The Priory Hospital Chelmsford

Quality Report

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Date of inspection visit: 2-3 March 2016
Date of publication: 17/08/2016

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

Ratings

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

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

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

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

Summary of findings

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

Overall summary

We rated the Priory Hospital Chelmsford as requires improvement because:

- The young people had no communal space that was exclusively for their use during the day. The lounges and the quiet room were used for other purposes such as therapy groups or staff meetings. The young people spent their leisure time during the day in the downstairs corridor. There were not sufficient sofas so they sat on the floor. Young people's bedrooms led directly off this main thoroughfare corridor leading to concerns about noise levels in these rooms.
- Patients on the adult wards sat in corridors as well due to lack of communal space. The eating disorder ward was used as a link corridor by staff and patients from other wards meaning that patients with an eating disorder had little privacy.
- Privacy and dignity was not protected. Male patients on the acute ward walked along the female bedroom corridor to use the patient kitchen, female patients could be seen on their beds from the corridor. We observed patients queuing in a corridor for their medication outside of the pharmacy, some patients were clearly unwell and in their nightwear, this did not promote privacy or dignity. Young people shared a clinic with the adult wards. This meant that they had to leave the ward and walk escorted onto the adult wards to be weighed.
- The CAMHS and Eating disorder wards were mixed sex and did not comply with the guidance for separate male and female areas. There were no separate lounges for females accessible during the day on the CAMHS and eating disorder wards.
- The staff team did not consistently complete risk assessments that would assist in the care and treatment of patients. Whilst risks were identified the risk management plans weren't clear in detailing the actions required to reduce the risks. Staff also did not update these assessments regularly after any new incidents.
- Staff were not able to easily observe all parts of the wards due to the layout. On the acute ward the men's bedroom corridor was upstairs which meant staff had to leave the main ward to maintain observations if male patients went upstairs to their room. The staff office was in a side corridor that did not allow the ward to be observed at all when staff were in the office. However, on the CAMHS ward staff were seen to regularly check all areas of the ward.

However;

- Staff were caring and had good interactions with patients.
- Staffing levels were good.
- The hospital was clean and food was of a very good standard.
- The hospital had effective governance systems and learnt from incidents and complaints well.
- Medicines were safely managed.

Summary of findings

Contents

Requires improvement

The Priory Hospital Chelmsford

Services we looked at

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

Summary of this inspection

Background to The Priory Hospital Chelmsford

The Priory Hospital Chelmsford provides 47 in-patient beds for the mental health assessment and treatment for patients with psychiatric needs. There were three wards. These were for eating disorders, acute mental health inpatient which also took people with addictions and substance misuse needs and a child and adolescent mental health ward. Patients could be detained under the Mental Health Act 1983.

The hospital also provides mental health assessment and treatment on an outpatient and day patient basis for private patients. We did not inspect this part of the service.

Our inspection team

Team leader: Gary Risdale, Inspection Manager

Our inspection team consisted of two CQC inspection managers, a CQC inspector, two specialist advisors with experience of acute mental health and eating disorders and a mental health act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all three wards and other therapy areas, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with eight young people on the child and adolescent ward, seven patients on the eating disorder ward and eight patients on the acute ward
- spoke with four relatives
- reviewed feedback from 15 patient comment cards
- spoke with the hospital director, the medical director, two senior managers, estates manager and two ward managers
- spoke with 21 other staff members; including consultants, pharmacist, therapies manager mental health act administrator, nurses,and healthcare support assistants.
- attended and observed a daily senior managers meeting
- attended and observed one hand-over meetings and one multi-disciplinary meetings;
- held five focus groups for staff and patients

Summary of this inspection

- looked at 12 care and treatment records of patients, eight incident forms and 12 incident reviews
- reviewed 10 complaints and how they were managed
- reviewed nine personnel files
- carried out a specific check of the medication management in the hospital
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients said that the majority of staff were caring and supportive. However, they expressed concerns that agency staff did not understand or meet their needs. They felt this led to a lack of consistency in their care.

Patients were unhappy about the lack of communal space during the day and the levels of noise on the wards. Patients with eating disorders on the CAMHS and eating disorder wards did not like having to eat their snacks in the corridor. Young people and patients on the eating disorder ward found the noise levels in the corridor where patients socialised outside their bedrooms excessive. On the acute ward patient's commented on the lack of privacy for female patients as male patients walked along the female bedroom corridor to access the kitchen. Young people did not like leaving their ward to use the clinic on the adult ward. Patients on the eating disorder ward felt uncomfortable with people using their ward as a corridor.

Patients on the acute ward told us that they sometimes did not feel safe on the ward due to the challenging behaviour displayed by some patients when they were acutely unwell. Patients felt that staff were not always confident in managing challenging behaviour.

Patients described their rooms as comfortable and the food as being of good quality.

Patients commented on the lack of access to fresh air and limited use of the garden space whilst patients on the acute ward expressed concern that there was a lack of gym or exercise facilities.

Young people told us they were involved in decisions about their care. However, patients on other wards described a lack of involvement in the care planning process.

Patients on the acute and eating disorder wards felt that there was a lot of time with nothing to do. Young people were mixed about the level of activities offered but they all enjoyed a weekly trip to the cinema.

Patients engaging in the substance misuse programme felt that they received a good service, as the size of the groups were small they were able to explore their issues in detail.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

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

- The CAMHS and eating disorder wards were mixed sex and did not comply with the Mental Health Act Code of Practice for separate male and female areas. There were no separate lounges for females accessible during the day.
- The staff team did not complete risk assessments that would assist in the care and treatment of patients, whilst risks were identified the risk management plans weren't clear in detailing the actions required to reduce the risks. Staff did not update these assessments regularly after new incidents
- Staff could not easily observe all parts of the wards due to the layout. On the acute ward the men's bedroom corridor was upstairs which meant staff had to leave the main ward to maintain observations if male patients went upstairs to their room. The staff office was in a side corridor that did not allow the ward to be observed at all when staff were in the office. However, on the CAMHS ward staff were seen to regularly check all areas of the ward.
- Patients told us that they did not always feel safe on the adult acute ward.

However,

- The wards were clean and tidy. Records relating to cleanliness were complete and up to date with comprehensive infection control audits and cleaning schedules.
- Staff ensured that environmental risk assessments were undertaken annually.
- There were enough staff working at the hospital to meet the care and treatment needs of patients. The hospital director reviewed staffing levels regularly and had increased the numbers of staff on the team.
- Staff knew how to make safeguarding alerts. Safeguarding training compliance was high.
- Mandatory training compliance was good at 95%.

Summary of this inspection

- Medicine was stored safely in a locked room and there was a regular auditing programme to monitor the safe dispensing of medicines. Emergency drugs were stored correctly and all were in date.
- The hospital had an effective incident reporting and review process. This included learning from across the Priory organisation.

Are services effective?

Good

We rated effective as good because:

- There was effective multidisciplinary working across the onsite multidisciplinary team
- Appraisals were good and meaningful.
- Adherence to the Mental Health Act and the Mental Capacity Act was good.
- Care planning on the CAMHS ward was comprehensive.
- Physical health monitoring across all wards was good.
- There were monthly team meetings.

