live healthier lives

- Patients had access to physical healthcare and specialists when needed.
- Patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Specialist support from staff such as dieticians was available for patients who needed it.

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

- Patients Mental Health Act status was not always documented for detained patients. This meant there was a lack of clarity on patients' conditions including restrictions placed on them. In Blackwell the legal status was documented as "unknown" in four of the eight records seen. Only two of the eight records seen on Walter ward listed the patients' status while other records stated "unknown." The legal status was not identified for one patient in Purdown. We noted that one patient had two different detentions logged on the wipe board and the staff on duty were unclear on the current status.
- Information telling informal patients they could leave the ward freely was not clearly displayed in Walter ward.
- Records did not confirm patients in acute wards and PICU were kept informed about their rights under Section 132 of the Mental Health Act (MHA) which describes the duty of managers to give information to detained patients. Audit results of detained patients in Walter ward dated 31 March 2021 showed four of the eight patients had their rights

explained to them under Section 132. From the three records reviewed in Blackwell only one patient was informed of their rights. In Purdown there were delays and some inconsistencies with informing patients of their rights. For one patient the records were not consistently completed on when they were informed of their rights. The ward wipe board was inaccurate and stated that another of the patients had received their 132 rights.

- Staff understood the roles and responsibilities of the Mental Health Act 1983.
- Staff had access to information on the Mental Health Act including policies, procedures and the Code of Practice.
- Information was on display within the nurse's office regarding access to independent mental health advocacy services. During the inspection an advocate was visiting a patient.
- Staff ensured patients were able to take Section 17 leave where this had been granted.

Good practice in applying the Mental Capacity Act

- Documentation was not always in place to demonstrate mental capacity assessments were carried out in acute wards and PICU. The standard of capacity assessments across all four records we viewed in Purdown were variable, two patients had capacity assessments with only minimal rational for the outcome. One patient had no documented capacity assessment. Despite staff assuring it had been completed we were unable to confirm this.
- Mental capacity assessments records showed that four patients of the eight we reviewed in Walter ward lacked capacity for care and treatment. There was no documented evidence that the mental capacity assessment form had been completed or that the clinical team had consulted with either the person, their next of kin or appointed an independent mental capacity advocate (IMCA) if appropriate.
- The medical team confirmed they did not use this form but completed a capacity and consent form for each patient instead. On review of the records we found only four patients in Walter ward had had this form completed. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and they knew who to contact for advice. The manager confirmed staff had received training relevant to their role.
- Staff had access to the Mental Capacity Act (MCA) policy including the Deprivation of Liberty safeguards (DoLS). During the inspection we found no patient subject to a DoLS authorisation.

Assessment of needs and planning of care

- The admission records were incomplete for some patients. For example, in Purdown the admission process was not consistently completed once staff had addressed patient's anxieties.
- Staff assessed the physical and mental health of all patients on admission. They developed care plans which were regularly reviewed through weekly ward rounds and multidisciplinary discussions.
- Staff completed a comprehensive mental health assessment of each patient either on admission or soon after. This was reflected in the records seen.
- Nursing staff completed care plans which were made up of four key areas namely; keeping connected, keeping well, keeping healthy and keeping safe. Each care plan had an identified review date.

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

Good

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

Kindness, privacy, dignity, respect, compassion and support

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

Good

- Staff treated patients with compassion and kindness and respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care treatment or condition.
- Staff were discreet and responsive when caring for patients in acute wards and on the PICU. We observed staff taking time to interact with patients in a respectful and considerate way. There was good interaction between staff and patients.
- Staff were kind to patients and told us how they ensured patients felt they mattered. A member of staff on Purdown told us they used "common ground to break the ice."
- We observed staff providing support and encouragement to a patient who had become anxious regarding their impending discharge.
- Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients.
- Staff said that they would respect the personal, cultural, social and religious needs of patients and how they may relate to their care needs.
- Staff explained when they would raise concerns about disrespectful, discriminatory or abusive behaviour.
- Staff maintained the confidentiality of information about patients.

