The Priory Hospital Southampton

Quality Report

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Date of inspection visit: 25 and 26 June and 12 July 2019
Date of publication: 19/09/2019

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
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

Our rating of this service stayed the same. We rated The Priory Hospital Southampton as good because:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices and followed good practice with respect to safeguarding.
- Staff developed holistic care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers ensured that these staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. There were mutual expectation meetings with staff and patients and young people to improve understanding between them. They actively involved patients and families and carers in care decisions. The staff on Skylark ward shared research with the patients to improve their understanding of their treatment. Staff on Skylark had arranged a carers education day aimed at helping them to support the patient on discharge.
- The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.
- The service was well led and the governance processes ensured that ward procedures ran smoothly. Leaders tested staff knowledge at daily flash meetings. Senior managers offered mentoring to staff to help develop future leaders.

However:

- The systems and processes in place for managing medicines were not robust on the acute ward and on the child and adolescent mental health ward ward.
- Staff on the acute ward did not assess and clearly record mental capacity on a decision specific basis for patients who might have impaired mental capacity.
- Care plans were not consistently recovery focused and personalised to each patient.
- Young people told us that there was not enough activity at the weekends.
- Not all staff understood young people's right to leave the ward.

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	Good 	Sandpiper ward is a 17 bed mixed gender acute ward for adults of working age.
Child and adolescent mental health wards	Good 	Kingfisher is a 12 bed mixed gender ward.
Specialist eating disorders services	Good 	Skylark is a 11 bed mixed gender ward.

Summary of findings

Contents

Good

Location name here

Services we looked at

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

Summary of this inspection

Background to The Priory Hospital Southampton

The Priory Hospital Southampton is an independent provider of therapeutic and recovery focused residential treatment as well as day care and outpatient services. The hospital provides specialist inpatient services for adults with acute mental health needs; adults with eating disorders and children and adolescents with acute mental health needs

The hospital provided care to a mixture of NHS, self-funded, and insurance funded patients. The young people and eating disorder patients were all NHS funded.

There are three wards at the hospital, each of which we visited as part of this inspection:

- Kingfisher ward is a child and adolescent mental health ward, mixed sex ward with 12 beds;
- Sandpiper ward is an acute ward for adults of working age, mixed sex with 17 beds;
- Skylark ward is an eating disorders ward, mixed sex with 11 beds.

The Hospital provided the following regulated activities:

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

A hospital director was in post at the time of our inspection, who was the registered manager of the service.

We last inspected in February 2017 and rated the service good overall and good in all domains.

Our inspection team

The team that inspected the service comprised three CQC inspectors, and a variety of specialists: three specialist advisors with experience in children and adolescence mental health services, acute services and eating disorders and an expert by experience.

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.

During the inspection visit, the inspection team:

Summary of this inspection

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with 16 patients who were using the service;
- spoke with three relatives or carers of patients who were using the service;
- spoke with two ward managers and a deputy ward manager across the three wards;
- spoke with 20 other staff members; including nurses, healthcare assistants, consultant psychiatrists, the hospital director, clinical director and the Mental Health Act administrator;
- spoke with two independent advocates visiting the service;
- spoke with three Mental Health Act hospital managers;
- attended and observed a patient activity meeting, a community meeting, a group exercise and a ward round;
- looked at 16 treatment records and 11 medicine charts of the patients and young people using the service;
- carried out a specific check of the medicines management on all the wards; and

looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to 16 patients who were using the service. They told us that they felt safe on the ward, staff were respectful, polite and supported them to keep in touch with friends and family. They were happy with the quality of the food. Patients generally felt involved in their care and knew how to complain if they wanted to and had access to support from advocates.

Patients told us that the ward was short staffed at times, but that escorted leave was never cancelled because of this.

We spoke with three relatives or carers of patients who were using the service. Carers felt their concerns were listened to and their input considered. They were generally very satisfied with and felt involved in the care their relatives received. However, they did sometimes have difficulties contacting the wards.

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?

Good

We rated safe as good because:

- All wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The wards did not use seclusion.
- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records – using a mixture of paper-based and electronic records.
- The service used systems and processes to safely prescribe and administer medicines. Staff regularly reviewed the effects of medications on each patient's physical health.
- The wards had a good track record on safety. 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.

However:

- The systems and processes used to record and store medicines and equipment was not fully robust. The clinic room on the acute ward had out of date equipment and destroyed medicines had not been recorded in line with the provider policy.

Are services effective?

Good

We rated effective as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed care plans, which they reviewed regularly through multidisciplinary discussion and updated as

needed. Care plans reflected the assessed needs and were holistic. Staff had attached calm cards to medicine cards to ensure staff had tried all agreed options before using medication to manage patient's anxiety.

- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives. On Skylark ward staff used outcome measures to show patients the progress they were making.
- 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 a 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 on Skylark ward shared the research with patients to help them understand their treatment. 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. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- 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.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005.

However:

- Staff on the acute ward did not assess and clearly record mental capacity on a decision specific basis for patients who might have impaired mental capacity.
- The care plans on the adult acute ward were not always personalised to each patient.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

Summary of this inspection

- 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 hospital held mutual expectation meetings for staff and patients to agree on their conduct. There was information on staff available to patients to help them get to know the staff better.
- 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 independent advocates.
- Staff informed and involved families and carers appropriately. Staff from Skylark were arranging a carers education day to help them support patients on discharge. Staff from Skylark would provide education and support to help providers meet patients' needs on discharge.

Are services responsive?

Good

We rated responsive as good because:

- Staff managed beds well. This meant that a bed was available when needed and that patients were not moved between hospitals unless this was for their benefit. Discharge was rarely delayed for other than clinical reasons.
- The design, layout, and furnishings of the ward/service supported patients' treatment, privacy and dignity. 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 a good quality and patients could make hot drinks and snacks at any time.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service.

Are services well-led?

Good

We rated well-led as good because:

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

Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- Staff engaged actively in local quality improvement activities.

Detailed findings from this inspection

Mental Health Act responsibilities

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

Staff on the wards had mandatory training on the Mental Health Act and the Code of Practice.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

The hospital had relevant policies and procedures that reflected relevant guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about mental health advocacy. An external IMHA visited all patients detained under the Mental Health Act to give them the option of support, which they could refuse if they wished to.

Staff explained to patients their rights under the Mental Health Act in a way they could understand and the Mental Health Act administrator would remind staff of the need to fulfil these legal requirements.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted. Staff requested an opinion from a second opinion appointed doctor (SOAD) when necessary.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly. The provider held a Mental Health Act administrators forum to support sharing of knowledge and best practice across the Priory group.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff on the wards had access to mandatory electronic training on the Mental Capacity Act. This had been completed by 86% of clinical staff across the hospital.

Staff understanding of the Mental Capacity Act, in particular the five statutory principles, was variable.

There were no deprivation of liberty safeguards applications (used to agree admission when a patient lacks capacity to make the decision) made in the previous six months.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it.

We saw evidence that staff assessed and recorded capacity to consent to treatment on admission. This was reviewed on a regular basis in the multidisciplinary team meetings.

The wards had arrangements in place to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from this.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

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

Good

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

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

Good

Safe and clean environment

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Staff did regular risk assessments of the care environment and drew up plans of the environment to highlight any issues. These plans included those bedrooms that were safer specification rooms, with anti-ligature fixtures and fittings, as well as the location of ligature cutters and resuscitation bags. The plans were stored in the nursing office and the doctor's room for easy access to this information which allowed. This allowed staff to respond to issues quickly and make sure patients were accommodated in rooms suitable to the level of risk they presented.

