The Priory Hospital Roehampton

Quality Report

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

Overall summary

As this was a focussed inspection, the provider's overall inspection rating or core service ratings were not altered.

We undertook this inspection to check the progress the provider had made in addressing the breaches of regulation identified at the previous inspection in October 2016. We also report on new issues found during our focussed inspection.

We found the following areas for improvement:

- Garden Wing did not provide a safe environment for patients. The ward layout made it difficult for staff to observe patients clearly.The door between the hospital's restaurant and Garden Wing did not have a secured entry system. Visitors, non-clinical staff and other patients accessed the ward. Staff found it hard to manage the acuity of patients on the ward within the current environment. At the October 2016 inspection, staff and patients from other wards accessed the dining area through Garden Wing, which impacted negatively on the privacy and dignity of patients. At the August 2017 inspection, the hospital had put an alternative route in place for staff and patients. However, we observed staff and patients from other wards continue to use Garden Wing as a thoroughfare.
- Physical health assessments and monitoring of patients' vital signs after rapid tranquilisation was not always taking place. At the October 2016 inspection, there were gaps in physical health assessments, and monitoring of patients' vital signs following rapid tranquilisation. At the August 2017 inspection, the hospital had failed to take sufficient steps to ensure that all staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation.
- Patients' physical health observations on Priory Court and Upper Court had not always been accurately recorded as prescribed, or physical health deterioration escalated by staff when needed.
- Some clinical equipment was not being checked appropriately to ensure it was operating correctly. At the October 2016 inspection, on Priory Court and Upper Court clinical equipment was not checked, maintained and calibrated regularly. At the August 2017 inspection, whilst the service had put in place a contract with an external providerto service clinical equipment, some staff lacked an understanding on how to use and calibrate blood glucose monitoring machines on a daily basis. On Upper Court, staff did

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not record that they completed weekly testing for the blood pressure machine. Emergency bags on Upper Court, Priory Court and Garden Wing contained some out of date items.

- The nasogastric feeding rooms on Priory Court and Upper Court were not safe or clean environments. On Priory Court, the nasogastric seating and trolley were visibly unclean. On Upper Court, there was no adequate space for staff to prepare the nasogastric feeds. At the October 2016 inspection, on Upper Court nasogastric feeding was being carried out in a therapy room, not a clinical area, with no appropriate seating in place. At the August 2017 inspection, this was no longer the case and there was a separate nasogastric feeding room with suitable seating arrangements.
- Some environments in the hospital needed updating and did not provide a therapeutic environment. On Upper Court and Priory Court the nasogastric feeding rooms were decorated in a way that was not therapeutic to patients. They were very clinical and sparse, with no pictures or decoration on the walls. At the October 2016 inspection, the small dining room on Upper Court was in need of updating in order to provide a positive therapeutic environment. At the August 2017 inspection, the planned work was still ongoing. The hospital estates plan aimed to complete this work by the end of October 2017. At the October 2016 inspection, there were no quiet areas available and no privacy for patients who were distressed on Priory Court. At the August 2017 inspection, the planned work was still ongoing. The hospital estates plan aimed to complete this work by the end of October 2017.
- Governance processes to monitor the time patients were waiting for a full initial assessment following admission, were not yet operating effectively. At the October 2016 inspection, the provider had no system in place to monitor waiting times for new patients to be assessed by nursing and medical staff from their time of arrival on the ward. At the August 2017 inspection, the provider had failed to take sufficient steps to ensure that there was a system in place to monitor the time new patients waited before staff completed a full initial assessment on admission to the acute wards.
- Access to patient information was not always managed appropriately. At the October 2016 inspection, permanent staff shared login details with agency staff. At the August 2017 inspection, the provider had made some improvements, but there were two occasions when student nurses used permanent staff log-ins. At the October 2016 inspection, staff on the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. At the August 2017 inspection, some improvements had been made, but some staff on the acute wards were still unaware of the contingency plans.

We found the following areas of improvement since the last inspection:

- Staffing had improved on the wards and staff received training to undertake their role. At the October 2016 inspection, the hospital had a high number of staff vacancies, a high use of temporary staff and significant staff turnover. At the August 2017 inspection, the hospital had made improvements having the required level of staffing for day and night shifts for all wards. Agency usage had dropped, staff turnover had improved and vacancy rates for nurses and healthcare assistants had improved. At the October 2016 inspection, staff compliance with mandatory training was low at 73%, and staff were not trained in intermediate life support. At the August 2017 inspection, there had been an improvement with a compliance rate of 87% for mandatory training and 84% of relevant staff had been trained in intermediate life support.
- The provider had completed work to ensure rooms that were safer for high-risk patients. At the October 2016 inspection, the hospital environment, particularly on the acute wards, was unsafe. At the August 2017 inspection, the provider had completed work to ensure safer rooms did not contain ligature anchor point risks and were completed to specification. All wards had ligature risk assessments in place that identified ligature anchor points. All wards apart from Garden Wing had a separate CCTV system that monitored areas of potential risk, in communal areas and bedrooms, to reduce ligature risk.
- The provider had completed work to ensure a safe environment for patient physical examinations and safe storage of medicines. At the October 2016 inspection, there was no clinical room available for staff to conduct physical examination of patients on Upper Court and East Wing. At the August 2017

inspection, this was no longer the case and patients received physical examinations in a clinical room on the ward. At the October 2016 inspection, the medicines fridge on Priory Court had not been working since 28 August 2016, although it was still being used to store medicines. At the August 2017 inspection, the medicines fridge on Priory Court was fit for purpose.