Involvement of patients

- Staff involved patients and sought their feedback on the quality of care provided.
- Each patient was given a welcome pack which provided information about the ward, mealtimes, restricted items and details of the Mental Health Act.
- We observed staff communicating well with patients to ensure they understood what was required of them. Staff told us that they would find other ways to communicate with patients should they be identified as having communication difficulties. This included for example the use of symbols or sign language.
- Some patients were given the opportunity of attending weekly community meetings where they could provide feedback on the service received. The manager informed us they had ordered a display board which would outline "You said, we did" to ensure they captured patient feedback. Currently patients were given feedback at the next community meeting.

Staff informed and involved families and carers appropriately

- We observed staff supporting families by telephone and giving them the opportunity to attend ward rounds virtually.

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

Good

Our rating of this service went up. We rated it as good

Discharge and transfer of care

- The care records in Walter ward showed the service aimed to discharge patients within 28 days. On the day of our inspection most patients in Walter ward were new to the ward except for two patients who had been there longer than 28 days. Staff informed us the extended length of stay was due to the unavailability of a suitable placement in the patient's home location. Discharge dates were not detailed in the records reviewed for Purdown although one patient had identified discharge as a goal.

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

Good

- Discharge plans were not part of the care planning process in all acute wards and the PICU. We found a phrase of "liaise with local teams to arrange discharge" used in eight different care records for wards such as Redcliffe, Walter and Purdown (PICU). In Walter ward most care records had dates for discharge but this appeared to be a generic date roughly a month from admission.

Access and discharge

- Patients were not moved between acute wards unless this was for their benefit.
- Records showed placements in two acute wards (Walter and Blackwell) were out of area placements. Out of area placements may be due to lack of provision in their area which limits choice.
- We observed nursing staff in Walter ward were reviewing referral paperwork for the proposed admittance of two patients. The manager confirmed that the decision to admit was based on whether they could meet the patient's needs considering acuity and current patient mix. The manager confirmed that they could decline any admissions where they did not feel they could meet the patients' needs.

Facilities that promote comfort, dignity and privacy

- The design, layout and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. The food was of good quality and patients could make hot drinks and snacks at any time.
- Patients had access to outside space. Patients assessed as safe to leave the ward could access the grounds area. Patients without leave could access the courtyard with a member of staff. We saw staff accommodating patient requests during the inspection.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care such as the clinic room to examine patients.
- Internet access on the wards was very limited but staff said patients could make phone calls to maintain contact with their families.

Meeting the needs of all people who use the service

- The service met the personal needs of all patients including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- Each patient received a welcome pack which provided information about the ward. Staff said they could provide the information in a language spoken by the patient if required. Staff could access interpreters or signers when needed. Translators were used for patients that needed support with articulating their needs to staff.
- Patients could access spiritual, religious and cultural support. We saw a notice on display for when the local chaplain would be visiting.

Listening to and learning from concerns and complaints

- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.
- Patient's welcome packs included information on how to make a complaint or raise a concern. On Purdown, the PICU we saw complaints leaflets in the office.
- Staff knew how to handle complaints appropriately and confirmed they received feedback on the outcome of an investigation and acted on the findings.
- We saw compliments on display in Walter ward which were used to celebrate success and improve the quality of care.

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

Good

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Good

Our rating of this service stayed the same. We rated it as good:

Leadership

- The hospital leaders had the skills, knowledge and experience to perform their roles. Both the two senior managers were new in post this year. They could explain clearly how they were working towards providing higher quality care across all the core services. The medical director was an experienced clinician and expressed their complete confidence in the new senior management team.
- Leaders were visible in the service and approachable for patients and staff. Both managers conducted daily walkabouts and had altered their working hours on occasion to meet night staff.
- The ward managers had the integrity, skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.
- There was a clear management structure with defining lines of responsibility and accountability. Managers were supported by a senior leadership team who had the autonomy to lead the service towards the shared vision and goals of the organisation.
- Walter ward was a new ward from January 2021. The manager had a good understanding of the service. They explained how the new staff team were working well together as a cohesive team to provide high quality care.
- Staff confirmed that the senior leadership team were visible, approachable and provided good support.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The organisation's values were displayed throughout the hospital. Each month the senior managers gave out 'shining star' awards to individual members of staff. They were nominated according to the specific organisational value they identified with.
- The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.
- We saw the provider's vision and values on display within the nurse's office. Staff described how they could access the information on the provider's intranet system.