The ward layout did not allow staff to observe all parts of the ward, and there were a number of blind spots. There were also potential ligature anchor points on the ward. A ligature anchor point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. Staff risk assessed the blind spots and included them in the environmental floor plan. Staff completed ligature and blind spot audits twice yearly to review and identify any issues that needed addressing. The risks were mitigated by mirrors and increased staff observation in these areas. There was CCTV at the hospital's entrance and in some communal areas. For example, the dining room. There were appropriate policies and procedures around the use of CCTV which included how staff could access recording if they need to review an issue.

Each patient was individually risk assessed for an history of suicidal thoughts or previous attempts, and patients who were higher risk stayed in the safer specification bedrooms with reduced ligature risks. Patients who were being prepared for discharge stayed in the rooms with identified ligature risks as those patients were considered to be low risk. The hospital did not accept patients who were considered high risk of ligature or self-harm. Staff would carry out a pre-admission risk assessment on each patient as part of managing the environmental risks.

The ward complied with guidance on eliminating mixed-sex accommodation. The ward had male and female patients. Although areas were not designated as male or female only, all bedrooms were en-suite and there was a female lounge on the ward. The staff also reviewed any potential risks before deciding which bedroom a patient was admitted to.

Staff had easy access to alarms, that were tested regularly to ensure they worked and there were alarm calls for patients in their bedrooms.

All ward areas were clean, had good furnishings and were well-maintained. Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. Staff adhered to infection control principles, including hand washing.

The service did not have a seclusion room.

The clinic room was fully equipped with accessible resuscitation equipment and emergency drugs that staff

checked regularly. Some equipment, including a large number of needles, syringes, a drug testing kit and three boxes of face masks, were found to be out of date and had not been disposed of. We raised this during the inspection and staff removed the equipment immediately. The hospital identified the need to ensure an effective protocol was put in place to include checks of equipment expiry dates in the clinic room. The stock check systems for the clinic room will be amended to include a comprehensive monthly check of all items in the clinic room. This is to be recorded in the clinic room audit folder. The ward will also now keep all equipment in their original boxes to reduce the potential for further errors in the future. The visiting pharmacist will also carry out quarterly checks of the equipment as an additional control measure.

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.

However, at the time of our inspection the establishment of qualified nurses on the ward was 10 and there was 5 vacancies. The vacancy rate for qualified nurses was 50%. The hospital was actively recruiting staff. There were no health care support worker vacancies.

The number and grade of nurses and healthcare assistants required on the ward had been calculated as part of the Priory safer staffing ladder, a hospital wide staffing calculation. The ward had two registered mental health nurses (RMNs) and three healthcare assistants on duty each day. An additional supernumerary RMN had been brought in on Mondays and Tuesdays to ensure all care plans and documentation were up to date for ward rounds and multidisciplinary team meetings.

The ward manager could adjust staffing levels to take account of case mix as needed. If a patient needed one to one support, then the third healthcare assistant on duty would take responsibility for this. If additional one to one support were needed, the ward manager could request additional staff, either from the other wards in the hospital or through bank or agency bookings. The ward manager told us that this was not needed often.

When necessary, the ward manager deployed bank and agency staff to maintain safe staffing levels. Agency staff regularly covered shifts, especially night shifts.

When agency and bank staff were used, they received an induction and where possible booked staff who were already familiar with the ward. Staff were also assessed for medicines and observations competencies before starting work on the ward.

A qualified nurse was present in communal areas of the ward at all times. Staffing levels allowed patients to have regular one to one time with a member of staff.

Staff shortages did not result in staff cancelling escorted leave or ward activities, but this did occasionally have to be rearranged. There were enough staff to carry out physical interventions (such as observations and restraint) safely, and staff had been trained to do so. Staff could also call for additional support from other wards if needed.

There was 24-hour medical cover day and night, with a doctor on site who could attend the ward quickly in an emergency.

Ninety five percent of staff were up to date with their mandatory training, which included safeguarding, fire safety and physical intervention training. Where staff were behind with any training, the ward manager would identify this and write to them to make them aware and to complete this. There was a training coordinator in post for the hospital to monitor training compliance and ensure this was completed. All staff employed at the hospital do basic life support training and qualified nurses do immediate life support training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and 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.

We looked at five care records during the inspection. Staff completed a risk assessment of patients on admission and updated this regularly, including after incidents. Staff completed risk assessments before patients had leave from the hospital.

Staff were aware of and dealt with specific risk issues, such as falls or pressure ulcers. The hospital had trained a staff member to manage soft tissue wounds. The ward also had an infection control lead.

Staff identified and responded to changing risks to, or posed by, patients.

Staff followed good policies and procedures for use of observation (including to minimise risk from potential ligature points), staff behaviour and for searching patients or their bedrooms.

The hospital had a named liaison police officer and a senior manager attended monthly police liaison meetings.

Staff applied blanket restrictions on patients' freedom only when justified. The ward had a list of restricted items which staff discussed with patients on admission. Staff would go through patients' belongings with them and remove any restricted items, placing these in a safe box until discharge. There was a local and national reducing restrictive practice group which reported in to the clinical governance meetings.

The hospital was in the process of preparing to become a smoke free site in July 2019 and were working to support patients with this forthcoming change.

Informal patients could leave at will and there was sign advising patients of this by the entrance to the ward.

The ward was locked, with a door buzzer system for people to enter and leave the ward. This was monitored and operated by the nursing station but was broken at the time of the inspection. The doors were being manually operated until this was replaced.

In the 12 months before the inspection there were no episodes of seclusion or long-term segregation on the ward. In the six months before the inspection there were 11 episodes of restraint on nine different patients, none of which were prone restraints.

Staff used restraint only after de-escalation failed. Staff did not use prone restraint. Staff used techniques from their prevention and management of violence and aggression (PMVA) training when restraining patients. Staff had attached "calm cards" to patient medicines charts, highlighting de-escalation techniques that worked with individual patients. These were developed with the patients to help reduce the use of as required medication and restraint.

Staff followed NICE guidance when using rapid tranquilisation. There was one reported use of rapid tranquilisation, in the month before the inspection, and no uses in the six-month period before that. Staff carried out appropriate physical health checks on the patient after using rapid tranquilisation and used a recording sheet supplied from the pharmacist to document this.

Staff did not have use of a seclusion room. If there were concerns about the safety of patients or increased risk of aggression, staff would support patients to leave communal areas and spend some time either in their rooms or a quiet area on the ward.

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 were trained in safeguarding. All staff were trained to level three and the safeguarding lead was trained to level four. At the time of our inspection compliance with training was at 93%. Staff knew how to make a safeguarding alert and did that when appropriate. Staff knew how to identify people at risk of or experiencing significant harm or abuse. This included working in partnership with other agencies. If staff were uncertain they could access the support of a hospital safeguarding lead or contact the local authority safeguarding team for advice.

Staff followed safe procedures for children visiting the ward. Visiting children had use of a separate room and would not come onto the ward at any time.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

The hospital used a combination of paper and electronic records. All information needed to deliver patient care was available to all relevant staff (including bank and agency staff) when they needed it and was in an accessible form. Staff updated computer records and printed copies off for patient care files. This did not cause any significant issues with entering or accessing information.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

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

Good

Staff generally followed good practice in medicines management (transport, storage, dispensing, administration and medicines reconciliation), and did this in line with national guidance. However, we found two occasions where staff had not correctly recorded the disposal of controlled drugs.

