

Priory Healthcare Limited

The Priory Hospital Woking

Inspection report

Chobham Road
Knaphill
Woking
GU21 2QF
Tel: 01483489211
www.priorygroup.com

Date of inspection visit: 2 June 2021 and 3 June 2021
Date of publication: 13/08/2021

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

Ratings

Overall rating for this location

Requires Improvement



Are services safe?

Requires Improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Requires Improvement



Summary of findings

Overall summary

The Priory Hospital Woking provides an acute inpatient service and an inpatient substance misuse treatment programme for men and women of working age.

During the inspection we found several areas of concern. Following this inspection, we wrote to the provider and told them that we required them to provide us with assurance that they would make immediate and ongoing improvements otherwise we would use our powers under Section 31 of the Health and Social Care Act 2008 Act. Section 31 of the Act allows CQC to impose conditions on a provider's registration if the provider does not provide assurance that they are addressing our concerns. The provider responded to us with an action plan that described the immediate and ongoing actions it was taking.

Our rating of this location went down. We rated it as requires improvement because:

- The management of ligature risks across the hospital was not robust. Not all of the wards were safe for all patients. The older part of the hospital had areas with significant ligature risks. The majority of these ligature points were not easily observable by staff and were in corridors with a closed door. All patients could have access to these areas.
- Staff did not have written guidance which included patients' risks of self-harm and suicidality, to determine which type of room a patient would be allocated to: a safer room, safe room or standard room. They did not have guidance on how staff should respond if a patient's risk changed when they were in a standard bedroom.
- Staff did not safely manage the searching of patients on return from leave or admission. Patients at a community meeting that we observed, told ward staff they still had lighters and illicit substances. Patients told us that searching was inconsistently applied when returning from leave or returning from off the hospital grounds.
- Staff did not record the rationale for decreasing observation levels or record a rationale in patients risk assessments for deciding which type of room a patient would be allocated to: a safer room, safe room or standard room.
- The governance processes needed to be strengthened to provide assurance that all the measures needed to maintain patient safety were in place.
- Patients told us they were involved in planning their care and treatment but did not receive a copy of their care plan.
- Staff and patients told us that, due to the COVID-19 pandemic, patients were not allowed visitors on site, unless there were exceptional circumstances. Staff told us that this was a Priory wide policy.

However:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Summary of findings

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.
- On the whole, staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff felt respected and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.
- Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Staff we spoke with were complimentary of the hospital director and director of clinical services. Staff said they were approachable and listened to feedback regarding the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to The Priory Hospital Woking	6
Information about The Priory Hospital Woking	8

Our findings from this inspection

Overview of ratings	10
Our findings by main service	11

Summary of this inspection

Background to The Priory Hospital Woking

The Priory Hospital Woking provides an acute inpatient service and an inpatient substance misuse treatment programme for men and women of working age. The hospital takes referrals for private patients, and those funded via medical insurance, and admits NHS patients. During the Covid-19 pandemic the number of NHS patients, and patients detained under the Mental Health Act (MHA), increased. At the time of inspection there were 13 privately funded patients and 14 NHS patients. Priory Hospital Woking has 35 rooms for patients across two gender specific wards. Cedar ward has 18 beds for men and Maple ward has 17 beds for women. There was one corridor of four beds which could become part of the male or female ward dependent on the gender mix required at the hospital at any time.

At the time of our inspection there were 27 patients receiving treatment.

The hospital has an acute treatment programme for a range of conditions which include depression, stress and anxiety. The hospital also provides a treatment programme for patients with addiction issues with substances and behaviour and provides medically assisted detoxification to patients who require this.

Patients who have completed the 28-day addictions programme at the hospital can access up to 12 months of follow-up care. The day programme also provides an individual or group therapy programme to people who have not been inpatients but have been referred to the programme by a consultant psychiatrist.

The Priory Hospital Woking was last inspected on 10 April 2019. This was an unannounced focused inspection. The inspection looked at safe and effective.