Culture

- Staff felt respected, supported and valued. They were focussed on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.
- Staff we met with were welcoming, friendly and passionate. It was evident that staff cared about the service they provided and told us they were proud to work at the hospital. Staff were committed to providing the best possible care for their patients.
- Staff on Walter ward said they enjoyed working on the ward, worked well together and felt respected, supported and valued.

- Staff had access to the employee assistance programme which provided help and support including advice on health and the provision of individual counselling.

Management of risk, issues and performance

- Senior Managers maintained and had access to the risk register at hospital level. Registered nursing staff vacancies were currently at 60% across the site. The recently introduced Government tax for agency staff (IR35 regulations) was having a negative impact on the hospitals ability to secure enough agency staff to always provide cover where they had gaps in staffing due to permanent staff vacancies. The provider was taking action to address this. We also reviewed the site improvement plan (SIP) which the senior management team used to identify all personnel and environmental issues affecting the hospital. Staff at a ward level could escalate concerns when required. The wards had a shared drive folder to record governance checks and processes, such as their audits and risk register.
- Outcomes data, audit and quality improvement opportunities and evidence-based policies and procedures were reviewed within the clinical governance framework.
- Ward managers had access to the risk register. For example, the ward manager in Walter told us they had access to information relating to risk management, information governance and how to raise concerns. Staff were knowledgeable about the service's incident reporting process.

Information management

- Information needed to deliver effective care and treatment was available to relevant permanent staff in a timely and accessible way. However, locum and agency staff were not all given access to ward information. We were told agency staff didn't have access to patient's electronic care records.
- The service used electronic records. Nursing and medical patient records were combined within the same record.
- Staff could access the hospital's intranet system and showed us how they accessed policies and documents. Information stored electronically was secure. Computer access was password protected and we observed staff logging out of computer systems when they had finished.

Engagement

- Patients had opportunities to give feedback on the service.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure had been highlighted by patients as requiring better connectivity and this was being actioned by the senior managers.

Learning, continuous improvement and innovation

- There was a focus on continuous improvement and quality. Systems to monitor risk and performance included risk register and clinical governance. Action plans were developed on ensuring standards were met. However, there were not all shortfalls were included in the action plans for improvements.

Governance

- While local clinical audits were completed in wards such as; weekly prescription charts and care notes, fortnightly MCA/MHA combined audit and quarterly restricted practice audit. Audits in place did not always accurately identify shortfalls in standards and action plans were not reflective of gaps in standards. Clinic rooms were in need of better cleaning routines, the skill mix of staff was not always suitable to meet the needs of patients. Care plans were not person centred and discharge plans were not part of the care planning process.
- Records did not consistently demonstrate there was adherence with the legal framework of the Mental Capacity Act 2005 and on when patients were informed of their 132 rights under the Mental Health Act 1983.

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

Good

- Ward managers were not always able to make decisions about referrals for placements. We were told the agreements on placements came through the “referrals” team and not from the ward managers.
- The senior managers had improved most governance processes within the hospital. The hospital now had a new clinical governance meeting with a significant agenda which included all the important quality monitoring issues such as: incidents, complaints and safeguarding. These were reviewed and discussed with any action points identified. Any themes identified were rolled out to the staff teams through the respective ward meetings.
- There was a clear framework of what must be discussed at a ward, team or hospital level team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.
- Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Long stay or rehabilitation mental health wards for working age adults

Good

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

Are Long stay or rehabilitation mental health wards for working age adults safe?

Requires Improvement

Our rating of safe went down. We rated it as requires improvement:

Safe and clean ward environment

- The clinic room and treatment room were not clean. We found a clinical waste disposal bin with no bag fitted in it, with stale blood stains on the lid and the inside of the bin. We raised this with the management team and the bin had been removed the next day and replaced with a clean bin with a waste disposal bag loosely inserted inside.
- There were no cleaning records available for either the clinic room or treatment rooms. We were told by staff that the cleaning of the clinic and treatment rooms was done as routine but there was no way of verifying that regular cleaning of the clinic room or treatment room took place. We raised this with staff, who said a specific cleaning rota for both rooms would be implemented imminently.
- Staff did regular risk assessments of the care environment. A ligature risk assessment had been completed, using a rating score.
- Ward layout allowed staff to observe all parts of ward. The ward is shaped in a square with four corridors and a courtyard in the middle. There are windows throughout the inner side of the building so staff could see across the ward. The service manages observation by staff presence and convex mirrors.
- There were no potential ligature anchor points – or staff had mitigated the risks adequately. All bedrooms were fitted with ligature-free furniture and fittings. Where ligature points had been identified in communal areas, staff had mitigated the risks appropriately.
- The ward complied with guidance on eliminating mixed-sex accommodation. The service is a 10-bedded unit with individual bedrooms for patients. The majority of patients were female and were allocated rooms on two adjoining corridors. There is one room at the start of the third corridor of the square shaped ward, which was reserved for male patients.