However,

- Staff on the adult acute ward were not confident that they had the skills and training to safely work with the NHS patients who were often acutely unwell at the time of admission.
- Staff did not receive regular supervision.
- Care planning on the adult acute ward was poor.

Are services caring?

Good

We rated caring as **good** because:

- Staff were kind and respectful to patients and recognised their individual needs.
- Staff involved young people in developing and reviewing their care plans.
- Families and carers were involved in the young people's care plans when this was appropriate.

However;

- Patients told us that agency staff did not understand their needs and they found this disempowering.
- Six out of seven care plans reviewed on the adult ward were not person centred and did not show any patient involvement.

Are services responsive?

Requires improvement

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

Summary of this inspection

- The young people had no communal space that was exclusively for their use during the day. The lounges and the quiet room were used for other purposes such as therapy groups or staff meetings. The young people spent their leisure time during the day in the downstairs corridor. There were not sufficient sofas so they sat on the floor. Young people's bedrooms led directly off this main thoroughfare corridor leading to concerns about noise levels in these rooms.
- Patients on the adult wards used the reception area to congregate during the day due to a lack of communal space.The main lounge was used for therapy sessions and patients who were not in therapy had nowhere else to go other than their bedrooms or the reception area.
- The eating disorder ward was used as a link corridor by staff and patients from other wards meaning that patients with an eating disorder had little privacy.
- Privacy and dignity was not protected. Patients used corridors as areas to sit as lounges were often in use. The eating disorder ward was used as a corridor to access other areas of the hospital.
- Patients with mobility issues could not access all areas of the hospital preventing their admission. The hospital would refer patients to other sites who would be able to accommodate them.

However,

- Complaints procedures were very well managed and open and transparent with good evidence of duty of candour.
- Discharge was well planned with liaison with outside services.
- Young people were happy with the level of activities on the ward.
- Substance misuse patients felt that their needs were well met, the group sizes were small so staff could explore their issues in detail and give them a lot of support in their recovery.

Are services well-led?

Good

We rated well led as good because:

- The hospital director provided clear leadership to the staff team with a visible presence on the ward.
- The hospital had effective governance processes which helped the hospital identify where it needed to improve.

Summary of this inspection

- There was good evidence of learning from incidents and complaints and from the wider organisation of Priory group.

However,

- The governance processes had not identified problems with the risk assessments or the impact on privacy and dignity of the use of corridors for peoples care.
- Although the hospital had increased staffing levels appropriately to manage the acuity of patients on the acute ward it had not addressed the staff team's development needs.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff ensured that detention paperwork completed correctly and up to date.

The qualified staff had a good understanding of the MHA, the MHA Code of Practice (2015) and the guiding principles. There was a rolling programme for qualified staff to receive this training.

Consent to treatment and capacity assessments for patients on section 3 were completed every three months. Copies of consent to treatment certificates were laminated and attached to medication charts.

Patients had their rights under the MHA explained to them on admission and routinely thereafter (if indicated).

Patients had access to independent mental health advocacy (IMHA) services and they were told about the service at the time of their rights being explained.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act does not apply to young people aged 16 or under. For children under the age of 16, the young person's decision-making ability is governed by Gillick competence.

All staff told us they had received training in the use of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and knew how the legislation applied to their work with patients.

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

Requires improvement

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

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

Requires improvement

Safe and clean environment

- The wards were in a purpose built building in the grounds of a large Victorian house. The physical layout of the wards did not allow all areas to be observed by staff. None of the bedroom doors had glass observation panels. In the acute ward (Chelmer) the ward office was set into a side corridor and the male bedrooms were upstairs. There were no mirrors to improve observation of blind spots, of which there were two on the male bedroom corridor. In mitigation staff told us that male patients who were considered to be at high risk of harm would be accommodated in a bedroom on the female corridor on the ground floor which caused privacy and dignity concerns due to male patients passing the female bedrooms. However on the CAMHS ward staff managed these areas well, with relational security (the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care). They knew where young people were and attempted to engage them if they isolated themselves.
- The hospital had completed a comprehensive risk assessment of all ligature points throughout the site. A ligature point is a place to which someone intent on self-harm might tie something to strangle themselves. The assessment identified a stairwell leading from the CAMHS ward to the garden as a ligature risk to the young people. The manager had requested CCTV cameras for this area that was currently being reviewed by the organisation. This was mitigated by having staff observe the stairwell when group access to fresh air was facilitated, however it prevented young people from accessing fresh air easily as it required staff to be present. The manager said maintenance issues were usually resolved quickly. Wards had designated anti-ligature rooms that had alterations like beds bolted to the floor. These rooms were occupied by patients who were considered to be at high risk of harm to themselves.
- The CAMHS and eating disorder wards did not comply with the Mental Health Act Code of Practice or Department of Health guidance on same sex accommodation. There was no designated female only lounges. Lounge areas were inaccessible during the day on the CAMHS ward, meaning that if an area was designated as female only young women would still be unable to use it. A female only lounge had recently been designated on the acute ward and staff were still in the process of finishing the décor during our inspection. The Priory group policy stated that each site should complete a privacy and dignity and mixed sex accommodation self-assessment. These assessments had not identified lack of female only lounges.
- The hospital only had one clinic room for all three wards, this was located on the acute ward. The clinic room had the necessary equipment to carry out physical health checks. The room was clean and well organised. There were suitable arrangements for the disposal of clinical waste. There was information on the wall to remind staff of the observation procedure following rapid tranquilisation. The distance from the

other wards meant that young people's physical examinations or wound care had to be done in their own bedrooms. Where this was not possible, young people had to leave the ward to have medical checks as the clinic room was on the adult acute ward. The clinic room was used for taking bloods and invasive procedures like nasogastric tube feeding where a tube is passed through the nose into the stomach. Young people also had to walk to Chelmer ward to be weighed. There was a small dispensing room in the office on the CAMHS ward and there were plans to build a larger one within the ward. But that would still not contain a couch for physical examinations. There were scales in the upstairs office but they had not been calibrated for two years.

- An emergency grab bag (necessary equipment for use in an emergency) and defibrillator an apparatus used to control heart fibrillation by application of an electric current to the chest wall or heart) was in all three wards nursing office. These were in working order and checked regularly. We found emergency drugs were stored correctly and in date.
- The hospital did not have a seclusion suite. If a young person required more intensive treatment then they were transferred to a PICU. Three young people had to be transferred in the last year. Staff on the acute ward said that patients would be taken to their rooms if they needed to be separated from the rest of the patients. This was not documented as seclusion as the patient was not forced to remain in their room.
- Staff conducted regular comprehensive audits of infection control and prevention, and staff hand hygiene to ensure that young people and staff were protected against the risks of infection.
- The wards were clean and well maintained. The décor throughout the ward was in good repair. Patients told us that standards of cleanliness were usually good. Housekeeping staff maintained the cleaning records. The manager monitored the housekeeping staff's adherence to the cleaning schedule to ensure the ward was both hygienic and clean. They were up-to-date and demonstrated that the environment was cleaned daily.
- Environmental risk assessments were undertaken regularly to ensure a safe environment for patients. These were completed monthly by the health and safety lead. For example, we saw the January 2016 assessment and action plan which identified doors were being propped open by staff members. There was a dated plan to address this matter. However these did not assess or identify the issues surrounding using the corridors as day areas.
- Young people had access to alarms in both their bedrooms and bathroom. Staff carried personal attack alarms to keep them and patients safe. All staff reported they had access to personal attack alarms. However, staff told us that sometimes agency staff did not always know how to use them safely, the alarm would identify the area where help was required but agency staff did not always go to the correct area as they did not check the alarm panel when an alarm was sounded. A response team consisting of nursing staff responded for support if staff activated the alarms.