The service received four requirement notices. We told the provider that they must take action to improve the following:

- The provider must ensure that all mitigating action identified in environmental ligature assessments is taken to ensure the health and safety of all patients.
- The provider must ensure they have legal authority when they deprive patients of their liberty for the purpose of receive care or treatment.
- The provider must ensure that they act in accordance with the Mental Capacity Act 2005.
- The provider must ensure that they act in accordance with the Mental Health Act 1983 as amended 2007.

We found that problems with these identified areas remained at this inspection.

Following this inspection, we wrote to the provider to inform them of our concerns about the management of environmental ligature risks at The Priory Hospital Woking. We wrote to the provider under section 31 of the Health and Social Care Act 2008. Section 31 of the Health and Social Care Act 2008 Act is an urgent procedure whereby CQC can vary any condition on a provider's registration in response to serious concerns. A letter of intent sets out our intention to take urgent action if the provider does not assure us that it will make the required improvements urgently.

The provider responded to our letter on 8 June 2021 with an action plan to address the issues. In the Section 31 letter we told the provider that we were concerned about the lack of adequate assessment and mitigation of environmental risks to patients at The Priory Hospital Woking. The management of ligature risks across the hospital was not robust. The majority of these ligature points were not easily observable by staff and were in corridors with a closed door; and one which all patients could have access to. We were told by staff members that these risks were managed through observation. However, we did not observe staff in these areas on either day of the inspection. We asked the provider to

Summary of this inspection

tell us how they will identify and mitigate the ligature risks that exist across the whole hospital, in a consistent way, to ensure safety of patients. The provider responded immediately to these concerns: suspended NHS referrals to the hospital, placed a member of staff to observe the second floor, and commenced the adaptation of four patient bedrooms to make them safer rooms.

We were concerned about the management of risk when allocating bedrooms to patients. Staff told us that patients would be assessed for ligature risk on admission, to assign appropriate bedrooms to patients. However, we did not see guidance or a policy in place for this to happen. Nor did we see guidance on the allocation of rooms for existing patients when their risk increases. We were concerned that staff did not consider other risks such as suicidality on admission when assigning rooms which would or may expose patients to the risk of harm. A patient had recently been admitted after attempting suicide but had been allocated a standard room. We asked the provider to tell us how they would ensure that there was protocol and guidance for staff on the allocation of bedrooms to patients which minimised the risks to that patient and allows for regular review dependant on their needs. The provider told us they have established and embedded a new standard operating procedure where each new patient will be admitted to a safer room. The consultant will review their risk and can transfer them to a different room dependent on their risk. The provider had included this in their welcome pack information to new patients.

We were concerned that patients will or may be exposed to the risk of harm because they are not appropriately searched or drug tested when returning from leave or being admitted to the hospital. Our inspectors observed a community meeting where patients told staff that they still had contraband items within their possession. Patients told us that searching was inconsistently applied when returning from leave or returning from the hospital grounds. This included lighters and illicit substances. We asked the provider to tell us how they will ensure that effective and consistent searches of patients and drug testing is carried out according to their policy. The provider told us they are re-launching their search policy and protocol and re-issuing search training to staff.

The provider supplied CQC with a plan for actions to address these concerns. The progress to completion is being monitored via a weekly call.

What people who use the service say

Patients told us that they feel safe in the hospital and knew what to do if they didn't feel safe.

Patients told us that the hospital environment is clean and well maintained. They said the ward is comfortable. A place they can relax.

The patients we spoke with said that there is always lots going on. However, sometimes activities are cancelled at the weekends.

Patients told us that staff are respectful and polite. They said that all staff are exceptional and very professional; from the cleaners to therapists. Patients told us that staff genuinely care about the wellbeing of the patients.

Patients said they were involved in their care decisions and two patients told us that their family members were involved in their care. However, patients said they had not been given copies of their care plans.

Patients said they could give feedback about the service in community meetings. Patients felt they could make suggestions about how the service is run and that staff took action where feedback or concerns were raised.