Maintenance, cleanliness and infection control

- The clinic room was in need of refurbishment. The surfaces were stained, old and the floor was unclean.
- General equipment such as wheelchairs and weighing scales had been well maintained and kept clean.
- Most of the ward area was clean, had good furnishings and was well-maintained. The living space, bedrooms, corridors and therapy rooms were all clean and well kept.
- Most areas had cleaning records that were up to date and demonstrated that the ward areas were cleaned regularly.

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff adhered to infection control principles, including handwashing. There were antibacterial hand gel dispensers and face masks available throughout the ward. We saw that staff were cleaning wheelchairs after each use and there was a poster reminding staff to do this.

Safe Staffing

- Managers had calculated the number and grade of nurses and healthcare assistants required. During the day there were two qualified nurses and a minimum of four healthcare assistants (HCA's) on shift, and during the night this reduced to one nurse and a minimum of two HCA's. At the time of inspection there were two vacancies for qualified nurses.
- Staff rotas showed that the ward staffing matched the calculated staffing requirements.
- The ward manager could adjust staffing levels daily to take account of case mix. Extra staff had been sought in a timely manner when this was required.
- When necessary, managers deployed agency and bank nursing staff to maintain safe staffing levels. The service rarely used agency healthcare assistants.
- When agency and bank nurses were used those staff received an induction and were familiar with the ward.
- A registered nurse was always present in communal areas of the ward. The ward had at least one qualified nurse on shift throughout the day and night.
- Staffing levels allowed patients to have regular one-to-one time with their named nurse. Patients we spoke with told us they were regularly having one-to-one time with their named nurse and felt these sessions were invaluable.
- Staff shortages rarely resulted in staff cancelling escorted leave or ward activities. The staff delayed escorted leave for 10-15mins if the ward was busy
- There were enough staff to carry out physical interventions (for example, observations, restraint and seclusion) safely (and staff had been trained to do so).

Medical Staff

- There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.

Mandatory training

- Staff had received and were up to date with appropriate mandatory training. Staff we spoke with told us they had received mandatory training and had refresher training when required.
- Overall, staff in this service had undertaken 82.3% of the various elements of training that the provider had set as mandatory. This included basic life support skills, Prevention and Management of Violence and Aggression (PMVA), safeguarding adults and children, infection control and safe handling of medications.

Assessing and managing risk to patients and staff

Assessment of patient Risk

- Staff did a risk assessment of every patient on admission and updated it regularly, including after every incident. Risk assessments were clearly visible in care records and regularly updated.
- Staff use a recognised risk assessment tool.

Management of patient risk

- Staff were aware of and dealt with any specific risk issues, such as malnutrition and skin integrity.
- Staff identified and responded to changing risks to, or by, patients.

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients or their bedrooms.
- Staff applied blanket restrictions on patients' freedom only when justified.
- Staff adhered to best practice in implementing a smoke-free policy.
- The service displayed a notice to tell informal patients that they could leave the ward freely. Patients who were informal knew their right to leave the ward at their will.

Use of restrictive interventions

- Staff used restraint in a planned way where this was clinically assessed.
- Staff used restraint only after de-escalation had failed and used correct techniques. Staff were able to explain how they used verbal de-escalation techniques to avoid restraint as much as safely possible.
- Staff understood and where appropriate worked within the Mental Capacity Act (MCA) definition of restraint.
- Staff followed the National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Rapid tranquilisation had not been used at the service since August 2020.

Safeguarding

- Staff were trained in safeguarding, knew how to make a safeguarding alert, and did that when appropriate.
- Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm. This included working in partnership with other agencies.
- Staff followed safe procedures for children visiting the ward.

Staff access to essential information

- The service used a combination of paper and electronic patient records.
- All information needed to deliver patient care was available to all relevant staff (including agency staff) when they needed it and was in as accessible form. This included when patients moved between teams.
- If staff were expected to record information in more than one system (paper or electronic), this did not cause them any difficulty in entering or accessing information.