We raised this during the inspection. This was found to be a case of human error. The visiting pharmacist completed weekly audits of controlled and other medicines, but had not visited following the error, and so would not have had the opportunity to pick up on this. The hospital raised the medicines disposal recording errors as incidents, and on investigation found that the process was not robust. The senior management team reviewed the incidents in the medicines management and clinical governance meetings. As a result, the hospital will nominate one person to take responsibility for destroying medicines on each ward, rather than for the whole hospital, to ensure the system is not reliant on one individual.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Care and Health Excellence guidance.

Track record on safety

The service had a good track record on safety.

The ward reported five serious incidents in the 12 months before the inspection. This included patient self-harm, AWOL (absence without leave) of a detained patient, and patient aggression towards staff.

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.

All staff knew what incidents to report and how to report them. Staff reported incidents through an electronic form. Staff discussed incidents in the morning flash meetings, and handover meetings. Staff investigated incidents and identified learning from these within the learning from experience meetings.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Staff received feedback from the investigation of incidents. This feedback was given during team meetings and handovers, or through learning from experience bulletins that were sent to all hospital staff.

The team made changes as a result of feedback. Incidents often led to additional training when any gaps or need for this were identified. We were given an example of a serious self-harm incident where a patient had been on one to one observations. The staff member had not observed them to be using a piece of their clothing to harm themselves. Following this incident all staff were given additional search training to support them to identify potential objects of harm. The observation policy was also updated to ensure that staff made sure they saw all of the patient on observations, particularly if a patient is covering part of themselves from staff view.

Staff were debriefed and received support after a serious incident.

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

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs and were recovery-oriented.

We looked at five care records during the inspection. While these were comprehensive, and included evidence of physical health assessment, the records were not personalised to the individual. There was limited evidence in some of the plans of patient involvement, and few care plans recognised patient strengths. This was raised during the inspection, and the hospital acknowledged that not all

care plans were as person centred as they would expect. The hospital were rolling out in house care plan training to all staff, and auditing care plans fortnightly to pick out any themes or trends.

Staff completed a comprehensive mental health assessment of the patient in a timely manner at, or soon after, admission. Staff assessed patients' physical health needs on admission and on a weekly basis or after an incident.

Staff developed care plans that met the needs identified during initial assessment. Staff regularly reviewed these and updated them when necessary.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). This included access to physical health care and psychological therapies.

Staff ensured that patients had access to physical healthcare, including referring patients to specialists when needed. All patients had a physical health assessment on admission. The ward manager was the physical health lead for the ward and the charge nurse completed regular physical health audits.

Staff supported patients to live healthier lives. The ward was focussing on smoking cessation support with patients in preparation for the site going smoke free on 31st July.

Staff used recognised rating scales to assess and record severity and outcomes, including the Health of the Nation Outcome Scales (HoNOS).

Staff participated in clinical audits, benchmarking and quality improvement initiatives. For example, staff completed audits of physical health care, the Mental Health Act and care plans. Ward managers and charge nurses undertook quality walk rounds, where they would visit other wards on the hospital to assess and rate the quality of the care provided.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. 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.

As well as ward consultants, nurses and healthcare assistants, the ward also had access to activity coordinators, occupational therapists, psychologists, therapists (including an art therapist), social workers and the ward clerk. A pharmacist also visited the ward on a weekly basis and was available for advice and support as needed.

Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group. Managers provided new staff with appropriate induction. Agency staff were also given an induction to ensure they were familiar with the ward. When possible the hospital used agency staff on longer placements or who had experience of working at the hospital.

Managers provided staff, including agency staff, with supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. The percentage of staff that had had an annual appraisal in the year before the inspection was 95%. These were reviewed after six months. The percentage of staff that received regular supervision in the year before the inspection was 98%.

Managers ensured that staff had access to regular team meetings.

The ward manager identified the learning needs of staff through supervision and learning from complaints and incidents and provided them with opportunities to develop their skills and knowledge. The ward manager ensured that staff received the necessary specialist training for their roles and would bring in external trainers to meet identified needs. Staff could receive a £200 annual contribution towards relevant external training. Staff had access to leadership training, and healthcare assistants were supported to access nursing training.

Managers dealt with poor staff performance promptly and effectively.

Multi-disciplinary and inter-agency 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. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular and effective multidisciplinary meetings. Healthcare assistants did not attend these as a matter of routine. The staff team did feel that this would be helpful to ensure effective handover of information to staff working with patients directly after these meetings. Staff shared information about patients at handover meetings within the team between shift changes.

The ward teams had effective working relationships, including good handovers with other relevant teams, both within and outside of the organisation. The hospital held daily flash meetings every morning to discuss staffing, safeguarding, risk and any other key issues as a hospital. Staff invited care coordinators to meetings. Representatives from the local mental health trust who block booked ten beds on the ward attended ward rounds to support and facilitate discharge planning.

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.

Staff on the ward had mandatory training on the Mental Health Act. This had been completed by 87% of clinical staff across the hospital. Staff were generally confident that they had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. An external trainer had recently delivered training in community treatment orders (CTOs) to the staff team after that was identified as a gap in knowledge.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrator was.

The hospital had relevant policies and procedures that reflected relevant guidance. Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about mental health advocacy. Not all staff fully understood the role of the independent mental health advocate (IMHA) and the patient's right to have them involved. There had previously been a lack of referrals to the IMHA service, but the ward had recently changed to an opt out rather than an opt in policy. An external IMHA visited all patients detained under the Mental Health Act to give them the option of support, which they could refuse if they wished to. This ensured that all patients were aware of and had access to the support available to them.

The Mental Health Act administrator also met with patients on the ward following their admission.

Staff explained to patients their rights under the Mental Health Act in a way they could understand, repeated it as required and recorded that they had done this. The senior management team in the hospital had access to an electronic diary that documented when patients needed to have their rights repeated to them, and the Mental Health Act administrator would remind staff of the need to fulfil these legal requirements.

Staff ensured that patients were able to take Section 17 leave (permission for patients to leave hospital) when this had been granted, although there were times when they had to wait a short while to ensure there were enough staff to facilitate escorted leave. Staff requested an opinion from a second opinion appointed doctor (SOAD) when necessary.

Staff stored copies of patients' detention papers and associated records (such as Section 17 leave forms) correctly and so that they were available to all staff that needed to access them. The master files were kept in the Mental Health Act administrator's office, with copies of the paperwork stored on the ward.

The staff team knew that informal patients could leave the ward freely and the service displayed a notice to tell informal patients of their rights.

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

Good

Staff did regular audits to ensure that the Mental Health Act was being applied correctly. The provider held a Mental Health Act administrators forum to support sharing of knowledge and best practice across the Priory group.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff on the ward had access to mandatory electronic training on the Mental Capacity Act. This had been completed by 86% of clinical staff across the hospital.

Staff understanding of the Mental Capacity Act, in particular the five statutory principles, was variable. It was unclear how much staff on the ward were considering mental capacity in their everyday work with patients as this was not being recorded in patient records.

There were no deprivation of liberty safeguards applications (used to agree admission when a patient lacks capacity to make the decision) made in the previous six months. If a deprivation of liberty safeguards application had to be made, this would be discussed in the multidisciplinary team meeting initially to see if this was appropriate.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy and had access to it. Staff knew where to get advice from within the team and would approach the social worker for guidance if needed.

We saw evidence that capacity to consent to treatment and admission was being assessed and recorded on admission. This was reviewed on a regular basis in the multidisciplinary team meetings. We did not see evidence of mental capacity assessments for day to day decisions unrelated to admission and treatment, for example if a patient needed treatment for their physical health needs. Staff told us that they did not believe that mental capacity was assessed for decisions other than related to mental health treatment. If this were assessed this would be not recorded as a formal assessment process and would be more of a single sentence stating the outcome.