Safe staffing

- The clinical service manager had carried out a review of nurse staffing levels. This set staffing levels on the ward. The manager said they followed the organisation staffing policy, and senior staff met regularly to ensure they met safe staffing levels on a daily basis. We reviewed the staff rotas for three months prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the organisation as safe. For example, on the CAMHS ward the organisation had assessed that two qualified nurses were to be on duty at all times and records confirmed this was the case. We were informed the current staffing establishments were 14.3 WTE qualified nurses, 10 were in post, three have been recruited with pending start dates and the remaining post had been advertised. The establishment for healthcare support workers was 14.6 WTE, there were no vacancies. Young people stated there were enough healthcare assistants to enable them to complete activities.
- A staffing calculator was used to provide a review of safe staffing levels on the wards. This had led to changes in staffing levels. For example in 2015 the calculator showed that across the hospital on all wards there was on average two patients on special observations at any one time. The capacity for staffing this had been increased permanently to address this, staffing on the acute ward was now four patients to one staff member, an increase from six to one.

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

Requires improvement

- Staff and patients told us that there was a high level of agency staff on the adult wards; it was not possible to corroborate this due to the rotas being unclear at the time of the inspection. Rota's were difficult to understand due to numerous alterations and re-writes of the rota, it was not clear from the rota's we reviewed how many agency staff had been on duty at any one time.
- The number of shifts filled by bank or agency staff to cover sickness, absence or vacancies on the CAMHS ward over three months was 57. The number of shifts that had not been filled by bank or agency staff where there was sickness, absence or vacancies over three months was zero. The manager said that agency staff were usually deployed to ensure young people had one to one observations. Shifts were regularly filled by staff of other wards to reduce agency/bank use and ensure consistency for the young people. However, young people at the focus group said they often didn't know the staff on duty at night.
- The clinical services manager met regularly with nursing agencies used by the hospital. Agency staff were offered mandatory training through the hospital. Managers said there was an agency induction process for each ward and that the majority of agency nursing was for special duty nursing. However patients felt they were usually not skilled enough and therefore put extra pressure on existing staff.
- Ward managers were able to request additional staff should the need arise, for example if young people on one to one observations or if specific activities were taking place. On the day of inspection the manager adjusted the rota to ensure an ill young person had one to one support. Young people spoken with confirmed activities like going to the cinema were rarely cancelled due to lack of staff. However, staff on the acute ward told us that they could not always engage in a pro-active manner with patients on the ward as their time was taken up with one to one observations.
- The staff numbers meant that there was enough staff to initiate a physical intervention while still allowing staffing presence in ward areas for the other patients.
- Sickness rates were 5%. On the CAMHS ward the rate was low at 3. 8%. Staff members in the focus group said the ward was a positive place to work which impacted upon sickness levels.
- Staff turnover was high with 51 leavers between 1 November 2014 and October 2015 out of a workforce of 144. The hospital director explained that the majority of these were during the six month probationary period. The biggest challenge for retention of nursing staff was London nearby paying higher rates and with better transport. The provider was being creative in its recruitment strategy for qualified nurses, providing various incentives to staff. Priory group introduced a program to sponsor support workers in nurse training. Personal invitations to apply for this program were in support workers personal files. Staff turnover on the CAMHS ward in the 12 month period was only 8%. One staff member had worked there for over 20 years.
- The doctors in the hospital were a mix of employed and self-employed. The hospital employed two consultant psychiatrists who worked on CAMHS and the eating disorder service. The remaining doctors, two on CAMHS, one on eating disorders and six on the acute ward were self-employed. The medical director was self-employed. The medical director said that the medical cover was adequate and that they could not cope with fewer doctors. A contract with another provider was in place for out of hour's medical cover. Doctors would be on site 24 hours, normally staying in accommodation on site. This was being refurbished at the time of the inspection, so provision was temporarily made for the doctor to stay nearby.
- Mandatory training compliance was at 95%. Mandatory training was refreshed on an annual basis and included courses such as health and safety awareness, basic life support, breakaway, safeguarding, infection control, and clinical risk management. Compliance with training was monitored by the site learning administrator.

Assessing and managing risk to patients and staff

- The staff team did not complete risk assessment that would assist them in the safe care and treatment of the young people. They did not update these assessments regularly after each incident. We looked at six young peoples 'electronic care records. Four of the six had omissions. Young people in the focus group confirmed

that risk assessments were mostly completed by patients. The assessments were not a working document for the staff team. They were summary of the patient's view of risks to themselves. They did not translate into comprehensive risk management plans or into the young people's care plans. For example on one young person's care notes we read that they had had four admissions in two months however the risk assessment was ticked 'no' to risk in all boxes. In the dialogue box it said "x returned to ward with their father and completed a risk assessment and indicated no risk. Bag search and contraband found' the notes did not detail what was found. Shortly after completing the assessment the young person was rushed to hospital having taken an overdose. The risk assessment had not been updated following this incident.

- Risk assessments did not always contain clear details about the individual`s risks, or how staff should manage them. For example, in one young person`s care record lots of current risks were ticked as 'yes' but there was no explanation written about the risks. Under the section named 'other risks' it was identified that there were problems with the young person's physical health, however, there was no physical health care plan. This patient had a diagnosis of an eating disorder (ED) but there was no ED section on the risk assessment. Ligature risks were assessed on an individual basis and would be documented in care notes. Care notes reflected where risk was assessed and risk items had been removed from patients, or observation levels increased to reduce the risk. However, the risk assessments did not always contain enough details of the measures and controls that staff needed to use to minimise the risk. Staff we spoke with said they would rely on handover or senior management meetings for updated information on ligature risk.
- We reviewed six individual care records on the adult ward. Staff had completed a range of comprehensive assessments, including risk assessments following a patient's admission to hospital. The records held appropriate personalised information to enable staff to have a clear understanding of patient`s needs.
- On the adult ward we saw in case records that where a person was considered to be at risk of harming themselves that items which they could use to hurt themselves with, were removed as part of a risk assessed approach. As the perceived risk reduced, items such as belts and telephone charger cords would be returned to the patient as per the organisational policy.
- The staff team ensured informal patients could leave at will. Information in six young people's care records reviewed and discussion with three young people confirmed this was the case. There was a sign on the exits to explain that if patients wished to leave it should be discussed with a staff member.
- The organisation had policies and procedures in relation to the use of observation and searching patients that were known to staff on the ward. There was a list of items that could not be brought onto the ward displayed in the corridor
- Staff used NICE guidance 'violence and aggression: short-term management in mental health, health and community settings' in relation to the use of rapid tranquillisation and prone restraint. Young people's care plans gave clear instructions on which medicines should be given and when, as well as physical monitoring observations.
- The hospital did not have a seclusion room.
- The majority of staff were up to date on safeguarding training, 96% of staff had completed safeguarding training for children and 88% had completed safeguarding of vulnerable adults. All staff spoken with knew which who the child protection lead was. Information was displayed in the ward corridor with contact details for safeguarding. Staff members explained their responsibilities to raise safeguarding concerns. They had access to written safeguarding processes and these were up to date and in line with current guidance.
- Medications were managed safely. On the CAMHS ward, medicines were dispensed from a separate room and all medicine cupboards and refrigerators were tidy and locked. The room was very small but was suitably equipped with locking cabinets. It was located in the ward office but was shortly going to be moved to another site on the ward. The keys were kept by a registered nurse. Fridge temperatures in the clinic were monitored and were within the guidelines for maintaining the effectiveness of medicines. There was a

community pharmacy service, which provided the medicines prescribed to patients and other medicines ordered on an individual basis. This meant that patients had access to medicines when they needed them.