Medicines Management

- Staff followed good practice in medicines management (that is, transport, storage, dispensing, administration, medicines reconciliation, recording, disposal, use of covert medication) and did it in line with national guidance.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance, especially when the patient was prescribed a high dose of antipsychotic medication.

Track record on safety

- There was one serious incident in the last 12 months.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them.
- Staff reported all incidents that they should report.
- Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss this feedback. There is evidence that changes had been made as a result of feedback.
- Staff were debriefed and received support after a serious incident. However, some staff we spoke with told us that these were very brief and were not as beneficial as they could be.

Are Long stay or rehabilitation mental health wards for working age adults effective?

Good

Our rating of effective stayed the same. We rated it as good :

Assessment of needs and planning of Care

- Staff completed a comprehensive mental health assessment of the patient in a timely manner, at, or soon after, admission. This was regularly reviewed and documented in patient's care records.
- Staff assessed patients' physical health needs in a timely manner during and after admission.
- Staff developed care plans that met the needs identified during assessment. Care plans in all records we reviewed were comprehensive and addressed the needs identified during the patients' assessment.
- Care plans were personalised, holistic, recovery orientated. Care plans were very detailed and showed that they had been individually personalised for each patient. Care plans included patients' views, encompassed all their needs and clearly described patients' strengths and goals.
- Care plans were regularly updated and clearly documented in patients' care records.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from NICE. Patients care and treatment was supported with medication and psychological therapies and, activities, training and exposure work intended to help patients acquire skills. Therapies included trauma-based therapy, family therapy and Eye Movement Desensitisation and Reprocessing (EMDR). EMDR is psychotherapy that enables patients to heal from the symptoms and emotional distress that are the result of disturbing life experiences.
- Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. Patients' had access to a dietician who supported them with meal plans and understanding why certain foods are offered and encouraged. Care records showed that physical healthcare of patients was being monitored regularly and appropriate support was in place to manage this.
- Staff had assessed and met patients' needs for food and drink and for specialist nutrition and hydration. We saw evidence of careful assessment of the patient's diet.
- Staff supported patients to live healthier lives – for example, through participation in smoking cessation schemes, healthy eating advice, managing cardiovascular risks, and dealing with issues relating to substance misuse.
- Staff used recognised rating scales to assess and record severity and outcomes (for example, Health of the Nation Outcomes Scales).
- Staff used technology to support patients effectively (for example, for prompt access to blood test results and online access to self-help tools).
- Staff participated in clinical audits, benchmarking and quality improvement initiatives.

Skilled staff to deliver care

Long stay or rehabilitation mental health wards for working age adults

Good

- The team included or had access to the full range of specialists required to meet the needs of the patients on the ward. The ward team included clinical psychiatrists, an assistant clinical psychologist, integrative therapists, a dietician, a speciality doctor, occupational therapist, nurses and health care assistants. The ward was visited weekly by a pharmacist and social worker weekly.
- Staff were experienced and had the right skills and knowledge to meet the needs of the patient group.
- Managers provided staff with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. Managers ensured that staff had access to regular team meetings.
- The percentage of staff that have had an appraisal in the last 12 months was 87%.
- The percentage of staff that received regular supervision was 86%.
- Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge.
- Managers ensured that staff received the necessary specialist training for their roles. Staff had received specific training to support their role in an eating disorder unit, such as nasogastric intubation (theory and practical), eating disorders, personality disorders and FFP3 mask fitting.
- Managers dealt with poor staff performance promptly and effectively. The management team had dealt with sub-standard staff performance appropriately, in a supportive and meaningful way.

Multidisciplinary and interagency team work

- Staff held regular and effective multidisciplinary team (MDT) meetings. Staff from all disciplines met once a week to review any patients waiting to be admitted and to plan discharges. Ward rounds were held twice a week to discuss all patients in detail.
- Staff shared information about patients at effective handover meetings within the team. Staff completed handover meetings before each shift change. These meetings were informative and covered all aspects of patients care and treatment.
- The ward teams had effective working relationships, including good handovers, with other relevant teams within the organisation.
- The ward teams had effective working relationships with teams outside the organisation. Staff had good working relationships with the local authority social services, community mental health teams and GPs. Care records showed that staff had regular contact with patients' care coordinators to inform them of patient progress and involve them in discharge planning.