Summary of this inspection

Patients were very positive about the food available. They said that it was of great quality and that kitchen staff accommodated requests. Patients told us that they could ask staff to make food outside of meal times and that they have access to fruit and biscuits throughout the day.

How we carried out this inspection

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

The team that inspected the hospital comprised two CQC inspection managers, four CQC inspectors, two specialist advisors, one expert by experience and a mental health act reviewer.

Before the inspection visit, we reviewed information that we held about the hospital.

During the inspection visit, the inspection team:

- Undertook two ward tours and a tour of the lodge,
- Looked at two clinic rooms,
- Spoke with a range of staff including nurses, healthcare assistants, senior healthcare assistants, kitchen staff, junior doctor, duty doctor, pharmacist, receptionist and therapy services manager,
- Spoke with the ward managers, the medical director, the director of clinical services and the regional director for private healthcare,
- Looked at a range of policies and procedures,
- Spoke with 8 patients,
- Looked at 4 complaints,
- Looked at observation records across both wards.
- We looked at electronic and paper copies of care and treatment records of patients and reviewed a range of documents relating to the running of the service. We also looked at the medicines management on all wards including medicine charts and associated Mental Health Act 1983 documentation.

Areas for improvement

Action the service **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service **MUST** take to improve:

We told the service that it must take action to bring services into line with 3 legal requirements.

- The provider must identify and mitigate the ligature risks that exist across the whole hospital, in a consistent way, to ensure safety of patients (regulation 12 (a)(b)(d))
- The provider must ensure that staff record a rationale for why patients observations are decreased. (regulation 12 (a)(b))

Summary of this inspection

- The provider must ensure that there is protocol and guidance for staff on the allocation of bedrooms to patients which minimises the risks to that patient and allows for regular review dependant on their needs. This must be understood and applied by staff in the hospital. (regulation 12 (a)(b))
- The provider must ensure that staff adhere to their policy regarding patient search and drug testing when arriving back from leave and on admission. (regulation 12(a)(b))
- The provider must ensure that governance processes are in place that provide assurance that ligature risks are identified and mitigated, that patient searches are conducted appropriately and safer bedrooms allocated in line with the hospital guidance. (regulation 17)

Action the service SHOULD take to improve:

- The provider should consider reviewing its visitor policy, in line with government guidance and the ease of restrictions nationwide.
- The provider should ensure that registered nurses and healthcare assistants receive regular supervision, in line with their policy.
- The provider should ensure that the clinic rooms are clean and that items are stored appropriately.
- The provider should ensure that all environmental and safety issues are recorded on the risk register and that appropriate mitigation is in place.
- The provider should ensure that they follow their admission criteria and only accept patients whose needs can be met by the hospital.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement
Overall	Requires Improvement	Good	Good	Good	Requires Improvement	Requires Improvement

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

Requires Improvement



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

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

Requires Improvement



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

Safe and clean care environments

Not all of the wards were safe for all patients. Each ward had patient bedrooms in the older part of the hospital which were less observed by staff and where there were numerous ligature risks. The hospital was tired and in need of repair. However, the safe rooms and safer rooms had better lines of sight and staff presence. All wards were mostly clean, well equipped, well furnished.

Safety of the ward layout

Five patient bedrooms, located in the older part of the building, had fewer anti-ligature furniture and fittings, doors without viewing panels and were further away from the nurses' office. There were significant ligature risks in these rooms including one remaining door closure brackets and other weight bearing fixtures. This meant that these rooms were less suited to patients with higher risks of self-harming or patients with a current higher risk of suicide. We were told that patients who did not have a risk of ligature would be allocated to these rooms and were always the last rooms to be allocated. However, the hospital did not have written guidance to reflect how they considered these patient risks when staff allocated the patient bedrooms. We did not see any evidence that staff considered the suicidality of patients on admission, when allocating patients their bedrooms.

The hospital had a ligature audit which included all areas of the hospital. The director of clinical services had recently updated the ligature audit action plan, to reduce the number of ligature points across the hospital and had created a heat map identifying risks in each area of the wards. However, these did not include sufficient mitigation for high risk areas, unobserved by staff.