There was no evidence in the care records we looked at on site that staff were making decisions in patients' best interests, recognising the importance of their wishes, feelings, culture and history, when appropriate to do so.

The ward had arrangements in place to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and took action on any learning that resulted from this. The application of the Mental Capacity Act in care records was audited as part of the regular ward quality walk rounds. It is not clear how effective these measures were in light of the issues we identified.

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

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.

The attitudes and behaviours of staff when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice as they needed it.

Staff supported patients to understand and manage their care, treatment or condition. Staff directed patients to other services when appropriate, and, if required, supported them to access those services.

Patients said staff treated them well and behaved appropriately towards them. Housekeeping staff made sure there were essential toiletries in the bedrooms of all new admissions.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs. When they need more support to do this the hospital provided training. For example, the were sending staff on training about (lesbian, gay, bisexual and transgender) rights.

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

Good

Staff told us they could raise concerns about disrespectful, discriminatory or abusive behaviour towards patients without fear of the consequences.

Staff maintained confidentiality of information about patients.

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 independent advocates.

Staff used the admission process to inform and orientate patients to the ward and to the service. Patients were given a different admission pack dependent on whether they were informal patients or detained under the Mental Health Act. Admission packs were kept in patient bedrooms, and included information about their rights under the Mental Health Act, meal times, laundry arrangements and how to make complaints. The hospital also produced a patient newsletter, which included updates on the hospital, activities and patient feedback.

While there was some evidence that staff involved patients in care planning and risk assessment, this was variable, and the patient voice wasn't always apparent throughout. Electronic records did not always show that patients were offered and received a copy of their care plan, but this was recorded on the paper care plan records where patients had signed the physical copy.

Patients were invited into multidisciplinary team meetings to discuss their care.

Staff communicated with patients so that they understood their care and treatment, including finding effective ways to communicate with patients with communication difficulties. For example, how to complain leaflets were available in easy read formats.

Staff enabled patients to give feedback on the service they received. The ward held a monthly patient council meeting, involving staff and patients. Following feedback from one of these meetings, staff will attend training from an organisation supporting LGBT (lesbian, gay, bisexual and transgender) rights. After feedback from another patient that information leaflets were too wordy and not very accessible, the staff planned to develop information posters that were more accessible to patients. The ward had also increased activity coordinators input following feedback from patients about a lack of weekend activities.

There were no advanced decisions in place at the time of the inspection.

Staff ensured that patients could access advocacy and were adopting an "opt out" approach to ensure that all patients were offered this service on admission.

Staff informed and involved families and carers appropriately and provided them with support when needed. Staff invited families and carers to CPA (care programme approach) meetings and ward reviews. They could also speak directly with the consultant if they wished to. Care plans had a section for inclusion of family and carer feedback, although staff didn't always complete this.

Staff enabled families and carers to give feedback on the service they received but acknowledged that this was something that could be improved on. Patients were given feedback forms to comment on the service, but this wasn't routinely extended to carers. The hospital social worker held a quarterly carers meeting and the hospital produced a carers newsletter. Staff did not routinely provide carers with information about how to access a carer's assessment.

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

Good

Access and discharge

Staff managed beds well. A bed was available when needed. Discharge was rarely delayed other than for clinical reasons.

The ward admitted both private, NHS patients and insurance funded. If a bed was available patients could be admitted the same day. The ward had clear exclusion criterion and would not admit a patient who had been violent in the previous week. The ward did not have a seclusion room and would not admit patients who were considered to be a high risk. Nurses completed a

pre-admission risk screen to ensure patients' needs could be met on the ward. The ward had refused or delayed admissions due to the high level of acuity on the ward if they felt that a person's needs could not be safely met at that time.

The average length of stay for patients discharged in the 12 months before the inspection was 25 days. This had increased slightly since the hospital had established a contract with a local NHS trust, who block booked 10 beds on the ward, and would spot purchase additional beds as needed. The ward manager viewed this positively, as it gave patients the opportunity to settle in one place for their entire hospital stay. This enabled patients to develop a more effective therapeutic relationship with staff, rather than being moved to a different hospital part way through their stay. This also made it easier for staff to engage with patients' local mental health teams. Before this contract was in place, the ward admitted more out of area patients, who were repatriated back to their local area as soon as a bed became available.

Beds were generally available when needed for patients living in the local area. There was always a bed available when patients returned from leave. When patients were moved or discharged, this happened at an appropriate time of day.

When needed a bed could be found on a psychiatric intensive care unit. Staff would start looking for available beds in other Priory group hospitals.

In the six months before the inspection, the ward had one delayed discharge and six readmissions within 90 days of discharge. While discharges were rarely delayed, these were generally due to delays in commissioning and arranging appropriate support.

Staff planned for patients' discharge, including good liaison with care coordinators and family where appropriate. This process started from the point of admission.

Staff supported patients during referrals and transfers between services, for example, if they required treatment in an acute hospital or transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. 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.

Patients had access to their bedrooms during the day and could request that staff lock their rooms to ensure they had somewhere secure to store their possessions. Patients did not have their own keys to the rooms. Patients could personalise their bedrooms if they wished to.

Staff and patients had access to the full range of rooms and equipment to support treatment and care, including a clinic room to examine patients, a gym, activity and therapy rooms.

There were quiet areas on the ward and a room where patients could meet visitors. Patients could use their own mobile phones to make private calls. However, patients without their own mobiles used a public phone which did not always enable them to have privacy.

Patients had access to outside space. There were large grounds around the hospital, but these were not a secure space. All grounds leave was risk assessed on an individual basis.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

When appropriate, staff supported patients with preparation for and access to education and work opportunities. Staff also supported ongoing contact with current employers and workplaces as needed.

Staff supported patients to maintain contact with their families and carers. Staff also encouraged patients to develop and maintain relationships with people that mattered to them, both within the services and the wider community. Patients spent time out of the hospital in the community as part of the discharge preparation process.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service made adjustments for disabled patients. There was an accessible ramp into the building, and doors and

corridors were wide enough to enable wheelchair access. One room on the ward was accessible and had been adapted to support the needs of disabled patients, including a wet room, increased space within the room, and a door that opened outwards for ease of access. There was also an accessible toilet on the ward. However, the dining room was on a different floor and was only accessible by stairs. A lift could not be installed due to the hospital being in a listed building. As such patients who could not access the dining room would have their meals brought to them on the ward.

Staff ensured that patients could obtain information on treatments, local services, patients' rights, and how to complain. For example, staff included leaflets in patient's admission packs. The information was provided in a form accessible to the patient group. Staff could also make information leaflets available in languages spoken by patients as needed. Staff had access to interpreters and/ or signers as needed.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups. There were meal choices available including halal, vegetarian and vegan options, as well as gluten free. Staff would let the kitchen staff know of any special meal requirements so they could cater for these.

Staff ensured that patients had access to appropriate spiritual support. The ward had a multi faith and family room. A vicar attended the ward on request, and staff had previously supported patients to access 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.

In the 12 months before the inspection there had been three complaints about the ward, one of which had been upheld, and one had been partially upheld. None of these had been referred to the Independent Healthcare Sector Complaints and Adjudication Service. There were no trends identified relating to complaints. During this time the ward had received 16 compliments. There had been no withdrawn complaints and the hospital director told us that all complaints would be investigated.

Patients knew how to complain or raise concerns. The ward had developed a guide for patients to demonstrate the process. When patients complained or raised concerns, they received feedback. The ward manager would aim to meet with patients within 24 hours of being notified about a complaint. The manager would aim to resolve this locally, gathering more information about the patient's preferred outcome from the complaint.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Staff knew how to handle complaints appropriately.