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

- Staff were trained in and had a good understanding of the Mental Health Act (MHA), the Code of Practice and the guiding principles.
- Staff had easy access to administrative support and legal advice on implementation of the MHA and its Code of Practice. Staff knew who their MHA administrators were.
- The provider had relevant policies and procedures that reflected the most recent guidance.
- Staff had easy access to local MHA policies and procedures and to the Code of Practice.
- Patients had easy access to information about independent mental health advocacy. Information was clearly displayed around the ward and patients were aware of the advocacy service.
- Staff explained to patients their rights under the MHA in a way that they could understand, repeated it as required and recorded that they had done it.
- Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this has been granted.
- Staff stored copies of patients' detention papers and associated records (for example, Section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Long stay or rehabilitation mental health wards for working age adults

Good

- The service displayed a notice to tell informal patients that they could leave the ward freely.
- Staff did regular audits to ensure that the MHA was being applied correctly and there was evidence of learning from those audits.

Good practice in applying the Mental Capacity Act

- Staff had a good understanding of the Mental Capacity Act (MCA), in particular the five statutory principles.
- The provider had a policy on the MCA, including Deprivation of Liberty Safeguards (DoLS). Staff were aware of the policy and had access to it.
- Staff knew where to get advice from within the provider regarding the MCA.
- Staff took all practical steps to enable patients to make their own decisions. Care records clearly documented patients' mental capacity to make decisions and it was evident that patients had been supported to make their own decisions.
- For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions.
- When patients lacked capacity, staff were aware of making decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. However, they rarely admitted patients who lacked capacity to make decisions in relation to their care and treatment.
- The service had arrangements to monitor adherence to the MCA.
- Staff audited the application of the MCA and acted on any learning that resulted from it.

Are Long stay or rehabilitation mental health wards for working age adults caring?

Good

Our rating of caring stayed the same. We rated it as good:

Kindness, privacy, dignity, respect, compassion and support

- Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.
- Staff supported patients to understand and manage their care, treatment or condition. Patients we spoke with told us their care and treatment were individualised and staff always showed extra effort to help them achieve their recovery goals.
- Staff directed patients to other services when appropriate and, if required, supported them to access those services. Patients had access to dentists, opticians and other physical health services in the community for routine appointments.
- Patients said staff treated them well and behaved appropriately towards them. All the patients we spoke with, or received feedback from, were highly complementary of the staff. Patients said staff were caring, respectful and the 'help and support had been faultless'.
- Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. Patients were assessed individually and there were examples of the service providing support for patients where a need was identified.
- Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Patients we spoke with felt they could raise concerns and patients were encouraged to participate in improvement of the service. We saw one patient attended and provided valuable input into a clinical governance meeting during this inspection.
- Staff maintained the confidentiality of information about patients.

Long stay or rehabilitation mental health wards for working age adults

Good

Involvement in Care

- Staff used the admission process to inform and orient patients to the ward and to the service. All patients were given a welcome pack which included information about the hospital, ward, staff, therapy, a typical weekly timetable and restricted items.
- Staff involved patients in care planning and risk assessment. This was evidenced in care plans, participation in multidisciplinary team reviews and access to a copy of their care plan. Patients told us they had an hour's session with the ward doctor in person before the weekly ward round, which gave them the opportunity to discuss their progress and treatment.
- Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties.
- Staff enabled patients to give feedback on the service they received. The service had various ways for patients and families to provide feedback including surveys, complaints and compliments procedures, community meetings and a letterbox.
- Staff ensured that patients could access advocacy. Patients we spoke with knew there was an advocacy service available but had not needed to access it during their care and treatment.

Involvement of families and carers

- Staff informed and involved families and carers appropriately and provided them with support when needed. Staff had involved families where they had consent to do this, and family visits were facilitated when this was assessed as safe and appropriate for patient recovery.
- Staff enabled families and carers to give feedback on the service they received. This was facilitated through surveys, complaints and compliments procedures and a letterbox.
- Staff provided carers with information about how to access a carer's assessment.