- Staff undertook risk assessments for patients and developed individualised care plans with patient involvement. They delivered care that was personalised without blanket restrictions. At the October 2016 inspection, risk assessments varied in consistency and detail for acute wards. At the August 2017 inspection, we found a general improvement in the quality of the risk assessments for patients on acute wards. At the October 2016 inspection, care plans varied in consistency and detail across acute wards. At the August 2017 inspection, we found an improvement in the quality of the care plans for patients. At the October 2016 inspection, care plans did not show patient involvement in the development of care plans. At the August 2017 inspection, we found an improvement in care plans that showed evidence of patient involvement. At the October 2016 inspection, the provider placed blanket restrictions on patients on Priory Court and most patients were not able to access their bedrooms during the day. At the August 2017 inspection, we found this was no longer the case and bedrooms were open and available to patients.
- The provider displayed CQC core service ratings correctly. At the October 2016 inspection, the provider had not displayed the core service ratings in a prominent place. At the August 2017 inspection, the provider displayed CQC core service ratings in the main reception area.

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Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Specialist eating disorders services.

Summary of this inspection

Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides support and treatment for people with mental health needs, eating disorders, and drug and alcohol addictions. The hospital provides care and treatment for adults and children experiencing acute episodes of mental illness, an in-patient detoxification and addiction therapy programme, and in-patient care and treatment for adults and children with eating disorders. Services are provided on the following wards:

• Lower Court is a mixed ward and provides care and treatment for children and adolescents up to 18 years old experiencing an acute episode of mental illness. (We did not inspect this service on this occasion)

• Upper Court provides an eating disorder services for adult female patients.

• Priory Court is a mixed eating disorders service for children and adolescents.

• East Wing provides care and treatment for female NHS patients.

• Garden Wing is a mixed adult ward for people experiencing acute mental illness. It provides services for up to 18 patients.

• West Wing is a private mixed acute psychiatric admission ward and a ward for people participating in the addictions therapy programme.

The provider is registered to provide care for the following regulated activities:

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

• Treatment of disease, disorder or injury

The service had a registered manager assigned to the hospital.

Our inspection team

The team that inspected the service comprised three CQC inspectors, an inspection manager and one specialist advisor.

Why we carried out this inspection

We undertook this inspection to check the progress the provider had made in addressing the breaches of regulation identified at the previous inspection in October 2016.

As this was a focussed inspection, the provider's overall inspection rating or core service ratings were not altered.

We visited the acute wards for adults of working age and specialist eating disorder services as these were the core services inspected in the last inspection. The inspection report also comments on new issues found during our focussed inspection.

At the last inspection in October 2016, we found breaches of the following regulations:

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

Regulation 10 (dignity and respect)

Regulation 12 (safe care and treatment)

Regulation 15 (premises and equipment)

Regulation 17 (good governance)

Regulation 18 (staffing)

Regulation 20A (requirement as to display of performance assessments)

At the last inspection, we found that the provider had failed to take sufficient steps to ensure that there were sufficient and consistent staff working on each ward. Due

Summary of this inspection

to the concerns, we undertook enforcement action against the hospital and served a warning notice (Section 29 of the Health and Social Care Act 2008) regarding staffing levels.

At the last inspection, we told the provider that it must take the following actions to improve acute wards for adults of working age and specialist eating disorder services.

• The provider must ensure that there are sufficient staff to provide safe and consistent care to patients on each shift.

• The provider must ensure that the hospital environment is safe for patients at high risk of self-harm or suicide.

• The provider must ensure that a suitable environment including seating, is available when patients require nutrition to be delivered through nasogastric tubes on Upper Court and that there is a suitable environment for the physical examination of patients on each ward.

• The provider must ensure that consistently rigorous risk assessments and care plans to address identified risks are put in place for patients on acute wards, and address gaps in physical health assessments, and monitoring of patients after rapid tranquilisation.

• The provider must ensure that the layout of the ward does not impact on the dignity of patients who are being restrained on Priory Court. Blanket restrictions on this ward must be reviewed. The thoroughfare of staff and patients from other wards walking through Garden Wing to the dining area must be addressed as this impacts on patients' privacy and dignity, and increases security risks.

The provider must ensure that gaps in staff mandatory training are addressed, including

intermediate life support training for nursing staff.

• The provider must ensure that gaps in staff mandatory training are addressed, including intermediate life support training for nursing staff.

• The provider must ensure that there is a system in place to monitor the time new patients wait for an assessment on admission to the acute wards.

• The provider must ensure that emergency medicines and equipment is checked, maintained and calibrated regularly on the eating disorder wards, to ensure the safe and effective treatment of patients.

• The provider must ensure that personal log-in details of permanent staff are not shared with agency staff.

• The provider must ensure that contingency plans in the event of unexpected computer system outage are made clear to staff on the wards.

• The provider must ensure that the current CQC inspection rating for all core services is displayed prominently at the hospital.

At the last inspection, we said the provider should take the following actions to improve acute wards for adults of working age and specialist eating disorder services.