- The pharmacist visited the hospital weekly to audit the stock and storage or medication and all relevant documentation. Audits included checks for high dose prescribing and PRN, (when required medication) with any concerns reported via email to the prescribing consultant. The pharmacist attended the clinical governance meetings to liaise about any issues. We looked at prescription charts and there were no gaps. The pharmacy had recently introduced a live view system that allows any errors to be reported via email to the wards immediately.
- Patients told us that staff explained the reasons why they were taking medication. They also said the doctors had explained treatments to them and gave them written information if they requested it. We saw that information leaflets about some medications were available in the communal areas. On the adult ward there was evidence in patient files of the doctor explaining the medicine being prescribed to the patient.
- We reviewed all the medication arrangements for patients detained under the Mental Health Act. This showed that the rules for treatment for mental disorder were being met, with people being given medication authorised on the appropriate legal certificates.

Track record on safety

- Information from the provider showed that there were 13 serious incidents recorded between 11 November 2014 and 02 November 2015 across all locations. The majority were on the CAMHS ward and related to allegations of historical abuse that were managed appropriately under safeguarding processes.

Reporting incidents and learning from when things go wrong

- The process for managers reviewing incidents had been changed across Priory group following learning from other hospitals. All staff we spoke with knew how to report incidents on the electronic incident reporting system. We reviewed eight incident reports and they contained an appropriate level of detail about both the event and any injuries sustained by staff or young people. All incidents were reviewed by the manager and forwarded to the organisation's governance team, who maintained oversight. The system ensured that senior managers within the organisation were alerted to incidents.
- Senior managers reviewed incidents within 48 hours with a prompt guide to ensure they were consistently checking forms were correctly completed and reviewing immediate actions. Team incident reviews were in place where the clinical team followed a structured format to review incidents. The team incident reviews recorded the multidisciplinary teams view on the clinical risk to patients and any recommendations. This included completing a detailed summary, a chronology and analysis with the recommended actions. The hospital had been the pilot site for the Priory group for this new system. All 12 of the reviews completed since the introduction in January 2016 were of good quality.
- Incidents and the findings of the clinical team review were discussed at a regular governance meeting called the learning outcomes group. There was evidence of change in practice following incident reviews, including planning permission being sought for a new fence and ensuring staff had flat footwear following some absconsions. However, the learning outcomes group did not consistently track the actions to be taken. For example, the meeting on 11 December 2015 raised the concern of whiteboards containing confidential information in a staff office being visible to patients. This included an action for an obscuring film to be used on the windows. However, four months later at our inspection the information the boards was still visible to anyone looking through the windows.
- Learning from the incidents was shared with staff at staff meetings and copies of a hospital learning log were available on the ward. Attendance at staff meetings was variable, so copies of the learning log were also distributed to staff via individual email.
- The hospital manager ensured that staff were open and transparent and explained to patients if things went wrong.

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

Requires improvement

- Staff spoken with confirmed they knew about improvements that had been made to improve practice. For example, staff had reviewed their practice about monitoring the doors after a young person had absconded.
- The majority of staff said they had the opportunity to have a formal de-brief after a serious incident and that they could access additional counselling support if needed.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- All patients had a physical health check on admission and arrangements were made to meet physical health care needs where required. All six young people's records reviewed confirmed that staff worked within NICE guidelines in relation to physical health checks. On the acute adult ward we saw evidence of a patient who had required a scan being taken to hospital and the active follow up of her care by the psychiatrist.
- Clinical information was held on each ward using an electronic care records system. Staff entered information directly or uploaded information. Information was stored securely and available to staff when they needed it. There was a mix of paper and electronic records. Records were up to date and included concerns or actions taken to ensure patient well-being. However, the quality and detail of care plans and assessments varied between the wards.
- Young people's assessments were comprehensive and holistic on the CAMHS ward, although they did not link in to the risk assessments. On admission all young people received an assessment from the nurses and the ward doctor**.** In five of the six young people's files we reviewed, the patient admission assessment was completed and written up within 24 hours. In one case the nurses assessment was completed and uploaded on the same day as admission but the doctor's assessment although completed on the day of admission was not uploaded until 10 days later. The ward rounds and multi-disciplinary team meetings were recorded in five of the six progress notes.
- Staff ensured young people were involved in their care. In four of the six care plans there was evidence of patient involvement. In two of the six plans there was no evidence in the text but there a ticked box to indicate the plan had been shared with the patient. The care plans did contain comprehensive points about the patient and showed evidence of updating except one of the six, which was not updated following an overdose.
- However, on the adult acute ward, six out of the seven care plans we reviewed were not holistic or person centred. Some patients described their care plan as appearing in their room overnight, they had not been involved in writing it. Care plans we reviewed used goals such as X to remain safe and alive on the ward; and X to gain insight into her mental illness. There was no evidence of recovery-oriented goal setting or maximising the patient's personal resources to boost their recovery.

Best practice in treatment and care

- Medical staff confirmed the use of National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. This was checked by the visiting pharmacist.
- Young people could access psychological therapies as part of their treatment and psychologists were part of the ward team. However, adult patients only had access to therapeutic groups if they were assessed as being well enough to attend.
- The staff team ensured records of physical health observations were completed. They were present in all six files reviewed. There was regular medical monitoring of bone density and other general health indicators, such as blood results for the patients with eating disorders. The consultant responsible for physical healthcare confirmed that they checked observation charts at ward rounds.
- The wards used a number of measures to monitor the effectiveness of the service provided. For example, CAMHS staff assessed patients using the Health of the Nation Outcome Scales (HoNOS) which covered 12

health and social domains. They also used young people satisfaction at beginning and end of a period time at the hospital. All six young people had HoNOS recorded and of the three young people with eating disorder two had the eating disorders examination questionnaire (EDEQ). One of the six had another incentive based outcome measure called the recovery star. This enabled the clinicians to build up a picture over time of their patients' responses to interventions.

- The service conducted a range of audits on monthly basis on incidents, staffing, patient experience, complaints, and safeguarding.