Staff received feedback on the outcome of investigation of complaints and acted on the findings. Managers reviewed complaints and lessons to be learned from these during their learning from experience meetings. The findings from these were shared with staff through email bulletins and team meetings. Following previous complaints about the different service provision for private, fee paying and NHS patients, the ward responded to this by identifying two different clearly defined pathways for patients to clearly identify the additional consultant and one to one therapy time that private patients could access due to the higher fees they paid.

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

Good

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

Leaders had a good understanding of the services they managed. They could explain clearly how the teams were working to provide high quality care.

Leaders were visible in the service and approachable for patients and staff. Senior leaders carried out regular walk rounds on the ward and were well known to staff and patients.

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

Good

Leadership training opportunities were available for staff. The provider offered course via the NHS leadership academy course and the Priory academy and local university.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's senior leadership team had successfully communicated the provider's vision and values to the frontline staff in the service.

Staff had the opportunity to contribute to discussions about the strategy for their service. Staff had access to a "Your Say" forum where they were encouraged to feedback any issues. They also had access to a patient council meeting for patients and staff to feedback on the service and make suggestions.

Staff could explain how they were working to deliver high quality care within the available budgets.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity, and provided opportunities for career development. They could raise concerns without fear.

Staff felt positive and proud to work within the hospital and the team. Staff felt that adding an additional member of staff to the ward on ward round days had made a significant difference to staff morale and stress levels. This took pressure off staff and enabled them to spend more time with patients on those days.

Staff felt able to raise concerns without fear of retribution. Staff knew how to use the whistle-blowing process.

Managers dealt with poor performance when needed.

The staff team worked well together and supported each other well.

Staff appraisals included conversations about career development and how it could be supported.

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

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were systems and procedures in place to ensure that the ward was safe and clean, that there were enough staff who were trained and supervised, patients were treated well, and incidents and complaints were reported, investigated and learnt from. When systems did not work effectively (as with the medicines management issues we identified on site), the senior management team had processes in place to review and update these.

There was a clear framework of what must be discussed at a ward level in team meetings to ensure that essential information, such as learning form incidents and complaints, was shared and discussed.

The were key performance indicators that the ward reported on which included supervision and training compliance, sickness monitoring, incidents and medicines management.

Staff undertook or participated in local clinical audits. Audits included care plans, Mental Capacity Act, Mental Health Act and physical health. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and externally, to meet the needs of the patients.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

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

Good

The ward manager had access to the risk register at ward level. Staff could escalate concerns as required. Staff concerns matched those on the risk register. All issues on the risk register were revisited monthly as part of the clinical governance meetings.

Staff told us that cost improvements did not compromise patient care. Where insufficient nursing staff had been identified as an issue, steps had been taken to increase the staffing in response to concerns raised.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

The service used systems to collect data from the ward that were not over-burdensome for frontline staff. Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve patient care. However, the record keeping system included both paper and electronic records, and it was not always immediately clear where information was located, or if this was recorded in paper or electronic format.

Information governance systems included confidentiality of patient records.

The ward manager had access to information to support them with their management role. This included information on the performance of the ward, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies such as the local authority and the CQC as needed.

Engagement

The service engaged well with patients, staff and equality groups to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Staff, patients and carers had access to up to date information about the work of the provider and the services they used. Patients and carers also had opportunities to give feedback on the service they received.

The ward manager had access to this feedback from patients, carers and staff and used it to make improvements.

Patients and staff could meet with members of the senior leadership team to give feedback.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

Staff were given the time and support to consider opportunities for improvements and innovation. This feedback was welcomed as part of the “Your Say” staff forum, and the patient council meetings. Following feedback from staff, the ward developed a series of flash cards, cue cards for staff unfamiliar with the ward. These cards were attached to computer stations and gave prompts and reminders to all staff for key tasks to be completed.

The ward did not participate in any accreditation schemes at the time of the inspection but were keen to do so in the future once the ward had a full complement of staff. There were no plans to start this process at the time of the inspection.

The site was currently following the Safe Wards model to improve safety on the ward.

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Safe and clean environment

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Staff did regular risk assessments of the care environment and addressed any issues that they found.

The ward layout did not allow staff to easily observe all parts of the ward. Staff mitigated blind spots by using mirrors and staff observation. Staff completed regular ligature audits and identify any issues that needed addressing. A ligature anchor point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. There were ligature cutters available on the ward and staff knew where they were. There was CCTV through out the ward which was monitored 24 hours by an external company, who contacted the ward directly if there was an issue. There were appropriate policies and procedures around the use of CCTV which included how staff could access recording if they need to review an issue.

The hospital did not accept young people who were considered high risk of ligature or self-harm. Staff would carry out a pre-admission risk assessment on each young person to make sure the environment was suitable for them.

The ward complied with guidance on eliminating mixed-sex accommodation. The ward had male and female young people. There were no separate areas for males or females, but all bedrooms were en-suite. The hospital had a policy on maintaining privacy and dignity on mixed sex wards, that the staff followed and included information on ensuring the rights of trans people were also protected.

All staff had access to alarms and there were call points for patients to use.

All ward areas were clean, tidy and in a good state of repair. Cleaning records we reviewed were up to date and showed the areas were cleaned regularly. Staff saw that staff followed infection control principles, including hand washing and the use of protective equipment such as disposable aprons when helping young people with personal care.

The service did not have a seclusion room.

The clinic room was fully there were emergency drugs that staff checked regularly. We checked drugs and equipment in the clinic room and it was all in date. Emergency resuscitation equipment including a defibrillator were kept in the office, they were checked daily and all items were in date.

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.

However, at the time of our inspection the establishment of qualified nurses for the ward was eight and there were 5 vacancies. The vacancy rate for qualified nurses on the ward was 62%. The hospital was actively recruiting staff. There were no health care support worker vacancies.

Good

Child and adolescent mental health wards

The number staff required on the ward had been calculated as part of the Priory safer staffing ladder, a hospital wide staffing calculation. The ward had two registered mental health nurses (RMNs) and three healthcare assistants on duty each day shift and one RMN and two healthcare assistants on each night shift. The ward manager could increase the number of staff if the level of support needed by the young people went up. For example, if more than one young person required one to one support.

The provider used bank and agency staff to cover sickness and vacancies. The provider used agency staff on longer contracts so that they knew the needs of the young people and the ward policies and procedures. During the inspection there were three full time and one part time RMN vacancies. The ward manager was agency staff member on a longer contract, six months, and he was due to leave. Agency staff were given an induction to the ward and given any training specific to the hospital and their role. For example, observations. Agency staff on longer contracts were provided supervision.

A qualified nurse was always present on the ward and staffing levels allowed for the young people to have regular one to one time with a member of staff.

Staff rarely had to cancel escorted leave or ward activities, due to staff shortages and if they did they would be rearranged immediately. There were enough staff to carry out physical interventions and staff had received appropriate training to do so.

There was adequate medical cover 24 hours a day and a doctor would attend the ward quickly when needed.

Ninety five percent of staff were up to date with their mandatory training. Managers could identify which staff needed to complete training and would prompt them to do so by emailing and speaking to them. There was a training coordinator for the hospital whose role was to monitor training compliance. All staff employed at the hospital do basic life support training and qualified nurses do immediate life support training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

We reviewed five care records during the inspection. Staff completed a risk assessment of the young people on admission and they regularly updated them. Staff reviewed risk assessments following changes in the young person's risk and incidents. Staff used observation levels to manage identified risks and were supported by policies and procedures, for example searching belongings and staff behaviour.

The hospital had a named liaison police officer and a senior manager attended monthly police liaison meetings.