• The provider should ensure that records of care plans show evidence of patient involvement in the process, and that they are person centred.

• The provider should review procedures on Priory Court that may provide blanket restrictions on patients.

• The provider should continue to engage with staff who are feeling demoralised regarding staff vacancies and a lack of response from senior management to requests made on the wards.

• The provider should ensure that the small dining room on Upper Court is refurbished, to provide a positive therapeutic environment.

These were the areas the inspection team focussed on during the August 2017 inspection visit.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?

Summary of this inspection

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

As this was a focussed inspection, we only looked at some areas of Safe, Effective, Caring, Responsive and Well-Led.

Before the inspection visit, we reviewed the provider's improvement action plan and the last inspection report.

During the inspection visit, the inspection team:

- spoke with the hospital director, the clinical service lead, the governance and audit coordinator, estates lead, and the therapy services manager
- spoke with the ward managers on Upper Court, Priory Court and West Wing, and the deputy ward managers on East Wing and Garden Wing
- spoke with six other staff members on the acute wards and eating disorder wards, including nurses and healthcare assistants
- spoke with one patient
- attended a learning and outcomes group that monitored complaints, safeguarding and incidents
- looked at the quality of each ward environment and observed how staff were caring for patients
- looked at 23 care and treatment records
- looked at 12 rapid tranquilisation records
- looked at policies, procedures and other documents relating to the running of the service

What people who use the service say

We gave patients the opportunity to speak to the inspection team during the two day focussed inspection. One patient said permanent staff members were caring and friendly, but did not like it when agency staff were on the ward, as they were unfamiliar to them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

At the current inspection we found the follow areas needed for improvement:

- Garden Wing did not provide a safe environment for patients. The ward layout made it difficult for staff to observe patients clearly. The door between the hospital's restaurant and Garden Wing did not have a secured entry. Visitors, non-clinical staff and other patients accessed the ward. Staff found it hard to manage the acuity of patients on the ward within the current environment.
- At the October 2016 inspection, we found there were gaps in physical health assessments, and monitoring of patients' vital signs following rapid tranquilisation. At the August 2017 inspection, we found the hospital had failed to take sufficient steps to ensure that all staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation.
- At the October 2016 inspection, we found there was no system in place to monitor waiting times for new patients to be assessed by nursing and medical staff from their time of arrival on the ward. At the August 2017 inspection, we found the provider had failed to take sufficient steps to ensure that there was a system in place to monitor the time new patients waited before staff completed a full initial assessment on admission to the acute wards.
- We found that that the nasogastric feeding rooms on Priory Court and Upper Court did not provide safe and clean environments. On Priory Court, the nasogastric seating and trolley were visibly unclean. On Upper Court, there was no adequate space for staff to prepare the nasogastric feeds.
- At the October 2016 inspection, we found that on Priory Court and Upper Court equipment was not checked, maintained and calibrated regularly. At the August 2017 inspection, whilst the service had put in place a contract with an external provider to service clinical equipment, we found that staff lacked an understanding on how to use and calibrate blood glucose monitoring machines on a daily basis.
- On Upper Court there was no evidence of weekly testing for the blood pressure machine. We found out of date items in the emergency bags on Upper Court, Priory Court and Garden Wing.

Summary of this inspection

- We found on Priory Court and Upper Court that staff had not always accurately recorded patients' physical health observations as prescribed or escalated physical health deterioration when they should have been.
- At the October 2016 inspection, the small dining room on Upper Court was in need of updating in order to provide a positive therapeutic environment. At the August 2017 inspection, the planned work was still ongoing. The hospital estates plan aimed to complete this work by the end of October 2017.

We found the following areas of improvement:

- At the October 2016 inspection, we found a high number of staff vacancies, a high use of temporary staff and significant staff turnover. At the August 2017 inspection, we found an improvement in shifts having the required level of staffing on day and night shifts for all wards. Agency usage had dropped, staff turnover had improved and vacancy rates for nurses and healthcare assistants had improved.
- At the October 2016 inspection, we found that the hospital environment, particularly on the acute wards, was unsafe. At the August 2017 inspection, we found that the hospital had completed work to ensure safer rooms did not contain ligature anchor point risks and were completed to specification. All wards had ligature risk assessments in place that identified ligature anchor points. All wards apart from Garden Wing had a separate CCTV system that monitored areas of potential risk, in communal areas and bedrooms to reduce ligature risks.
- At the October 2016 inspection, we found that risk assessments varied in consistency and detail for acute wards. At the August 2017 inspection, we found a general improvement in the quality of the risk assessments for patients on acute wards.
- At the October 2016 inspection, we found that on Priory Court and Upper Court, weighing scales had not been checked and calibrated as appropriate to ensure their accuracy. At the August 2017 inspection, we found the hospital had an agreed contract with an external provider that had the responsibility to service clinical equipment. Records demonstrated clinical equipment had been serviced recently.
- At the October 2016 inspection, we found that on Priory Court the medicines fridge had not been working since 28 August 2016, although it was still being used to store medicines. At the August 2017 inspection, we found that on Priory Court, there was a fridge fit for purpose.