Skilled staff to deliver care

- The clinical team included consultants, dietician, psychotherapist, psychologist, nurses, ward doctors, head teacher, occupational therapists, family therapist, teachers and administration staff.
- When staff started working at the hospital, they completed an induction, which consisted of completion of all the mandatory training. New staff were required to complete the competencies during the probationary period. Staff also received an orientation period on the ward that included familiarisation with policy and procedure. These were completed in the majority of staff files reviewed. However one member of staff told us that this hadn't been followed during their induction, the induction booklet had been looked at once in their six month probationary period and then signed as completed.
- We received mixed feedback from patients about the care they received on the adult wards. Some felt they had made good progress and were being heard and others felt that they had taken a step backwards. Some patients felt that their needs of having an eating disorder could not be met on Chelmer ward as the staff did not have the knowledge or training to support them. Patients on the acute ward told us they were concerned at staff ability to manage the more complex presentations that were being admitted. Staff and patients told us that the level of staffing was insufficient to meet the needs of the patients and staff; however, staffing numbers that had recently been increased in line with safer staffing.
- The hospital did not ensure that staff received regular clinical and managerial supervision. In 2015staff received one-to-one supervision at irregular intervals. For example, on the CAMHS ward three staff members only had one supervision session in the year and another three times in the year. In January 2016, the CAMHS manager started a training matrix to ensure staff received monthly supervision, however only eight of the 23 staff received supervision and in February it was six of the 23 staff. On the adult ward six staff members had supervision sessions scheduled in February 2016 and records indicated that only two staff had actually received supervision.
- Staff received yearly appraisals. Appraisals were completed annually during three months of the year. 98% of staff had received appraisals in 2015. All members of staff had a personal development plan that was monitored, assessed and modified during the annual appraisal process. All appraisals were recorded well and had objectives and training needs identified and were individualised.
- The provider was able to offer non vocational qualifications in a wide range of clinical and management areas. Staff told us they could attend external training programmes through which they could achieve nationally-recognised qualifications. However specialist training for working with young people could be developed further for registered staff. Locally developed training was in place for healthcare assistants. This looked at a variety of subjects including mental health problems, medication and physical healthcare.
- There were monthly team meetings. The attendance at these meeting was limited. In the last three team meetings the average attendance was five members of staff. Staff told us it was difficult to attend the meetings due to workload commitments. However, staff felt well supported by colleagues on the ward.
- There was a weekly consultant meeting and a weekly peer group meeting for continuing professional development where staff undertook case presentations, present journal articles. Nursing staff had regular medicines competency tests that were recorded in the personnel files.
- We reviewed nine personnel records. All staff working within the hospital had appropriate checks and references completed before commencing

employment. Disclosure and barring service checks were completed regularly every three years. Clinicians who needed professional registration were reminded and checked by the HR administrator. An audit system was in place to ensure that the relevant paperwork was in each personnel file.

- Where serious concerns were raised about an individual's performance there were detailed investigations with appropriate actions taken and recorded.

Multi-disciplinary and inter-agency team work

- There were regular weekly multi-disciplinary team meetings. On the day of inspection two consultants, dietician, psychotherapist, psychologist, nurses, student nurse, ward doctor, head teacher, occupational therapist, ward manager and family therapist attended the CAMHS meeting. The care records showed evidence of multidisciplinary working across the wards. Young people did not attend multidisciplinary meetings; however, they were able to contribute through attending meetings with the consultant to review their care notes and level of observations. Patients on the acute ward were encouraged and supported to attend their meetings.
- The wards held care programme approach meetings (CPA) three months after admission and six monthly thereafter, these are multi-agency meetings to review the progress of the patient and plan for their recovery and discharge.

Adherence to the MHA and the MHA Code of Practice

- Staff received regular training on the Mental Health Act (MHA) and the Code of Practice: Mental Health Act1983. Staff had online and face to face MHA training. The most recent training session in the past six months included: the revised Code of Practice, receipt and scrutiny of detention papers, explaining rights to patients, restrictive practice, independent mental health advocacy and consent. Four out of the five qualified nurses across the three wards (child and adolescent ward, Springfield and Chelmer ward) we spoke with had a good working knowledge of the MHA.
- Staff on told us that on the child and adolescent ward it was quite usual to have low numbers of detained patients. They said all attempts were made to treat young people informally and the decision to detain patients was usually seen as a last resort.
- The MHA administrator on site supported clinical staff and accessed legal advice if needed via the senior management team. The medical director felt that the MHA manager offered staff advice and appropriate support. The wider organisation had a networking group for their MHA administrators for support, advice and guidance as needed. Staff confirmed they could get advice when required.
- Staff ensured that the documentation in detained patients' files was compliant with the MHA and the Code of Practice. For example, there was a record of the discussion between the patient and the responsible clinician and a statement that the patient consented. Relevant medication on the prescription charts had T 2 and T3 forms in order.
- The CAMHS consultant assessed young people' capacity/consent to admission and treatment. Their capacity/consent to treatment was reviewed after the initial three month period of detention and on renewal of the section. It was also regularly reviewed and documented in young people care files.
- Information on the rights of patients who were detained was displayed in wards. Independent advocacy services were available to support young people if required. Staff understood the need to explain patients' rights to them to ensure they understood their legal position and rights in respect of the MHA. Patients lacking understanding were automatically referred to an independent mental health advocate (IMHA). Information leaflets about how to contact the IMHA were on the wards and young people could self-refer. The IMHA visited the acute ward on a weekly basis and visited the CAMHS ward as requested. Staff were clear about the role and remit of the IMHA.
- The MHA administrator carried out monthly audits of documents relating to consent, treatment certificates, and section 17 leave (granted leave of absence from the hospital) rights under section 132, IMHA referrals. Any errors/omissions were escalated to the clinical

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Requires improvement

governance team. Weekly reminders were sent to ward staff about dates for treatment certificates and section renewals. There was also a monthly MHA report to clinical governance team.

Good practice in applying the MCA

- Mental Capacity Act (MCA) training took place at induction and was ongoing throughout the year. Staff had completed training in January 2016 and there was more planned for April 2016. The clinical support manager and a ward manager lead on MCA. Staff we spoke with on the acute ward had limited understanding of the MCA and DoLS legislation despite records showing 19 staff had been trained on that ward.
- Staff spoken with were clear about the application of the MCA for young people aged 16-17 who lack capacity and were aware of the need to assess for Gillick competence for children under the age of 16. There was a MCA policy and staff knew who to approach if they need support.
- At the time of inspection there were no Deprivation of Liberty Safeguards (DoLs) applications. mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available
- The young people's files contained capacity assessments relating to admission and treatment conducted by the consultant psychiatrist on admission. Other capacity assessments seen were decision and time specific. The assessments were carried out by nursing or medical staff. There were also best interest meetings. These included family, carers or IMCA (Independent Mental Capacity Advocacy introduced as part of the Mental Capacity Act 2005 This gives people who have an impairment, injury or a disability which results in them being unable to make a specific decision for themselves, the right to receive independent support and representation) unless the patient has specified otherwise.
- The clinical support manager completed MCA audits to monitor adherence to the MCA. Ward managers told us they found this useful.