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Good

Our rating of responsive stayed the same. We rated it as good :

Access and discharge

- There was always a bed available when patients returned from leave. Patients bedrooms were assigned to them for the whole duration of their stay.
- Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interest of the patient. This had happened on one occasion in a 12-month period prior to inspection and was clinically justified by the multidisciplinary team.
- When patients were moved or discharged, this happened at an appropriate time of day. Patients were made aware of any moves or discharges and were supported to plan for this and make arrangements where required.
- A bed was always available in a psychiatric intensive care unit (PICU) if a patient required more intensive care and this was sufficiently close for the person to maintain contact with family and friends. The hospital had a PICU unit on the same premises which could be accessed easily, in a timely manner with little disruption for the person.

Discharge and transfers of care

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff planned for patients' discharge, including good liaison with care managers/co-ordinators. We saw care coordinators were kept informed of patient's progress and they were involved in discharge planning. This was documented well within patient care records.
- Staff supported patients during referrals and transfers between services - for example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit. We saw an example of how staff had provided extensive support for a person transferring from Lotus ward to a PICU, following a rapid deterioration in their mental state.

Facilities that promote comfort, dignity and privacy

- Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Bedrooms were clean, bright and promoted dignity and comfort. Patients had unrestricted access to their rooms throughout the day and night. All bedrooms had en-suite toileting and showering facilities.
- Patients could personalise bedrooms. We saw patients had personalised their rooms with things that were meaningful to them, such as photographs and artwork.
- Patients had somewhere secure to store their possessions. Patients could store possessions in their rooms and had the option to store valuables in a locked box in the ward office.
- Staff and patients had access to the full range of rooms and equipment to support treatment and care. The service had a clinic room, treatment room, female lounge, therapy rooms and a living room. The living room was well equipped with things for meaningful activity and self-care, for example games, books, arts and crafts, skincare face masks and hand masks.
- There were quiet areas on the ward and a room where patients could meet visitors.
- Patients could make a phone call in private. Patients were able to use their personal mobile phone/ technology devices outside of therapy sessions to maintain contact with friends and family in private.
- Patients had access to ample outside space. Patients could access a courtyard in the middle of the ward and the main grounds of the hospital.
- The food was of a good quality. All patients had an individual meal plan written collaboratively by the patient and dietician. This allowed for the patients' preference whilst maintaining nutritional intake. Patients we spoke with told us that food was tasteful and of high quality.
- Patients could make hot drinks and snacks 24/7. Staff would provide access to the kitchen area based on individual patient risk. Patients' whose nutritional intake was being monitored were supported by staff to access the kitchen, to ensure food and fluid charts were completed accurately.

Patient engagement with the wider community

- When appropriate, staff ensured that patients had access to education and work opportunities. We saw examples of patients being able to continue their work remotely from the hospital, which promoted their integrity and dignity.
- Staff supported patients to maintain contact with their families and carers. Patients we spoke with felt that they had good contact with their families and carers, and staff had facilitated family visits when safely possible during the Covid-19 pandemic.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community.

Meeting the needs of all people who use the service

Long stay or rehabilitation mental health wards for working age adults

Good

- The service made adjustments for disabled patients, for example, by ensuring disabled patients had access to premises and by meeting patients' specific communication needs. The ward was all on one level and easily accessible by someone using a wheelchair. Where a patient had specific communication needs, staff would access support from the local authority or within the Priory hospital for support with translators, sign language specialists and Makaton (a language programme that uses signs together with speech and symbols, to enable patients to communicate).
- Staff ensured that patients could obtain information on treatment, local services, patients' rights and how to complain. Throughout the ward there were several information boards with information for patients, including advocacy, safeguarding, complaints, eating disorder leaflets and chaplaincy. The information provided was in a form accessible to the patient group, and easy-read versions were available when this was required.
- Staff made information leaflets available in languages spoken by patients. Staff knew who to contact to access leaflets in languages other than English.
- Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. Patients were individually assessed, and meals were prepared on-site to ensure dietary requirements of religious and ethnic groups could be facilitated. Managers knew who to contact to access specific ingredients for a variety of diets; such as kosher, halal and gluten-free.
- Staff ensured that patients had access to appropriate spiritual support.

Listening to and learning from concerns and complaints

- Patients knew how to complain or raise concerns. The ward had no formal complaints in the 12-month period before the inspection.
- When patients complained or raised concerns, they received feedback.
- Staff protected patients who raised concerns or complaints from discrimination and harassment.
- Staff knew how to handle complaints appropriately.
- Staff received feedback on the outcome of investigation of complaints and acted on the findings.