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- At the October 2016 inspection, we found that compliance with mandatory training was low at 73%, and staff were not trained in intermediate life support. At the August 2017 inspection, we found there had been an improvement, with a compliance rate of 87% for mandatory training and 84% of relevant staff had been trained in intermediate life support.

Are services effective?

We found the following areas of improvement:

- At the October 2016 inspection, we found that care plans varied in consistency and detail across acute wards. At the August 2017 inspection, we found an improvement in the quality of the care plans for patients.

Are services caring?

At the current inspection we found the follow areas needed for improvement:

- At the October 2016 inspection, we found that on Garden Wing, there was regular flow of staff and patients from other wards accessing the dining area through the ward, which impacted negatively on the privacy and dignity of patients. At the August 2017 inspection, we found the hospital had put an alternative route in place for staff and patients. However, we observed staff and patients from other wards continue to use Garden Wing as a thoroughfare.

We found the following areas of improvement:

- At the October 2016 inspection, we found that care plans did not show patient involvement in the development of care plans. At the August 2017 inspection, we found an improvement in care plans that showed evidence of patient involvement.

Are services responsive?

At the current inspection we found the follow areas needed for improvement:

- At the October 2016 inspection, we found that on Priory Court there were no quiet areas available and no privacy for patients who were distressed. At the August 2017 inspection, the planned work was still ongoing. The hospital estates plan aimed to complete this work by the end of October 2017.
- At the August 2017 inspection, on Upper Court and Priory Court we found that the nasogastric feeding rooms were decorated in a way that was not therapeutic to patients. They were very clinical and sparse, with no pictures or decoration on the walls.

Summary of this inspection

We found the following areas of improvement:

- At the October 2016 inspection, we found on Upper Court and East Wing there was no clinical room available for staff to conduct physical examination of patients. At the August 2017 inspection, we found that this was no longer the case and patients received physical examinations in a clinical room on the ward.
- At the October 2016 inspection, we found that on Upper Court nasogastric feeding was still being carried out in a therapy room, not a clinical area, with no appropriate seating in place. At the August 2017 inspection, we found this was no longer the case and there was a separate nasogastric feeding room with suitable seating arrangement.
- At the October 2016 inspection, we found blanket restrictions were placed on patients on Priory Court and most patients were not able to access their bedrooms during the day. At the August 2017 inspection, we found this was no longer the case and bedrooms were open and available to patients.

Are services well-led?

At the current inspection we found the follow areas needed for improvement:

- At the October 2016 inspection, we found that login details of permanent staff should not be shared with agency staff. At the August 2017 inspection, we found some improvements had been made, but we found two occasions when student nurses used permanent staff log-ins.
- At the October 2016 inspection, we were concerned that staff on the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. At the August 2017 inspection, we found some improvements had been made, but some staff on the acute wards were still unaware of the contingency plans.

We found the following areas of improvement:

- At the October 2016 inspection, we found the provider had not display the core service ratings in a prominent place. At the August 2017 inspection, we found that the CQC core service ratings were displayed in the main reception area.
- At the October 2016 inspection, we found that some staff advised that morale on some of the wards was low due to staffing issues. At the August 2017 inspection, we found that the provider had made improvements to the identified staffing issues in the last inspection.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- At the October 2016 inspection, we found that the hospital environment, particularly on the acute wards, was unsafe. Safer rooms for high-risk patients included a number of ligature anchor point risks and had not been completed to specification. Risk assessments did not include ligature anchor points and other risks to patients on the wards, including areas out of sight and access to staff offices. At the August 2017 inspection, we found that the hospital had completed work to ensure safer rooms did not contain ligature anchor point risks and were completed to specification. All wards had ligature risk assessments in place that identified ligature anchor points. All wards apart from Garden Wing, 'had a separate CCTV system that monitored areas of potential risks in communal areas and bedrooms, with cameras only turned on in bedrooms with patient consent. We saw evidence that staff completed capacity assessments where appropriate to assess patient consent. The cameras were monitored by an external body and alerted staff on a hand-held device when ligature anchor points were tampered with. This system helped to ensure the safety of patients who were at high-risk of self-harm or suicide.
- However, the environment on Garden Wing was not safe. Safer rooms were on a separate corridor and the standard CCTV that monitored the rooms and the corridor was not constantly monitored. We observed on our inspection that the CCTV cameras were unattended at times. Unlike the other wards, Garden Wing did not have the separate CCTV system installed that monitored areas of potential risk and alerted staff on a hand-held device when ligature anchor points were tampered with.
- The ward layout on Garden Wing made it difficult for staff to observe patients clearly. The door between the hospital's restaurant and Garden Wing did not have a secured entry system. Visitors, non-clinical staff and other patients accessed the ward. Patients had access to the garden and other areas of the ward. These areas contained many environmental risks. Garden Wing was joined to West Wing, which meant patients from either ward were able to access both wards.
- There were three patients on Garden Wing who were high risk, due to their self-harming. There had been two incidents on Garden Wing between July 2017 and August 2017 that demonstrated that staff found it hard to manage the acuity of patients on the ward within the current environment.
- We checked the emergency bags on the acute wards and found two items out of date on Garden Wing. This included two intravenous needles that expired in June 2016 and micropore tape that expired in June 2017. During this inspection, this information was highlighted to senior management who ensured these items were replaced immediately.