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

Good

Kindness, dignity, respect and support

- We observed friendly and relaxed interactions between staff and patients on all the wards. The staff were respectful and polite in their responses to patients. Staff discussed patients in a respectful and knowledgeable manner during staff handovers. Staff interaction demonstrated that they had a good knowledge and understanding of the patient's needs.
- Young people were positive about the support they were given by staff. They said they had good relationships with staff and that they were involved in decisions about their care. All young people in the focus group told us the substantive staff were kind and very helpful. All the staff were motivated and committed to working with the complex needs of the young people.
- However all eight young people at the focus spoke of examples of when bank or agency staff had spoken to them in a manner which had upset them. We spoke to the manager about these issues and they told us they had been unaware of these concerns but would now investigate them. Patients on the adult wards also raised concerns about agency staff. They told us the staff didn't always treat them with dignity and respect because they didn't understand the complexity of their condition. They said this left them feeling disempowered
- Staff respected patient's privacy and dignity. They spoke to them politely and ensured they knocked on bedroom doors before entering. Staff demonstrated a good understanding of individual young people's needs. For example, when one young person withdrew herself from the group a staff member immediately went to assist her as they recognised it as a potential trigger for other behaviours.

The involvement of people in the care they receive

- Young people told us they were involved in decisions about their care. They said that their care plans were

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Requires improvement

discussed and developed with them and they were encouraged to attend their review meetings. Four young people said they had a copy of their plan to read. Information in the six care records seen confirmed that care plans were offered to all of the young people and only some chose to keep them.

- Young people were encouraged to give feedback and contribute to the running of the CAMHS unit. Staff held community meetings daily. Young people could raise issues or give feedback at the meeting. For example, the young people asked for menu to be changed so there was more child friendly food available. We saw they had compiled a list of food they would like on the menu last week and this list was currently with the cook to inform the next menu. Patients on the adult wards were also able to attend monthly community meetings, feedback from these meetings was displayed on the "You Said, We Did" notice board.
- Patients on all of the wards in the hospital had access to advocacy services. The advocate visited the hospital weekly and information regarding this including telephone contact details was displayed information on the ward and included in welcome packs.
- Staff gathered the views of the patients through the use of surveys after discharge. Staff discussed responses to surveys at team meetings and used this information to develop practice and make changes where needed.
- Patients were involved with the recruitment of staff. On the CAMHS ward young people had designed a speed dating/interviewing with five minutes with each candidate. Managers found it harder to involve patients on Chelmer due to their short length of stay not allowing time to help prepare patients for the interview process. Alternative engagement was used including groups to support patients to write questions that were important to them for the interview panel.
- There was evidence in the case notes on the adult ward that the patient's views of their treatment were sought, records demonstrated that the patients had at times challenged the treatment being suggested and if appropriate, the challenge would lead to amendments in the approach adopted. However, some care plans were not completed with the patient. Care plans were written in an instructive non-person centred style.

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

Requires improvement

Access and discharge

- The hospital did not have a catchment area. They provided care and treatment for young people who, in the main, came from local areas like Essex, Surrey, Kent, Ipswich and Suffolk. Young people had the opportunity to be discharged to a unit within the organisation that was closer to their home when one became available. The average length of stay on CAMHS ward was three months.
- Admissions on the adult wards were managed by the nursing staff who reviewed referral information and liaised with the psychiatrist regarding the suitability of the placement. Staff had mixed views about their ability to refuse an admission if they felt it to be unsafe. One member of the team said that their concerns for the safety of patients and staff would be listened to if the complexity of the referred patient was too high; others said that they did not feel able to refuse an admission. Both patients and staff said that they thought there were too many new admissions and this had a negative impact on the running of the ward.
- The admissions and discharge process on the acute ward meant that the qualified staff spent the majority of their time in the office during our inspection and not on the ward involved in direct patient care.
- Discharges on the acute ward could happen without prior planning for NHS patients if the referring authority re-patriated the patient to their local area. This could impact on recovery and the opportunity to engage in therapeutic activities. However, on the CAMHS ward young people and their carers could decide the times when they were moved or discharged. It was usual for young people`s discharge plans to fit in with family work patterns and school schedules.
- Staff on all wards liaised with the referring authorities regarding discharge planning. We observed staff at the

multidisciplinary team meetings discuss young people's plans for discharge. For example, one young person who was planning discharge discussed ways the service could help them engage in the community and staff were linking in with a local college to look at courses for them to attend.

- Substance misuse patients who completed the 28 day programme were able to access free aftercare once a week for a year following discharge.
- Staff told us that 95% of young people on the CAMHS ward were discharged back to their home environment. A senior staff member said it could sometimes be hard to find suitable placements for young people who are ready to move on from the hospital but they rarely had delayed discharges. Of the five recent discharges, four were timely and one young person had to wait 28 days until a bed in a suitable PICU was found. In 2015 five patients were admitted to PICUs or high intensity units in trusts or within the independent sector from the CAMHS ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The hospital did not have sufficient facilities to promote dignity and confidentiality for the patients as space on the wards was limited.
- The CAMHS ward was set on two floors with long corridors. On the first floor of the hospital there was the office, bedrooms, a small kitchen for snacks, lounge, quiet room, staff toilet and an educational room. On the second floor there was a small office, lounge, bedrooms and a small kitchen for snacks. However, during the day both lounges and the quiet room were used for other purposes like multi-disciplinary team meetings, team meetings, therapy or education. This meant the young people had no communal space that was available for their exclusive use during the day. They could not access the lounges if they were not able to attend education or therapy. There was no quiet space where young people could have time out. Seven young people described this as annoying as it meant the only space they had to be private was their bedrooms.
- The lack of access to a lounge area was also present on the acute and eating disorder wards. Corridors had been converted into communal areas with sofas and an eating area but they were essentially busy thoroughfares. We were very concerned of the impact on patients with an eating disorder. The adult eating disorder ward was used by all staff as a corridor to other areas of the hospital. When observing the daily senior managers meeting, the whole senior management team walked through the eating disorder ward past the patients sitting in the corridor. Patients from other wards were also escorted past the patients with eating disorders. This meant there was little privacy or dignity. We were also concerned that young people with an eating disorder had to eat their snacks sitting at the table in the corridor in full view of any patients who were around at the time. Three young people in our focus group commented on the arrangement and said they found it difficult.
- We were concerned that, on both days of inspection, young people were seen sitting on the floor in the corridors as there was not sufficient sofa space. On the first day of inspection the corridor was very crowded and noisy. Some young people sat on the floor, one young person played a guitar, another played the piano, staff tried to talk to patients and the housekeepers were pushing equipment through the space. We asked young people in the focus group what it was like to use the corridor as the main communal space. One person told us it was cosy and five people told us that it was fine if the ward was calm but during December 2015 when there were many incidents and they described the atmosphere as unbearable.
- The wards were clean and the furnishings were clean and of good quality. Bedrooms were en-suite and well-furnished. However, bedroom doors did not have viewing panels which meant that staff had to either physically open the door to conduct observations or for more vulnerable patients sit outside the room with the door open. Patient's told us that they found it very intrusive that staff came into their bedrooms when they were sleeping to do observations.
- One to one observations on the acute ward were maintained by keeping the patients door open to allow the staff member in the corridor to observe the patient. On the female corridor this meant that a female patient was visible to male patients as they walked down the corridor to access the patient kitchen.
- Patients bedrooms lead directly off the main thoroughfare corridors and four young people in a focus

group told us how noisy it was in their rooms. Young people said it was very difficult to have early night because they could hear people talking in the corridor. Young people in the first floor bedrooms said there was nowhere on the ward where they could be assured they could have a quiet peaceful time.