The provider only used blanket restrictions when appropriate. The ward gave the young people a list of restricted items on admission. Staff would check the young person's property on admission and store any restricted items securely.

Informal young people could leave the ward if they wanted too. However, some young people told us that they had not been able to leave. The consultant told us that if a young person had capacity they would be able to leave and the staff we spoke to were aware of this. However, if staff were concerned about the safety of a young person they would stop them leaving until it was safe for them to do so. When staff stopped a young person leaving they would review the incident and decide if they need to use the Mental Health Act.

In the six months before the inspection there were 50 episodes of restraint on 14 different young people, none of which were prone restraints. The ward did not have a seclusion room.

Staff were trained to use prevention and management of violence and aggression (PMVA) when restraining young people. Staff had attached "calm cards" to the young people's medicines charts, highlighting de-escalation techniques that worked with individual patients, these were developed with the young person and were written in the language the young person used.

Staff followed National Institute for Care and Health Excellence guidance when using rapid tranquilisation. There was no reported use of rapid tranquilisation, in the six-months before the inspection.

As staff did not have a seclusion room they would support the young people to leave communal areas and spend some time either in their rooms or a quiet area on the ward.

Safeguarding

Staff were trained in safeguarding. All staff were trained to level three and the safeguarding lead was trained to level four. At the time of our inspection compliance with training was at 93%. 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. The provider had a named lead for child safeguarding.

Staff were trained in safeguarding children and knew how to make an alert to the local authority. Staff knew how to identify safeguarding issues. The ward staff worked in partnership with other agencies and could get support and advice from the hospital's safeguarding lead or the local authority safeguarding team.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff, including agency and bank, could access all the information they needed to provide safe care to the young people admitted on the ward. The hospital used both paper and electronic records. The electronic record was the primary record, but staff kept a paper copy of key information in case the computer system was unavailable. We did not find any discrepancies between the records.

Medicines management

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

Staff followed good practice in medicines management (transport, storage, dispensing, administration and medicines reconciliation), and did this in line with national guidance. We reviewed four drug prescription cards and found that medicines were administered and recorded correctly. Staff recorded room and fridge temperatures and knew what to do if they were not within the correct range. However, we found that nurses had not recorded the date a liquid medicine that had been opened which meant they would not know when it was no longer safe to use. The pharmacist was due to visit the following day, and this would have been identified at this check. We told staff about this and they disposed of it.

Track record on safety

The ward reported 12 serious incidents in the 12 months prior to our inspection. The incidents recorded included allegations of abuse by third parties, self-harm, AWOL (absence without leave) of a detained young person and young people being aggressive towards staff and other young people.

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.

Staff reported incidents through an electronic form, all staff knew what and how to report incidents on the electronic system. Staff discussed incidents in the morning flash meetings, shift handovers and at the weekly multidisciplinary meetings. The provider investigated incidents and any identified learning was discussed at the learning from experience meetings and circulated to all staff via emails, meeting and supervision.

Staff were open and honest with the young people and their families. Staff understood their responsibility under the duty of candour and gave young people and their families a full explanation when things went wrong.

The provider made changes following learning from incidents and often gave additional training. We were given an example of changes following incidents, the provider had changed the key rings they used when a young person had been able to use one as a ligature during an incident.

The provider offered debriefs following serious incidents and identified any additional support staff needed.

Good

Child and adolescent mental health wards

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, were personalised and holistic.

We reviewed five care records during the inspection. All records had up to date care plan and risk assessment present. Most care plans were personalised, holistic and the young people had received a copy them. However, not all plans were recovery focused.

Staff always completed a mental health assessment of the patient on, or soon after, admission. Staff assessed patients' physical health needs on admission and monitored any identified needs as required.

There were care plans in place for any identified need and risk management plans for any risk identified. Staff regularly reviewed these and updated them when necessary.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit.

The provider offered the care and treatment recommended by the National Institute for Health and Care Excellence (NICE). This included access to education and psychological therapies.

Staff made sure the young people had access to physical healthcare, including referring patients to specialists when needed. Staff carried out a physical health assessment on admission. The ward manager completed regular physical health audits.

The ward staff provided education about healthy eating and healthy lifestyles and supported the young people to achieve this.

Staff used recognised rating scales to assess and record severity and outcomes, including the Health of the Nation Outcome Scales (HoNOS).

The provider conducted clinical audits (including physical health, Mental Health Act and care plan audits), to understand how they were performing and identify ways to improve the quality of the service. Staff on the wards were involved in carrying out the audits. There were daily quality checks carried out by ward manager they would also conduct quality walk rounds on other wards to check the quality of the care provided.

Skilled staff to deliver care

The ward team included or had access to the full range of specialists required to meet the needs of patients on the ward. 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.

The team had access to the full range of professional needed to meet the needs of the young people. There was a consultant psychiatrist, nurses, healthcare assistants, activity coordinators, occupational therapists, psychologists, social workers and education staff. The provider had a contract to for pharmacy and a pharmacist visited the ward on a weekly basis to offer advice and support.

Staff had the right experience and qualifications to address the needs of the young people admitted. All staff including agency and bank were given an appropriate induction.

Managers provided supervision to staff in line with the providers policy and in the three months prior to our inspection all staff (100%) had received supervision. The percentage of staff that had had an annual appraisal in the year before the inspection was 100%. Appraisal were reviewed, against the agreed goals, every six months.

There were regular team meetings. These were minutes recorded of meetings, so staff who had not attended could see any agreed actions.

Good

Child and adolescent mental health wards

The ward manager used supervision and appraisals to identify the training needs of staff. The provider identified and provided any specialist training that was needed. External companies were used when required and staff could apply for a financial contribution towards training.

We saw that managers addressed poor staff performance quickly, developing support and training plans.

Multi-disciplinary and inter-agency 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. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular and effective multidisciplinary meetings. We attended one meeting and saw that staff worked well together and respected each other's professional opinions. The staff team involved the young people in the meetings and explain the reasons why decisions were made.

Staff had handovers meetings between each shift. Staff shared information about the young people's general well-being, changes to care and risk.

The ward teams had good relationships with their colleagues in the hospitals and with external teams such as the local authority. The hospital leadership team held daily flash meetings every morning to ensure all staff were aware of relevant issues within the hospital. For example, staffing issues and incidents. The ward staff invited patients' care coordinators to multi-disciplinary meetings to keep them up to date and to plan for discharge.

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.

Training on the Mental Health Act was mandatory at the hospital and 87% of clinical staff had completed the training at the time of our inspection. Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice.

The provider had appropriate policies and procedure around the use of the Mental Health Act. Staff could get support from a Mental Health Act administrator, employed at the hospital, and knew who they were.

Staff referred the young people to an independent mental health advocate (IMHA) when they felt it was appropriate or if the young person requested it. There was information available to young people about the role of the IMHA and how they could access one on the ward.

Staff regularly explained to young people their rights under the Mental Health Act and in line with the code of practice. The hospital management team could audit this electronically and staff would be reminded to explain young people their rights when they needed to.

The young people were given Section 17 leave (permission for patients to leave hospital) when appropriate and staff planned so that the young people could use it.

There were copies of the young people's detention papers and other Mental health Act paperwork stored on the electronic record. The original copies of the paperwork were kept in the Mental Health Act administrator's office.

The provider completed regular audits to ensure the Mental Health Act was being used properly.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 applied to young people aged 16 and 17 and the principles of Gillick competence as they applied to patients under 16 years of age. Staff assessed and recorded consent and capacity or competence clearly for patients who might have impaired mental capacity or competence.