Safe staffing

- At the October 2016 inspection, we found a high number of staff vacancies, a high use of temporary staff and significant staff turnover. This meant that there was not always sufficient staff who knew the service and the patients. At the August 2017 inspection, we found an improvement in shifts having the required level of staffing for day and night shifts.
- We found overall agency staff usage for the hospital had dropped within the last three months. The hospital had introduced three-month contracts for agency staff to

ensure staff were familiar with the ward. However, we found high use of unfamiliar agency staff on weekend shifts on Garden Wing. On one weekend shift, the ward had seven agency staff (three agency nurses and four agency healthcare assistants) who worked across a whole day. There was one permanent staff member on that day, who was a healthcare assistant. This meant that the hospital did not ensure that consistent care and treatment was provided to patients during weekend shifts when unfamiliar agency staff were used.

- Staff turnover had reduced from 47% at the last inspection to 30% at this inspection. The vacancy rate had improved across the hospital, there were no healthcare assistant vacancies and seven qualified nurse vacancies. Following the week of the inspection, the provider held interviews to fill these vacancies.
- At the October 2016 inspection, we found that compliance with mandatory training was low, across the hospital site, 73% of staff were up to date with mandatory training. At the August 2017 inspection, we found there had been an improvement, with 87% of staff up to date with mandatory training. At the October 2016 inspection, we found that all staff had completed basic life support training, but staff had not yet had training in intermediate life support. The provider stated in their October 2016 inspection action plan that all relevant staff would receive training in intermediate life support by the end of August 2017. At the August 2017 inspection, we found the provider had made good progress with intermediate life support training and their compliance rate was 84%.

Assessing and managing risk to patients and staff

- At the October 2016 inspection, we found that risk assessments varied in consistency and detail, so that there was a risk of in-patients' needs not being met. At the August 2017 inspection, we reviewed nine records and found an improvement in the quality of the risk assessments for patients. Risk assessments were consistent with ongoing risks for patients and we found that risk assessments were updated following incidents. Staff compliance for risk assessment training was 100%.
- At the October 2016 inspection, we found there were gaps in physical health assessments, and monitoring of patients' vital signs following rapid tranquilisation. This meant staff may have not promptly identified deterioration in patients' physical health following rapid tranquilisation. At the August 2017 inspection, we found the hospital had failed to take sufficient steps to ensure that all staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. One out of three rapid tranquilisation incidents we reviewed did not demonstrate that staff completed physical health assessments, and monitored vital signs for patients, in accordance to their policy. This included one incident on East Wing, where following administration of rapid tranquilisation, a patient's blood pressure was not recorded for two hours after rapid tranquilisation was given; this was not in line with the provider's policy where it stated blood pressure should be monitored from the start. NICE (The Institute for Health and Care Excellence) recommends that vital signs should be monitored after rapid tranquillisation, and blood pressure, pulse, temperature, respiration and hydration should be recorded regularly, at intervals agreed by a multidisciplinary team, until the person becomes active again.
- At the October 2016 inspection, we found there was no system in place to monitor waiting times for new patients to be assessed by nursing and medical staff from their time of arrival on the ward. At the August 2017 inspection, we found the provider had failed to take sufficient steps to ensure that there was a system in place to monitor the time new patients waited before staff completed a full initial assessment on admission to the acute wards. We found two incidents where new patients on the acute wards had to wait long periods before staff assessed them. For example, one new patient on East Wing had to wait 30 hours for an assessment. The provider completed quarterly audits of admission waiting times that spot-checked nine admissions across the three wards. This was an insufficient number of checks to be assured that patients received a prompt assessment on admission.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- At the October 2016 inspection, we found that care plans varied in consistency and detail, so that there was a risk of in-patients' needs not being met. At the August

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

2017 inspection, we reviewed nine records and found an improvement in the quality of the care plans for patients. Patients had clear detailed care plans, which included a care plan for safer rooms where appropriate. We found that patients had 'keep safe' care plans that clearly outlined their needs and current experiences, and included up to date incidents.

- However, we found one example on East Wing where staff did not provide a care plan to a patient with an identified need. Staff had noted there had been weight loss throughout the patient's admission, but failed to complete a care plan for the safe management of this. The inspection team highlighted this to staff on the inspection and a care plan was put in place by the end of our inspection.

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

Kindness, dignity, respect and support

- At the October 2016 inspection, we found that on Garden Wing, there was regular flow of staff and patients from other wards accessing the dining area through the ward, which impacted negatively on the privacy and dignity of patients. At the August 2017 inspection, the hospital had put a protocol in place to manage people-traffic through Garden Wing. There was a designated walkway for patients and staff to use as an alternative route to the dining room. However, during the inspection we saw that staff and patients did not always follow this system. We observed staff and patients from other wards continue to use Garden Wing as a thoroughfare. This compromised the safety, privacy and dignity of patients on the ward. Staff told us they felt overstretched in having to respond to the buzzer to let staff and patients onto the ward. Following the inspection, the provider informed us that an extra member of staff had been placed on the ward between 8.00am to 7.00pm to manage the buzzer and re-direct patients and staff from other wards.
- At the October 2016 inspection, we found that care plans did not show patient involvement in the development of care plans. At the August 2017 inspection, we reviewed nine care plans across the acute wards and found evidence that patients had been involved in the care plan and patients were offered a copy of their care plan.