Are Long stay or rehabilitation mental health wards for working age adults well-led?

Good

Our rating of well-led has stayed the same. We rated it as good

Management of risk, issues and performance

- Senior Managers maintained and had access to the risk register at hospital level. Qualified staffing vacancies were currently at 60% across the site. A recent addition we saw was the negative impact of the Governments change to tax for agency staff (IR35 regulations). As a consequence, significant locum agency staff have left. The provider was undertaking a high level meeting that week to identify remedial actions. We also reviewed the site improvement plan (SIP) which the senior management team used to identify all personnel and environmental issues affecting the hospital. Staff at a ward level could escalate concerns when required. The wards had a shared drive folder to record governance checks and processes, such as their audits and risk register.
- Staff maintained and had access to the risk register at ward or directorate level. Staff at ward level could escalate concerns when required.
- Staff concerns matched those on the risk register.
- The service had plans for emergencies, for example, adverse weather or a flu outbreak.
- Where cost improvements were taking place, they did not compromise patient care.

Information management

- Locum staff were not all given access to ward information, such as patient records. We were told agency staff didn't have access to patient's electronic care records.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. There was an ongoing issue with wireless internet connectivity, which management had tried to resolve but due to the location remained an issue.
- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.
- Information governance systems included confidentiality of patient records.
- Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.
- Information was in an accessible format, and was timely, accurate and identified areas for improvement.
- Staff made notifications to external bodies as needed.

Vision and strategy

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in this service.
- Staff had the opportunity to contribute to discussions about the strategy for their service, especially where the service was changing.
- Staff could explain how they were working to deliver high quality care within the budgets available.

Culture

- Staff felt respected, supported and valued.
- Staff felt positive and proud about working for the provider and their team.
- Staff felt able to raise concerns without fear of retribution.
- Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian.
- Managers dealt with poor staff performance when needed.
- Teams worked well together and where there were difficulties managers dealt with them appropriately.
- Staff appraisals included conversations about career development and how it could be supported. Leaders had supported healthcare assistants who expressed interest in phlebotomy and electrocardiography (ECG), to access this specific training.
- Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression.
- Staff had access to support for their own physical and emotional health needs through an occupational health service.
- The provider recognised staff success within the service - for example, through staff awards.

Engagement

- Staff, patients and carers had access to up-to-date information about the work of the provider and the services. This was available through the intranet, bulletins and community meetings.
- Patients and carers had opportunities to give feedback on the service they received in a manner that reflected their individual needs.
- Managers and staff had access to the feedback from patients, carers and staff and used it to make improvements.
- Patients and carers were involved in decision-making about changes to the service.
- Patients and staff could meet with members of the provider's senior leadership team and governors to give feedback.

Learning, continuous improvement and innovation

Long stay or rehabilitation mental health wards for working age adults

Good

- Staff were given the time and support to consider opportunities for improvements and innovation and this led to changes.
- Staff used quality improvement methods and knew how to apply them. Staff participated in national audits relevant to the service and learned from them.
- Staff were in the process of applying for a Quality Network for Eating Disorders (QED) accreditation.

Leadership

- At the time of inspection, the ward manager was on extended leave and the deputy manager was due to leave the following week. The staff were unaware of the plans in place to cover the leadership of the ward. The registered manager told us contingency plans to cover leadership on the wards was in place.
- Ward leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.
- Leaders were visible in the service and approachable for patients and staff.

Governance

- Ward managers were not always able to make decisions about referrals for placements. We were told the agreements on placements came through the "referrals" team and not from the ward managers.
- Clinical audits, were not always accurate. For example, audits had taken place to show that the emergency equipment such as defibrillator had been checked although the pads were out of date. This meant that audits were not picking up issues in compliance.
- There was a clear framework of what must be discussed at a ward, team or directorate level team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed. The service had monthly team meetings to share information around health and safety, concerns, training compliance, updates/ changes etc. The service also held regular quality improvement meetings to review their quality improvement plan.
- Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts at the service level.
- Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. There was a strong culture of staff supporting other wards when required.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider must continue to ensure the cleanliness and safety of the clinical rooms and emergency equipment and implement systems and processes to assure compliance with national guidelines and best practice.** **Regulation 12 (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.**