- Décor in the CAMHS ward was tired and not young people friendly and the equipment such as the games machines in the lounges was very dated.
- Young people shared a clinic with the adult wards. This meant that they had to leave the ward and walk escorted onto the adult wards to be weighed or have medical checks. Young people described this as "the walk of shame" and that it was distressing. All young people in the focus group commented negatively about this arrangement.
- There was a room for patients to meet visitors in private off the ward however most visits occurred on the ward as the visit room was also used for multidisciplinary meetings and as a quiet room and as the hospitals multifaith room.
- We observed a medicine round. Patients from both Springfield and Chelmer ward share the pharmacy room for receiving medications. Patients stand in line/queue to receive their medication from the pharmacy room via a half door system. Some patients were standing in their nightwear to receive their medication. The pharmacy room was located on a busy corridor that is a thoroughfare to Chelmer Ward and this practice did not promote privacy or dignity.
- Patients used their own mobiles to contact friends or family. There were some restrictions in place about the use of mobile phones with cameras to protect the privacy of patients. These were listed on the wall in the corridor. There was access to telephones in main corridors but this did not afford any privacy as it was by the sofas.
- The young people had access to a large enclosed outside garden with a smoking area. In the garden there was a range of play equipment including hula-hoop's and balls. There was also a small raised vegetable plot. However, young people rarely used it. Access was via a staircase to the ground floor which had been identified as a high-risk ligature area. Education and therapy took place mostly within the ward so young people rarely left the ward during the day. The staff team had tried to introduce a compulsory daily visit to the garden. In January 2016 ward staff started recording the number of young people who went into the garden each day. We looked at these records for one week in February 2016 and found that the majority of young people only went into the garden once in that week.
- Patients on the adult wards had limited access to a shared, outside space. Patients used a courtyard area for smoking. Patients felt they had limited access to fresh air. Staff told us the limited outside space often frustrated patients and led to incidents occurring on the wards and in the courtyard area when patients did not want to come in. On the day of the inspection it was a bright crisp sunny day but there were no patients accessing the grounds of the hospital. We observed one patient ask staff three times to be taken outside for a walk with staff as this had been agreed with the psychiatrist. The patient was becoming distressed as they had been asking for this activity since lunchtime and it was starting to get dark outside and it would not be possible to go outside once it became dark. There was not a safe garden area for patients to go out unescorted.
- The hospital has its own restaurant. Some patients ate their food on the table in the corridors on the wards. We were concerned about the impact of patients from other wards walking through the eating disorder ward to access the restaurant at mealtimes during bad weather.
- The food menu was of good quality with healthy options available. Menus were displayed on ward areas and the patients had input into them. There were fixed mealtimes in place and snacks were kept in the kitchen area on the ward and available at all times. Patients had access to hot water to make drinks at any time of the day . Cold drinks were available at all times. Patients gave us positive feedback about the food. However, two young people said they would like more child friendly food like macaroni cheese as they found the menu confusing.
- Hot drinks and snacks could be prepared at any time on the wards. Patients on the acute ward told us that this wasn't well stocked and often milk and other supplies weren't replaced regularly. Team meeting minutes confirmed this, as staff were reminded in team meetings to ensure that these stocks were replenished.

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Requires improvement

- Patients were able to personalise their bedrooms. They showed us their rooms and there had photographs of family and friends and posters. Patients could safely store their possessions securely as all bedrooms had either a lockable safe or a lockable wardrobe top box.
- The young people commented positively on the range of activities like going to the cinema. Other activities included a cookery group, baking and arts and crafts. The occupational therapist post was vacant following staff leaving but a new person was being appointed.
- On the adult wards, apart from group therapy, there were no organised activities for patients to take part in.
- The hospital had a day hospital with 19 staff. It had a program of individual and group sessions for private patients. Only five patients from the wards accessed the day hospital. We were told this was because other patients were too ill to participate in the sessions the day hospital provided.

Meeting the needs of all people who use the service

- The hospital was not accessible in all areas to patients with limited mobility or wheelchair users. CAMHS was on the top two floors of the building with no lift. The CAMHS ward manager told us they would not admit any patients with limited mobility. The hospital would refer people with limited mobility to other sites. There was no level access approach to the acute ward. Staff told us that patients with mobility problems would have to access via the eating disorder ward which meant walking through the corridor which was also the main communal space. There was no lift to the upstairs male bedroom corridor, male patients with reduced mobility would be provided with a bedroom on the female corridor.
- Patients' needs were met, including their cultural, language and religious needs. Dietary needs such as halal food were available on request. Patients could request a weekly visit from representatives from different faiths. We observed a chaplain on the eating disorders ward. Patients had been supported to visit places of worship.
- Ward staff could access interpreters to help assess patient's needs and explain their rights, as well as their care and treatment. Interpreters had been used to assist patients on the adult wards. Leaflets explaining patients' rights under the Mental Health Act were available. These were available in different languages if required.
- Patients had a choice of meals if they did not want the meal provided. The menu had evidence of patient's choices and ensured patients with particular individual assessed needs or preferences ate appropriate meals.

Listening to and learning from concerns and complaints

- The hospital had received 18 formal complaints in the 12 months prior to inspection. Six of these were upheld. A review was completed of ten complaints. Managers response to complaints was comprehensive. Detailed investigations were completed within agreed timescales. The hospital director or the clinical services manager then wrote letters to the complainant. The letters were of a high standard, warm and compassionate in tone. Where a complaint was upheld a full apology was given. One letter to a patient where a complaint had not been upheld gave a full detailed explanation of the reasons. The letter then praised the patient's actions with encouragement.
- Patients could make a complaint at their community meetings or via the complaints forms. Complaints were monitored by the manager and senior staff members who conducted quality assurance visits.
- Young people, relatives, and others involved in supporting young people were made aware of how to make a complaint. They were given information at admission in their welcome pack and at reviews. Information on how to make a complaint was also displayed in the corridor and office. This included information about the role of independent advocacy services in complaints. Young people in the focus group were mixed about staff response to their complaints. Some said they complained about the noise and nothing was done. Others said they complained about the food and this was sorted out quickly.
- Patients on the adult wards told us that they knew how to complain and felt confident to do so.
- Staff members ensured that complaints were monitored as part of the organisational risk register. Staff addressed young people's concerns informally as they arose. The complaints policy and procedure was part of

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Requires improvement

staff induction process, and staffs understanding was reviewed through training, supervision and appraisals. Staff were aware of what to do if the young people made a complaint and how to support them.

- The CAMHS ward manager ensured that learning from complaints was discussed at team meetings and changes took place. For example, a relative had raised concerns about not having a meal plan for their child on a home visit. Following the complaint the staff team ensured that each young person had a meal plan to take home.

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

Good

Vision and values

- Managers knew the organisation `s vision and values We found staff engagement with the vision and values to be mixed in that some were unaware and others had some understanding.
- The manager said communication from senior managers was effective. There were regular emails and staff forums where senior staff shared communications and invited comments from staff teams on the running of the service.
- The Staff team had regular contact with senior managers who visited the wards. Staff members spoken with knew who senior managers were. Staff said they were very accessible.