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

The facilities promote recovery, comfort, dignity and confidentiality

- At the October 2016 inspection, we found on East Wing that there was no clinical room available for staff to conduct physical examination of patients, and this usually took place in their bedrooms. At the August 2017 inspection, we found that this was no longer the case and patients received physical examinations in a clinical room on the ward. At this inspection, we noted that patients on Garden Wing received physical examinations in their bedrooms. Senior management informed us during the inspection that plans were in place to install a clinical room for physical examinations. This was not identified on their estates plan.

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

Good governance

- At the October 2016 inspection, we found that login details of permanent staff should not be shared with agency staff. At the August 2017 inspection, we found some improvements had been made. An agency nurse on West Wing had their own personal log-in. Ward managers were aware of the temporary log-ins that were to be issued by agency staff. However, we found one occasion on West Wing where a student nurse used a permanent staff member's login.
- At the October 2016 inspection we were concerned that staff on the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. At the August 2017 inspection, we found some improvements had been made. Staff on West Wing knew what to do in the event of an IT outage.

However, staff in charge of East Wing and Garden Wing did not know what to do in the event of an IT outage. Senior management advised that a laptop was available, and couriers could deliver dongles if needed.

- At the October 2016 inspection, we found the provider had displayed the CQC overall inspection rating for the hospital in the main reception area, but had not display the core service ratings. At the August 2017 inspection, we found that the CQC core service ratings were displayed in the main reception area.
- At the October 2016 inspection, we found that some staff advised that morale on some of the wards was low due to staffing issues. At the August 2017 inspection, we found that the provider had made improvements to the identified staffing issues in the last inspection. We found staff morale was mixed across the acute wards. Staff we spoke with on West Wing said there had been an improvement in staffing since the last inspection and that the hospital director had been responsive. On Garden Wing, staff we spoke with felt overstretched in regards to staffing. The hospital had worked towards improving staff morale by holding 'Your Say Forums' to encourage staff engagement and keep them informed in regards to staffing. The provider used a 'morale-o-meter' whereby a survey was sent to all staff members to gain feedback on staff morale.

Specialist eating disorder services

Safe	
Caring	
Responsive	
Well-led	

Are specialist eating disorder services safe?

Safe and clean environment

- At the October 2016 inspection, we found that the hospital environment, was unsafe. Safer rooms for high-risk patients included a number of ligature anchor point risks and had not been completed to specification. Risk assessments did not include ligature anchor points and other risks to patients on the wards, including areas out of sight and access to staff offices. At the August 2017 inspection, we found that the hospital had completed work to ensure safer rooms did not contain ligature anchor point risks and were completed to specification. All wards had ligature risk assessments in place that identified ligature anchor points. Both Priory Court and Upper Court, had a separate CCTV system that monitored areas of potential risk, in communal areas and bedrooms. The cameras would only be turned on in bedrooms with patient or parental consent. The cameras were monitored by an external body and alerted staff on a hand-held device when ligature anchor points were tampered with. This system helped to ensure the safety of patients who were at high risk of self-harm or suicide.
- We found that that the nasogastric feeding rooms on Priory Court and Upper Court did not provide safe and clean environments. On Priory Court, the nasogastric feeding room had no hand soap, this meant staff did not have the handwashing facilities to ensure infection control. The seating and trolley for nasogastric feeding were visibly unclean. The sharps bin was not signed or dated and the lid was loose. The inspection team highlighted this with senior management on the day of inspection. On Upper Court, the nasogastric feeding room was an ex-bedroom. Nasogastric feeds and equipment were stored around a toilet in the en-suite bathroom. There was no adequate preparation space for staff to prepare the nasogastric feeds.
- At the October 2016 inspection, we found that on Priory Court and Upper Court, sporadic checks were undertaken on emergency medicines and equipment, and there was a lack of cleaning records for clinical areas. At the August 2017 inspection, we found the hospital had an agreed contract with an external provider that had the responsibility to service clinical equipment. Records demonstrated clinical equipment had been serviced recently. However, we found that staff lacked an understanding of how to use and calibrate the blood glucose monitoring machines on a daily basis. This meant the provider could not be assured that the blood glucose monitoring machines were taking accurate recordings from patients. We found on Upper Court that there was no evidence of weekly testing for the blood pressure machine. This was highlighted to senior management on the day of inspection. We were told that the provider had provided a one-off training session for staff on how to calibrate machines, and in light of our evidence planned to do further sessions to meet this training need.
- At the October 2016 inspection, we found that on Priory Court the medicines fridge had not been working since 28 August 2016, although it was still being used to store medicines. At the August 2017 inspection, we found that on Priory Court, there was a fridge fit for purpose. Staff completed regular fridge temperature checks that ensured it worked safely.
- We checked emergency bags on Priory Court and Upper Court and found a number of out of date items. On Upper Court, the oxygen tank had expired in June 2017 and the testing solution for the blood glucose-monitoring machine had expired in March 2017. On Priory Court, we found 14 items that had expired. This included the defibrillator pads in July 2017 and two intravenous needles in December 2015. The medical

equipment checklist had been signed as checked weekly since May 2017. This meant staff had not thoroughly checked the medical equipment when completing their weekly checklist. During this inspection, this information was highlighted to senior management who ensured the stock was replenished immediately.