Staff had easy access to personal alarms and patients had easy access to nurse call systems. Staff in the lodge would ring through to the wards if they needed extra assistance.

Although patients could access both wards, the hospital complied with eliminating mixed sex accommodation guidance.

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

Requires Improvement 

Maintenance, cleanliness and infection control

The wards were tired and going through a period of refurbishment. We were told that there had been delays in refurbishing the wards due to the COVID-19 pandemic.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing and it was evident that additional infection control procedures had been introduced in order to manage the spread of Covid 19. However, we saw an instance where a nurse completed blood pressure checks without cleaning the equipment before and after.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Maple ward clinic room was dusty and dirty on the floor and around the skirting boards. The floor was being used to store items.

We found inconsistency across the two wards of where the EpiPen was kept (one in the bag and one in a plastic wallet on the shelf). An EpiPen is a medical device for injecting a measured dose or doses of adrenaline in an emergency. It is used to treat an allergic reaction. In an emergency, this could cause confusion and result in a delay in responding to an emergency. We informed the provider at the time of the inspection and they addressed these concerns.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

Both wards had a normal establishment of two nurses and one healthcare assistant if the number of patients was below 13. If above this, they would have two nurses and two healthcare assistants. On the days of inspection, Maple ward had two registered nurses and four healthcare assistants and Cedar ward had two registered nurses and two health care assistants.

The hospital had 13 registered nurse and one healthcare assistant vacancy. Managers told us that they had ongoing recruitment and had an action plan in place to fill these vacancies. The vacancies were also recorded on the hospital risk register. The hospital covered its vacant positions with locum agency and bank staff, to ensure a continuity of care.

The ward managers could adjust staffing levels according to the needs of the patients. However, staff felt that the staffing numbers did not match the acuity of patients on Maple ward. Staff across both wards told us that if a patients' observations decreased from high level observations, agency and bank staff would be sent home without pay.

The hospital told us that they were struggling to fill shifts with agency staff but had recently found three new agencies to request staff from. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Medical staff

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

Requires Improvement 

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not record the rationale for decreasing observation levels in patients risk assessments. Staff did not have any written policy for assigning bedrooms to patients based on patient risks of ligature, suicidality or self-harm. Staff did not safely manage the searching of clients on return from leave or on admission. However, staff followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, but risk assessments were inconsistent across the two wards. We told the provider at their last inspection in 2019, that they should ensure that the rationale for the downgrading of patient risks is clearly recorded in patients' records. This had been clearly documented on Cedar ward. However, on Maple ward, we saw no recorded rationale for why five patients' observation levels had been downgraded.

At the last inspection in 2019, we told the provider they should ensure that individual risks for patients with complex physical health conditions are assessed and recorded and that management of these risks is included in their care plan. We saw evidence that patients with physical health conditions were risk assessed and management plans were in place. However, on Maple ward we saw one patient had been recorded as under weight but there was no evidence of a food and fluid chart in place to monitor this.

We were told by staff that patients were risk assessed on admission for a history of self-harm using a ligature. This dictated which room the patient would be allocated to; a safer room, safe room or standard room. We reviewed 13 patients' care records. In none of the 13 patients' records was there any assessment of, or reference to, individual risk assessments for managing each patient's safety in the hospital environment or identifying suitable bedrooms with reference to the environmental ligature risks. The service had no formal policy or procedure in place to manage this risk.

Management of patient risk

Patients told staff in a community meeting on the day of inspection, that staff were inconsistently searching patients and drug testing them when returning from leave and on admission. Patients told staff that they had contraband items and drugs in their possession. We were informed that a patient had a bag in their possession since admission and had contemplated self-harm with this item.

We reviewed the observation records for eight patients on Cedar ward and the observation records for all patients on intermittent observations on Maple ward. Maple ward observations were generally good. However, the observations on Cedar ward were inconsistent. A patient had a gap in their observations for 1 hour and 11 minutes following a disclosure of attempted self-harm. We identified that there was a theme of early morning checks being missed by staff. One patient had 2 checks missed in one hour.