All staff working on the ward needed to complete mandatory training in the Mental Capacity Act. At the time of our inspection 86% of clinical staff were compliant with Mental Capacity Act training.

Staff appeared to have a good understanding of the Mental Capacity Act and we saw examples in the young people's records where they had considered capacity. For example, when discussing the use of CCTV in the young person's bedroom.

There had been no applications for deprivation of liberty safeguards made in the past six months prior to inspection.

Good

Child and adolescent mental health wards

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy, how to access it and where to get advice.

We saw evidence in the young people's records and during multi-disciplinary meetings that capacity to consent to treatment and admission was being reviewed and record.

The ward monitored the use of Mental Capacity Act and this was audited as part of the hospital weekly quality walk rounds.

Are child and adolescent mental health wards caring?

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.

All interactions we witnessed between staff and the young people were caring and respectful. Staff discussed young people in a supportive manner.

Staff discussed the treatment options with the young people and encouraged them to take responsibility for managing their care.

The young people we spoke to told us that they felt safe on the ward and the staff treated them well. However, they told us that there was not always enough to do at weekends and that not all staff understood their rights. For example, an informal young person was told they needed an escort to leave the ward.

Staff we spoke with could explain the needs of the young people on the ward and how the team was meeting them.

The young people and staff told us they would be happy to raise concerns about how the young people were being treated.

Staff kept information about the patient on a secure computer system, when information was on a hard copy it was kept in locked offices and information boards were closed when rooms were accessed by other young people.

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 independent advocates and to child helplines.

Staff showed the young people around the ward when they were admitted and introduced them to the other young people and staff. The young people were given an induction pack that covered information such as advocacy, rights, the Mental Health Act, meal times, and complaints. The young people were also given a gift bag on admission that included activities for them to completed designed by other young people using the service. The hospital also kept the young people up to date with any changes via a newsletter.

We saw evidence that the young people were involved in planning their care and this was recorded in the care plans we reviewed. All the patients had had a copy of their care plan and this was recorded in the care record. However, we saw that the amount of involvement the young people had in planning their care varied.

The young people were always invited to attend their multidisciplinary team meeting and staff gave them the opportunity to express their opinion about their care.

Staff encouraged the young people to give feedback on the service. They held weekly meetings for the young people to give their suggestions. We saw that the service responded to suggestions from patients. For example, staff had received training in supporting LGBT (lesbian, gay, bisexual and transgender) rights and the service was sending staff on a training course with an external provider in this area. The ward had 'you said we did' posters which identified changes the service had made to the young people.

Staff informed and involved families and carers appropriately.

Good

Child and adolescent mental health wards

Staff involved families and carers in the young person's care appropriately. Staff invited families and carers to multidisciplinary meetings and CPA (care programme approach) meetings. The consultant would speak directly with families and carers.

The was a quarterly carers meeting held at the hospital by the social worker and there was a carers newsletter.

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

Good

Access and discharge

Staff managed beds well. A bed was available when needed and that patients were not moved between wards unless this was for their benefit. They liaised well with services that would provide aftercare and were assertive in managing the discharge care pathway. As a result, patients did not have excessive lengths of stay and discharge was rarely delayed for other than a clinical reason.

The ward only admitted NHS patients and would admit on the same day if a bed was available. There was a clear exclusion criterion, and they would not admit young people who were a high risk of violence to other or of self-harm. Nurses would complete a risk assessment prior to admission to ensure the young people were suitable for the service. The ward staff could refuse admissions if they felt the young person's needs could be met. Senior managers could review these decisions, but staff told us they were rarely changed.

The average length of stay for young people in the 12 months before the inspection was 67 days. Staff started planning for the young person's discharge on admission and engaged with local teams to support this.

The average level of occupancy in the last 12 months was 88%, this meant that beds were usually available when young people needed admission. The service did not admit young people in to the beds of patients on leave. The service would look to admit young people as soon as it was agreed. Discharges or moves to other services were planned to take place at an appropriate time of the day. If the young person was on leave when due to be discharged the consultant would arrange to visit them to avoid the young person having to return to the hospital.

If needed the service could move the young people to a service that was able to manage higher levels of risk. They would usually look for beds within the Priory Group first. Delays to discharge were rare and usually due to commissioners finding alternative placements.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the ward supported the young persons' treatment, privacy and dignity. Each young person 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 the young person could make hot drinks and snacks at any time.

All the young people had their own en-suite bedroom. Young people could access their bedrooms at any time. The young people did not have keys for their rooms but could ask staff to lock them, they had access to secure storage on the ward. The rooms had recently been redecorated and although they could still personalise their rooms there was limited space for putting up posters and this gave the rooms a more clinical feel.

The was a full range of rooms available to the young people and staff including: a clinic room, lounge, quiet room and an education suite.

There was a family room where the young people could meet visitors. The young people were allowed mobile phones to make private calls or they could use the ward phone in a private area.

The young people had a private garden they could access when they choose to. At the time of our inspection the young people were engaged in a project to redesign the garden to make it a nicer therapeutic space.

We were told the food was good and the young people could make hot drinks and snacks 24 hours a day.

Patients' engagement with the wider community

Staff supported young people with activities outside the service and made sure young people had access to high quality education throughout their time on the ward.

Good

Child and adolescent mental health wards

There was an education programme for each of the young people admitted to the ward. The hospital provided a full education programme for children under 16 in line with the national curriculum, the provider employed qualified teachers and young people had been supported to complete their GCSE examinations. The young people were engaged in a project to develop the garden and were being supported by staff to engage with local business to secure funding and equipment for the project. Young people had been supported to take part in charitable events within the local area. During our visit the young people were engaged in a project about diversity and the LGBT community.

Staff supported the young people to keep contact with families and other important people. Parents we spoke to told us they were always welcome on the ward and staff would arrange for them to take their loved one on leave in the grounds or wider community when they visited. The young people would spend time at home on leave as part of their discharge plan.

Meeting the needs of all people who use the service

The service met the needs of all young people – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service made reasonable adjustments for disabled young people. There was an accessible ramp into the building, and doors and corridors were wide enough to enable wheelchair access.

Staff gave the young people information on treatments, rights and how to complain. Information could be given in a form the young people could understand. For example, different languages or easy read format.

The hospital could meet all dietary requirements. For example, different religious and ethnic background or for different diets such as vegetarian or gluten free.

There was spiritual support available to the young people.

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.

In the 12 months prior to the inspection there had been five complaints about Kingfisher ward, one of was upheld, three had been partially upheld and one was waiting an outcome. None of these had been referred to the ombudsman and there were no identified trends. There had been no withdrawn complaints and the hospital director told us that all complaints would be investigated. The ward had received 21 compliments during the same period.

The young people told us they knew how to complain. The ward manager tried to resolve complaints locally and within 24 hours of the young person making the complaint.

Staff knew how to handle complaints and ensured the patients were protected when they did complain. The young people told us they were happy to complain and felt safe to do so.

Complaints were investigated, and managers gave staff feedback on the outcomes and any agreed actions. Managers reviewed the outcomes of complaints and agreed any lessons to be learned during the learning from experience meetings. The findings from these were shared with staff.

Are child and adolescent mental health wards well-led?

Good

Leadership

Leaders had the integrity, skills and abilities to run the service. They understood the issues, priorities and challenges the service faced and managed them. They were visible in the service and supported staff to develop their skills and take on more senior roles.

The leadership team on Kingfisher ward had the knowledge and experience needed to perform their roles. The ward leadership understood the goals aims of the service and could explain how they aimed to offer good quality care.

Leaders, including members or the hospital senior leadership team, were visible on the ward. The ward manager completed a daily quality check on the ward and the hospital director and clinical lead visited the ward daily and made themselves available to young people and staff.