- At the October 2016 inspection, the small dining room on Upper Court was in need of updating in order to provide a positive therapeutic environment. The floor showed signs of wear, which could have appeared unclean. At the August 2017 inspection, the planned work was still ongoing. The hospital estates plan aimed to complete this work by the end of October 2017.

Safe staffing

- At the October 2016 inspection, we found a high number of staff vacancies, a high use of temporary staff and significant staff turnover. This meant that there was not always sufficient staff who knew the service and the patients. At the August 2017 inspection, we found an improvement in shifts having the required level of staffing for day and night shifts.
- We found overall agency staff usage for the hospital had dropped within the last three months. The hospital had introduced three-month contracts for agency staff to ensure staff were familiar with the ward.
- Staff turnover had reduced from 47% at the last inspection, to 30% at this inspection. The vacancy rate had improved across the hospital, there were no healthcare assistant vacancies and seven qualified nurse vacancies. Following the week of the inspection, the provider held interviews to fill these vacancies.
- At the October 2016 inspection, we found that compliance with mandatory training was low, across the hospital site, 73% of staff were up to date with mandatory training. At the August 2017 inspection, we found there had been an improvement, with 87% of staff up to date with mandatory training. At the October 2016 inspection, we found that all staff had completed basic life support training, but staff had not yet had training in intermediate life support. The provider stated in their October 2016 inspection action plan that all relevant staff would receive training in intermediate life support by the end of August 2017. At the August 2017 inspection, we found the provider had made good progress with intermediate life support training and their compliance rate was 84%.

Assessing and managing risk to patients and staff

- We reviewed 14 patient records and found an improvement in the quality of the risk assessments for patients. Risk assessments were consistent with ongoing risks to patients and we found that risk assessments were updated following incidents. However, we found one occasion where staff had not completed a risk assessment for a patient who had a fall on Upper Court. Staff had not completed a falls risk assessment in response to this falls incident. The patient had a second fall and there was no update to their risk assessment or completion of a falls incident to reflect this. This meant staff did not safely manage the risks of this patient. Staff did not update the patient's risk assessment following the two falls incidents or respond appropriately to deal with the specific risk issues associated with a fall.
- At the October 2016 inspection, we found there were gaps in physical health assessments, and monitoring of patients' vital signs following rapid tranquilisation. This meant staff may have not promptly identified deterioration in patients' physical health following rapid tranquilisation. At the August 2017 inspection, we found the hospital had failed to take sufficient steps to ensure that all staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. Four out of eight rapid tranquilisation incidents we reviewed on Priory Court did not demonstrate that staff completed physical health assessments, and monitored vital signs for patients, in accordance to their policy. We found on two occasions staff had not completed physical observations as prescribed following rapid tranquilisation. On two other occasions of rapid tranquilisation, the patient's physical observations were missing. We found one incident on Lower Court (child and adolescent ward) where staff had failed to carry out the post-physical health assessments and monitoring of vital signs for one patient due to staff having to attend to other incidents.
- At the August 2017 inspection, we found on Priory Court and Upper Court that staff had not always accurately recorded patients' physical health observations as prescribed, or escalated physical health deterioration when they should have been. On both wards, staff recorded physical health checks using the management of really sick patients with anorexia nervosa – modified early warning scores(MARSI MEWS) score sheet that was

specifically designed to calculate the physical health risks to patients with eating disorders. We found two records that showed patients' physical health observations were noted to be normal, but their scores on the MARSI-MEWS chart indicated potential physical health deterioration. This meant that doctors were not always notified that a patient's physical health was deteriorating. We found more than half of the MARSI-MEWS scores we reviewed had either not been recorded or were scored inaccurately.

Are specialist eating disorder services caring?

Kindness, dignity, respect and support

- At the October 2016 inspection, we found that care plans did not show patient involvement in the development of care plans. At the August 2017 inspection, we reviewed 14 care plans across the eating disorder wards and found evidence that patients had been involved in their care plans. We found one example where there was a lack of evidence to show a patient's care plan had been signed.

Are specialist eating disorder services responsive to people's needs? (for example, to feedback?)

The facilities promote recovery, comfort, dignity and confidentiality

- At the October 2016 inspection, we found that on Upper Court nasogastric feeding was still being carried out in a therapy room, not a clinical area, with no appropriate seating in place. Patients were fed whilst sitting on a standard chair. This heightened the risk of injury if the patient had to be restrained. At the August 2017 inspection, we found this was no longer the case and there was a separate nasogastric feeding room with suitable seating arrangement.
- At the October 2016 inspection, we found on Upper Court there was no clinical room available for staff to conduct physical examination of patients, and this usually took place in their bedrooms. At the August 2017 inspection, we found that this was no longer the case and patients received physical examinations in a clinical room on the ward.
- At the October 2016 inspection, we found on Priory Court there were no quiet areas available and no privacy for patients who were distressed. Restraint of patients took place in full view of other patients. At the August 2017 inspection, the planned work was still ongoing. The hospital estates plan aimed to complete this work by the end of October 2017.
- At the October 2016 inspection, we found inappropriate blanket restrictions were placed on patients on Priory Court, for example, most patients were not able to access their bedrooms during the day. At the August 2017 inspection, we found this was no longer the case and bedrooms were open and available to patients. There were set times where access to rooms and toilets were restricted post mealtimes in accordance with the therapeutic model to manage eating disordered patients.
- On Upper Court or Priory Court we found that the nasogastric feeding rooms were decorated in a way that was not therapeutic to patients. They were very clinical and sparse, with no pictures or decoration on the walls.