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

Requires Improvement 

Not all identified risks were recorded on the patients' observation charts. One patient who had an identified risk of harm to others/staff and had a history of harm to staff, did not have this noted on their observation records.

Staff told us that there had been an increase in inappropriate referrals. The hospital had responded to the risk, by setting out clear exclusion criteria, which had improved the situation.

Reception staff operated the front door and managed patient safety well. The hospital had a clear process in place to hand over any patient risks to the reception staff after their flash meeting. Reception staff would then facilitate patients access to the hospital grounds, throughout the day. The lead receptionist had created a manual on how to manage the reception safely.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

The hospital conducted a restrictive practice audit each year. Their most recent audit, in December 2020 and found no concerns.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff access to essential information

Staff had easy access to clinical information, which was stored securely.

Clinical records were stored on an electronic system, which staff had easy access to.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. However, the recording and storing of unknown substances was poor. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

We reviewed 13 patients' medicines records and saw that staff followed the correct systems and processes when safely prescribing, administering, recording and storing medicines. Staff regularly reviewed patients' medicines. However, there was no evidence that staff gave medication information to patients.

Staff correctly stored and monitored controlled drugs on both wards. However, staff had stored unknown substances, removed from patients. There was no stock balance and they did not have identifiable patient names for who they belonged too.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

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

Requires Improvement 

Staff told us that the in full then abbrev (PMVA) training was bespoke to the service and uses real life examples. Staff told us that they were consulted on, when updating this training.

Lessons learned were shared in the staff bulletins and staff were aware of recent incidents that had taken place.

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

Good 

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

Assessment of needs and planning of care

Care plans were in place for all patients. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. They reflected patients' assessed needs, and were personalised, holistic and recovery oriented.

Care plans were in place for all patients. Care plans were holistic, recovery orientated, and person centred. Care plans across both wards showed clear patient involvement. As a result of the managers weekly care plan audit, the Maple ward manager had implemented a new process, to keep the documents updated and encourage staff to involve patients in their care planning.

Across both wards, there was no evidence that patients had received a copy of their care plan. Patients told us that they felt involved in their care but most said they had not seen their care plan.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. However, Staff did not perform physical health checks in line with the patients needs.

Staff provided a range of care and treatment suitable for the patients in the service. The hospital had access to a contracted occupational therapist and therapy services team.

The hospital ran a general therapies programme seven days a week. They had arranged weekend activities in response to patient feedback. This included activities such as a movie night, table tennis and gardening. Patients on the addiction treatment programme had a comprehensive timetable of therapies.

The therapies team told us that NHS patients could access all module 1 and module 2 therapy groups at this time. Private paying patients had access to more 1:1 therapies such as art therapy, psychotherapy and CBT each week.

The service had a wellbeing co-ordinator and a mindfulness lead, who facilitated some activities for the patients such as massage and exercise classes.

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

Requires Improvement 

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. However, we found that national early warning score (NEWS2) charts were being completed weekly for all patients, regardless of assessed needs. We fed this back to the provider at the time of the inspection.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Each new member of staff received a full induction to the service before they started work.

Managers supported staff through regular supervision and constructive appraisals of their work. However, in April and May on Maple ward, supervision rates were below 70% for registered nurses and HCA's, which was below the providers target.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff from across the hospital attend learning from experience meetings.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. The hospital had four healthcare assistants on nursing apprenticeships with a local university to become qualified mental health nurses. The service was sponsoring two nurses to complete post graduate nursing studies. Staff had requested personality disorder training and this was actioned by the senior management team.