Good governance

- Overall there were effective governance systems and meeting structures in place. Regular clinical governance meetings were well attended by senior clinicians and managers in the hospital. The meetings focussed on a range of safety and quality issues. They included information such as complaints, incidents and the senior managers quality walk rounds. The meetings also included reviews, prescribing reviews, and discussion of national guidance. The medical staff, the hospital director, the clinical services manager, the MHA administrator and the contracted pharmacist attended these meetings.
- The hospital risk register had risks identified by the senior team in the clinical governance group. This was escalated monthly to senior staff within the Priory group. The risk posed by absconsions and lack of a secure fence had been escalated via this process resulting in agreement of capital funding to address the issue. Ward managers could submit items to the organisations risk register.
- Identification of risks in other Priory hospitals was shared with Priory hospital Chelmsford. These were discussed in governance meetings. The information was disseminated to staff by email in learning outcome and clinical governance bulletins. The hospital director was able to identify learning points from other hospitals that had resulted in change within the hospital. For example, in another hospital a patient had tied together moist facial wipes into a ligature that was difficult to cut with normal ligature cutters. Staff in the hospital were made aware of this risk and monitored their use in patients at risk of self harm.
- A daily flash meeting was held each morning for ward managers, and senior managers to consider risks and discuss actions needed to meet those risks. This meeting was a result of learning from an incident in another part of the organisation and was intended to ensure that the hospital manager and the senior management team had a full understanding of the risks and issues on the ward.
- Compliance with mandatory training was high.
- Ward managers had access to systems of governance that enabled them to monitor and manage the hospital and provide senior staff in the organisation with information. One example of this was the electronic records that monitored the training that staff had received and informed staff and their managers when training needed to take place.
- Data collected monthly on performance was sent to senior managers. These included audits on care plans, risk assessments, incidents and complaints. An annual audit plan was in place to review quality of systems such as the ligature audits and infection control.

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Requires improvement

- The organisation monitored ward manager's completion of audits and action plans. However, the audit of young people's risk assessments was not effective as we found many omissions in the six files we reviewed.
- Ward managers said they had enough time and autonomy to manage the ward. Where they had concerns, they could raise them. The manager had the support of a full-time ward clerk.
- However, supervision did not occur regularly and the supervision notes did not contain sufficient detail to demonstrate that staff were being supported in their roles. The arrangements to ensure staff received regular supervision and attended staff meetings could also be further developed.

Leadership, morale and staff engagement

- Senior managers in the hospital spoke positively about the staff team. However, they felt that engagement through traditional forums such as the hospital wide staff meeting was difficult. Although wards sent a representative to meetings it was still hard to reach all staff despite changing the times and days of meetings. Minutes were provided in hard copy and email. Staff told us that they raised concerns re safety issues with the management team but these concerns had not always been addressed.
- The senior management team told us that they had recognised that staff had not felt listened to. To address this senior managers had implemented a monthly Your Say forum, staff listening groups which were facilitated by a HR director external to the hospital management team, team meetings and management walk arounds and out of hours management ward visits to improve communication. The hospital director placed a great focus on the senior staff quality walk rounds as a way of engaging staff. The walk rounds were recorded and issues raised by staff discussed by the senior team at the hospital clinical governance meeting. Staff were aware of some of these initiatives, but they felt that attendance at the meetings was still difficult as the wards had to be staffed.
- All staff spoken with said they had a strong sense of team and they worked well together.
- Senior managers walked round the hospital on a regular basis completing 'quality walk rounds'. Formal records of the walk rounds had actions taken if any concerns were raised by the staff or about the environment. However, these had not recognised the impact of privacy and dignity the use of the corridors as seating areas had.
- There were leadership programs offered to staff identified with the potential to develop. For example, the hospital director had been offered training and support into her current role after initially joining Priory as a senior staff nurse. Managers said that leadership training had recently moved to a coaching based program which they felt was more positive. Some senior staff had been through this program with ward managers, therapy managers and head chef scheduled to undertake it in the near future.
- Whistleblowing process was clearly publicised. Senior managers from elsewhere in Priory would come to Chelmsford to investigate any concerns raised. Managers in the hospital would not lead the investigation. A summary of the findings would be published for all staff in the hospital to see. The hospital director said that where there had been whistleblowers in the past action had been taken. Staff were able to describe the whistleblowing process and the whistle blowing policy.
- The CAMHS ward was well-led. There was evidence of clear leadership from the manager. However, staff said the manager not always was visible on the ward during the day due to the high demands on her time. The culture was open and encouraged staff to bring forward ideas for improving care.
- However, on the acute ward the clinical services manager was temporarily covering the absence of the manager and deputy manager. Therefore, it was difficult to observe how the ward was being managed and led. Staff felt they were listened to by ward management and felt supported but also felt that change as a result of their concerns was very slow, leaving staff resentful of their workload. Staff on the acute ward felt they did not have enough people on duty to meet more complex care needs.
- Most staff we spoke with were positive about working in the hospital. When asked how much they rated their job satisfaction and engagement the staff members, in the CAMHS ward focus group and the whole hospital focus group, rated it highly. They told us they felt able to, raise concerns, report incidents and make suggestions for improvements.

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

Requires improvement

- Sickness and absence rates were low around 3.8 %. Staff members attributed this to the strong sense of team work on the ward for support when staff got stressed.
- All staff spoken with told us they worked in an open and transparent manner. The CAMHS ward manager was able to give examples of when the team had been open with relatives and carers about areas they could develop further. For, example giving relatives meal plans to use when young people go home on leave.
- Staff told us that they did not have a room for them to take their breaks, they had been provided with a shed for this, but they described it as cold and lacking in privacy.

Commitment to quality improvement and innovation

- The hospital were participating in Quality Network Inpatient CAMHS (QNIC) standards and were anticipating a QNIC inspection shortly.
- The CAMHS manager stated that they had a new pathway for young people with eating disorders. They had employed a nurse to work with the key workers, the dietician and the consultant.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The registered provider must ensure that female sleeping areas are separated and women on observations are not able to be observed by male patients when in their rooms and that female young people have access to a female only lounge
- The registered provider must ensure the layout of the wards is reviewed so that patients have access to communal space during the day which is not a corridor and patients with an eating disorder do not eat their snacks in the corridor.
- The registered provider must ensure that young people do not have to go to another ward to access the clinic.
- The registered provider must ensure that the staff team complete risk assessments that enable then to care for patients safely.
- The registered provider should ensure care planning on the adult ward involves the patients.

Action the provider SHOULD take to improve

- The registered provider should ensure that young people have regular access to the outside space.
- The registered provider should ensure that staff members have access to staff meetings.
- The registered provider should ensure that that nurses have time to provide one to one meetings with patients to ensure they can meet their needs.
- The registered provider should ensure that all staff have sufficient skills to care and treat young people safely and specialist training is available to them to develop their skills.
- The registered provider should undertake a full and thorough review of whether the problem of access can be resolved to ensure the hospital is not in breach of relevant regulations.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10 (2)(a) Patients privacy and dignity were not being protected against the risks associated with mixed sex accommodation.

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15 (1)(c) People should be able to easily enter and exit premises and find their way around easily and independently. If they can't providers must make reasonable adjustments in accordance with the Equality Act 2010 and other current legislation and guidance.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Accommodation for persons who require treatment for substance misuse

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

Diagnostic and screening procedures

Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9 (3)(a) (b)

Carrying out collaboratively with the relevant person an assessment of the needs and preferences for care and treatment of the service user

Designing care or treatment with a view to achieving service user's preferences and ensuring their needs are met.