Are specialist eating disorder services well-led?

Good governance

- At the October 2016 inspection, we found that login details of permanent staff should not be shared with agency staff. At the August 2017 inspection, we found some improvements had been made. Ward managers were aware of the temporary log-ins that were to be issued to agency staff. However, we found one occasion on Priory Court where a student nurse used a permanent staff member's login.
- At the October 2016 inspection, we were concerned that staff on the wards were not aware of contingency plans to address unexpected downtime of the computerised records system. At the August 2017 inspection, we found some improvements had been made. Staff on Priory Court and Upper Court knew what to do in the event of an IT outage. Senior management advised that a laptop was available, and couriers could deliver dongles if needed.

Specialist eating disorder services

- At the October 2016 inspection, we found the provider had displayed the CQC overall inspection rating for the hospital in the main reception area, but had not display the core service ratings. At the August 2017 inspection, we found that the CQC core service ratings were displayed in the main reception area.
- At the October 2016 inspection, we found that some staff advised that morale on some of the wards was low due to staffing issues. At the August 2017 inspection, we found that the provider had made improvements to the identified staffing issues in the last inspection. Staff we spoke with on Upper Court and Priory Court said morale had improved since the last inspection. The hospital had worked towards improving staff morale by holding 'Your Say Forums' to encourage staff engagement and keep them informed in regards to staffing. The provider used a 'morale-o-meter' whereby a survey was sent to all staff members to gain feedback on staff morale.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff complete physical health assessments and monitor vital signs for all patients following rapid tranquilisation. The provider must ensure there are robust systems in place to monitor this.
- The provider must take sufficient steps to ensure that there is a system in place to monitor the time new patients wait before staff complete a full initial assessment on admission to the acute wards.
- The provider must take sufficient steps to ensure there is a safe environment for patients on Garden Wing.
- The provider must ensure staff accurately record patients' physical health observations and escalate physical health deterioration appropriately, on Priory Court and Upper Court.
- The provider must ensure that the layout of the ward does not impact on the dignity of patients who are being restrained on Priory Court.
- The provider must ensure that emergency medicines and equipment are checked regularly on Priory Court, Upper Court and Garden Wing, to ensure safe treatment of patients.
- The provider must ensure that all staff complete the necessary training to ensure competency in calibration of blood glucose monitoring machines.
- The provider must ensure that the nasogastric feeding rooms on Priory Court and Upper Court are clean, and that cleaning records are up to date to demonstrate that the rooms are cleaned regularly. On Upper Court, the provider must ensure that nasogastric feeds and equipment are stored safely, and there is adequate preparation space for staff to prepare nasogastric feeds.

Action the provider SHOULD take to improve

- The provider should ensure that familiar staff are working on the weekends on Garden Wing to provide consistent care to patients on each shift.
- The provider should ensure that a suitable environment is provided for the physical examination of patients on Garden Wing.
- The provider should ensure that personal log-in details of permanent staff are not shared with agency or student staff.
- The provider should ensure that contingency plans in the event of unexpected computer outage are made clear to all staff on the wards.
- The provider should ensure that the small dining room on Upper Court is refurbished, to provide a positive therapeutic environment.
- The provider should ensure that the nasogastric feeding rooms on Priory Court and Upper Court are decorated to provide a positive therapeutic environment.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Patients on Priory Court and Garden Wing did not have access to private areas and, the management of incidents, including restraint, compromised patients' dignity. This was a breach of Regulation 10(1)(2)(a).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way. On Priory Court and Upper Court, staff did not always accurately record patients' physical health observations or escalate these when they should have been. On Priory Court, the nasogastric feeding room had no hand soap and the seating and trolley was visibly unclean. The sharps bin was not safely maintained. On Upper Court, nasogastric feeds and equipment were stored around a toilet and there was no adequate preparation space for staff to prepare nasogastric feeds. This was a breach of Regulation 12(1)(2)(a)(b)(c).

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have a system in place to monitor whether staff were competent in calibration of the blood glucose monitoring machines. This was a breach of Regulation 17(1)(2)(a)(b).

The provider did not ensure equipment was always suitable for the purpose it was being used for. On Priory Court, Upper Court and Garden Wing emergency equipment was found out of date.

This was a breach of Regulation 15 (1)(c).

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had failed to take sufficient steps from the previous inspection, to ensure that all staff completed physical health assessments and monitored vital signs for all patients following rapid tranquilisation. Garden Wing did not provide a safe environment for patients. We served a warning notice in respect of Regulation 12(1)(2)(a)(b)(d) on 17 August 2017.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 HSCA (RA) Regulations 2014 Good Governance The provider had failed to take sufficient steps from the last inspection, to ensure that there was a system in place to monitor the time new patients wait before staff completed a full initial assessment on admission to the acute wards. We served a warning notice in respect of Regulation 17(1)(2)(a)(b)(c), on 17 August 2017.