Managers recognised poor performance, could identify the reasons and dealt with these. Staff harassment concerns were dealt with in line with the provider policy and action had been taken as a result. However, some staff felt they were not supported by management following false accusations.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. The hospital held a daily flash meeting to discuss patient risks. A new therapy and nursing communication protocol was in place and had improved handover between the nursing team and therapies team. This was learning identified as a result of a serious incident.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

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

Requires Improvement 

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff were very positive about the support given to them by the mental health act administrator.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Staff explained to patients their right to see an independent mental health act advocate (IMHA). IMHA contact details were clearly displayed on both wards. Patients we spoke with told us that they did not understand the role of the IMHA.

Records showed that staff explained to patients their rights under the MHA. However, at the time of the inspection we did not see where this had been repeated.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Good practice in applying the Mental Capacity Act

Staff kept up to date with Mental Capacity Act training and there was evidence of capacity assessments in patients care plans and risk assessments.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Assessments of capacity to consent to admission and treatment were recorded on admission. We saw examples of where some information had not been completed.

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

Good 

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

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff were warm, showed a genuine interest in patients' wellbeing and respected patients' privacy and dignity. Patients told us that staff were kind.

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

Requires Improvement 

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to a general advocate but did not routinely refer detained patients to an independent mental health advocate. However, most patients told us that they did not receive a copy of their care plans.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each patient received an induction booklet to introduce them to the hospital, the ward and the therapies available.

Patients told us that they understood the care they were receiving and were involved in decisions about their care. However, patients told us that they did not receive a copy of their care plan. The ward manager of Maple ward told us that they had recently implemented a new process to ensure patient contribution to their care plans and risk assessments. It was too early in the process to say whether this had a positive effect.

Patients could give feedback on the service and their treatment and staff supported them to do this. Patients attended a community meeting every Thursday and told us that they felt confident that these would be acted on. "You said, we did" boards were present on the ward and showed that action had been taken as a result of patient feedback.

Staff made sure patients could access advocacy services. A general advocate attended the ward once a week and patients were familiar with them.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers, where they had consent to share the information. Staff told us that families could attend ward rounds via video conference and often gave feedback over the phone regarding their relative's care.

Staff helped families to give feedback on the service. However, we had been told that due to the inability to visit the hospital grounds; there were limited opportunities for staff to ask for feedback.

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

Good 

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

Access and discharge

The hospital had 25 out of hours admissions between November 2020 and April 2021. These admissions often took place in the early hours of the morning between 1am and 4am. Managers monitored out of hours admissions.

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

Requires Improvement 

Discharge and transfers of care

The hospital admitted NHS patients from anywhere in the country. NHS patient admissions tended to be shorter as the patient was repatriated back to their area in which they lived as soon as a bed becomes available.

Facilities that promote comfort, dignity and privacy

The five bedrooms in the old part of the hospital were problematic and contained multiple ligature risks. However, the safe rooms and safer rooms were fit for purpose. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. The food was of good quality and patients could make hot drinks and snacks at any time.

Each patient had their own bedroom. Each patient was individually risk assessed to have access to a key for their bedroom. Patients had a lockable space inside their bedrooms to store personal possessions.

The service had large grounds that patients could access throughout the day. Each patient was risk assessed to have access to the grounds.

The service offered a variety of good quality food. All patients spoke highly of the food. Patients could make their own hot drinks. The service had fruit and biscuits available throughout the day and patients could ask kitchen and nursing staff for other food throughout the day and night.

Patients' engagement with the wider community

Patients who were not on the addiction treatment programme were allowed access to their own mobile phones. Patients on the addiction treatment programme had allocated times that they could access their mobile phone.

At the time of the inspection and due to the COVID-19 pandemic, staff and patients told us that patients were not allowed visitors on site. We were told that staff could make a case to the hospital director with exceptional circumstances or patients could use their leave to see visitors off-site. We raised concerns about the restrictiveness of this policy and received assurances from the provider that this would be reviewed and changes made to make visiting easier for patients.

Meeting the needs of all people who use the service

The service met the needs of all patients. Staff helped patients with communication, and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that kitchen staff catered for allergies and had vegetarian and halal options.

Patients had access to spiritual, religious and cultural support. Staff told us that they had supported previous patients to places of worship.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

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

Requires Improvement 

We reviewed four complaints and saw evidence of appropriate action taken as a result. The hospital held learning from experience meetings, where actions for incidents and complaints are reviewed. Learning from experience meeting minutes are shared with the wider team.

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

Requires Improvement 

Our rating of well-led went down. We rated it as requires improvement.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Staff we spoke with were complimentary of the hospital director and director of clinical services. Staff said they were approachable and listened to feedback regarding the service.

Staff harassment concerns were dealt with in line with the provider policy and action had been taken as a result.

Vision and strategy

Staff were unsure about the provider's vision and values for the hospital. We were told by management that the hospital was aiming to be a hospital for only private paying patients. However, due to the demand for NHS placements, the hospital had accepted several NHS patients over the past year. Staff felt this changed the dynamic of the hospital and saw an increase in the acuity of their patient group.

The hospital had admission criteria to decide whether they could meet the needs of the patient. Staff told us that there had been cases where patients had been admitted and subsequently, they could not meet their needs, due to changes in patient risks. They had raised these concerns with senior clinicians but felt they had not always been listened to.

Culture

Staff felt respected and valued. They said the provider promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff told us that they felt respected and valued by their team and the wider senior management team. Staff felt they had good working relationships and that there was generally a good morale within the teams.

The hospital had four healthcare assistants on nursing apprenticeships with a local university to become qualified mental health nurses. The service was sponsoring two nurses to complete post graduate nursing studies.

Staff had requested personality disorder training and this was actioned by the senior management team.

Governance

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

Requires Improvement 

Our findings from the other key questions demonstrated that overarching governance processes across the hospital needed to be strengthened and the management of risk was not adequately managed. However, staff performance was managed well.

The governance processes had failed to identify that whilst the ligature risk assessment covered all areas of the ward, it did not have sufficient mitigation for areas of concern. We were told by staff that ligature points were mitigated through observation by staff. We identified at least three areas that were high risk of ligature and self harm, that were not easily observable by staff and did not have staff presence on either day of the inspection.

Senior managers failed to ensure that staff were following the provider policy for searching patients. This enabled harmful and illicit substances to be brought on to the wards. Staff only became aware of these items when incidents occurred.

Clinical governance meetings were thorough and well documented. They covered discussions of risk and shared lessons learned from other Priory sites.

Managing risks, issues and performance

The service had an overall electronic risk register, which covered high risk areas of the hospital and described mitigations to manage the risks. However, there were risk which we identified in this report which had not been included in the risk register, nor actions taken to mitigate them.

Various audits were in place at ward level and learning had been taken from these audits. However, pharmacy audits were marked as actioned, but there was no clear explanation as to what action had been taken and whether the action had been completed.

Incidents, safeguarding and complaints were appropriately logged and investigated.

Managing information

Staff collected analysed data about outcomes and performance and engaged actively in local quality improvement activities. At the time of the inspection the hospital was working through two quality improvement programmes: a gardening project and learning at work culture.

Engagement

Patients had opportunities to give feedback on the service they received. Patients feedback for the period 6 August 2020 to 7 May 2021 was very positive. Less positive feedback was regarding the cleanliness and condition of the ward environments. Feedback from patients was shared through clinical governance meetings and daily flash meetings.

Staff attended monthly “Your say” forum. Staff were encouraged to put forward suggestions for discussion.

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

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not ensure that governance processes were in place that provided assurance that ligature risks are identified and mitigated, that patient searches are conducted appropriately and safer bedrooms allocated in line with the hospital guidance.

Regulated activity

Treatment of disease, disorder or injury

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

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

The provider did not identify and mitigate the ligature risks that existed across the whole hospital, in a consistent way, to ensure safety of patients.

The provider did not ensure that staff record a rationale for why patients observations were decreased.

The provider did not ensure that there was protocol and guidance for staff to follow, on the allocation of bedrooms to patients which minimised the risks to that patient and allows for regular review dependant on their needs.

The provider did not ensure that staff followed their policy regarding patient search and drug testing when arriving back from leave and on admission.