Good

Child and adolescent mental health wards

The provider offered leadership training opportunities. The provider offered course via the NHS leadership academy course and the Priory academy and local university.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. They were aligned to local plans and the wider health economy. Managers made sure staff understood and knew how to apply them.

All staff we spoke to understood the provider's vision and values and how the ward worked to achieved them.

Staff could express their view about the future direction of the service. The provider had a "Your Say" meeting had the opportunity to contribute to discussions about the strategy for their service. Staff had access to a "Your Say" to provide feedback. The young people were encouraged to give feedback about service development.

Staff understood and explain how they delivered quality care with the resources they had available.

Culture

Staff felt respected, supported and valued. They felt the service promoted equality and diversity and provided opportunities for career development. They could raise concerns without fear.

Staff felt that supported by managers. Staff told us their opinions were respected by the leadership team and that they responded to their needs. For example, add extra staff to support busy times on the ward. This took pressure off staff and enabled them to spend more time with patients on those days.

Staff told us they could raise concerns if they needed to. Staff knew where to find the whistle-blowing policy if they needed it.

Managers dealt with poor performance and we saw examples of where they had followed the providers policies to help staff address their performance issues.

Managers address career development in appraisals and agreed and set goals to help staff achieve this.

There was a staff awards scheme to recognise staff achievements and hard work.

Governance

Leaders ensured there were structures, processes and systems of accountability for the performance of the service. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There were strong local governance processes in place which ensured the ward followed the providers policies to keep the young people safe, provided with the correct treatment and that the service learnt when things went wrong. There were key performance indicators that the ward reported on which included supervision and training compliance, sickness monitoring, incidents and medicines management.

There was a clear process in place so that information was shared with staff at ward level including learning from incidents.

Staff took part in clinical audits and acted on the results.

Staff understood their role within the ward and when working with external teams.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

The ward manager could add items to the hospital risk register and staff knew how to escalate concerns. The risk register was reviewed monthly as part of the clinical governance meetings.

The leadership team acted to address issues that effected young people's care. For example, extra staffing added at busy times in response to how this impacted on the care of the young people.

Information management

The information technology systems worked well and were straight forward for the staff team to use. There was both paper and electronic records in place, but staff were clear to us that the electronic system was the primary one.

All information about the young people was kept safe and secure.

Good

Child and adolescent mental health wards

The ward manager could access information to inform them of the wards performance and used these to drive quality.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

The provider gave the young people, carers and staff, information about the service, changes and gave them the opportunity to help shape the service.

The ward manager used feedback from the young people, parents and staff to make improvements.

The senior leadership team made themselves available to the staff and young people.

Learning, continuous improvement and innovation

All staff were committed to continually improving services and had a good understanding of quality improvement methods. Leaders encouraged innovation and participation in research.

The provider showed a commitment to continued improvement through its learning from experience meetings and using quality improvement methods. The provider has identified staff to lead the quality improvement throughout the hospital. This has included work to reduce medication errors.

Kingfisher ward is accredited with The Quality Network for Inpatient CAMHS, this scheme is provided by the royal college of psychiatrists to promote the highest level of care.

The site was currently following the Safe Wards model to improve safety on the ward.

Good

Specialist eating disorder services

Safe	Good
Effective	Good
Caring	Outstanding
Responsive	Good
Well-led	Good

Are specialist eating disorder services safe?

Good

Safe and clean environment

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose. Staff completed regular audits of the environment and addressed any issues.

The ward layout did not allow staff to observe all areas of the ward. Mirrors and staff observations were used to mitigate blind spots. There were regular ligature audits completed and staff would arrange for issues to be addressed. A ligature anchor point is anything which could be used to attach a cord, rope, or other material for the purpose of hanging or strangulation. There were ligature cutters available to staff and they knew where to get them. The risks were mitigated by mirrors and increased staff observation in these areas. There was CCTV at the hospital's entrance and in some communal areas. For example, the dining room. There were appropriate policies and procedures around the use of CCTV which included how staff could access recording if they need to review an issue.

Staff assessed all patients prior to admission to make sure they were suitable for the environment and would not admit patients whose risk of ligature or self-harm was too high for the environment.

Staff had easy access to alarms, that were tested regularly to ensure they worked and there were alarm calls for patients in their bedrooms.

The ward complied with guidance on eliminating mixed-sex accommodation.

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.

However, at the time of our inspection the establishment of qualified nurses for the ward was six and there was 2 vacancies. The vacancy rate for qualified nurses was 33%. The hospital was actively recruiting staff. There were no health care support worker vacancies.

The ward used the Priory safer staffing ladder to agree how many staff it needed. At the time of our inspection there were two registered mental health nurses (RMNs) and three healthcare assistants on duty each day shift and one RMN and two healthcare assistants on each night shift. The ward manager could increase staffing when need to cover observations.

There was two RMN vacancy and two healthcare assistant vacancies on the ward. There was limited use of bank and agency staff as permeant staff filled most vacant shifts. When agency or bank staff were needed the ward used people who were familiar with the ward.

There was always a qualified nurse present on the ward and staffing levels allowed for patients to have regular one to one time with staff.

Staff rarely needed to cancel escorted leave and would rearrange any leave that was cancelled due to staff shortages. There is always enough staff to carryout physical

interventions on duty. However, the service had not needed to use any physical interventions (when staff have to take hold of a patient to keep them or others safe) in the 12 months prior to our inspection.

There is a doctor on duty at the hospital site 24 hours a day and they will respond quickly when needed.

Staff had access to mandatory training at the time of the inspection staff were 95% compliant with training. The ward manager could see which staff needed to complete training and would remind them via emails and in meetings. There was a hospital wide training coordinator who monitored training levels throughout the hospital. All staff employed at the hospital do basic life support training and qualified nurses do immediate life support training.

Assessing and managing risk to patients and staff

We reviewed three care records during the inspection of Skylark ward. Staff completed a comprehensive risk assessment on admission. Staff reviewed risk assessments weekly and following any changes to the patient's risk or following an incident. All three risk assessments we reviewed had been updated in the past week. Staff followed the providers observation, search and contraband policies to manage identified risks.

The hospital had a named liaison police officer and a senior manager attended monthly police liaison meetings.

The provider avoided blanket restrictions unless they were appropriate. Staff gave patients a list of banned items on admissions and checked patients personal belongs to ensure they did not have any. The staff could securely store any banned items until they were discharged or sent home with families. There was a local and national reducing restrictive practice group which reported in to the clinical governance meetings.

The patients were not prevented from leaving the ward if they were not detained, but they were asked to sign a patient agreement that covered when they could leave the ward.

Staff were trained to use prevention and management of violence and aggression (PMVA) when restraining patients, training included consideration for patients with very low body weights or who were using naso gastric tubes for feeding. However, there had been no restraints on the ward in the past 12 months prior to inspection. Staff followed the NICE guidance on rapid tranquilisation, but they had not need to use rapid tranquilisation for over 12 months prior to inspection. Staff did refresher courses to make sure they stayed competent to use PMVA techniques. There were cards attached to medication cards to remind staff of what action they needed to have taken before using medication to help a patient to calm and these reflected the patients' choice.

There was no seclusion room on the ward.

Safeguarding

Staff were trained in safeguarding adults and children. All staff were trained to level three and the safeguarding lead was trained to level four. At the time of our inspection compliance with training was at 93%. Staff knew how to recognise safeguarding issues and would raise an alert when they needed to. The ward staff could get advice from the designated safeguarding lead and work with other agencies including the local authority safeguarding team when needed.

Staff access to essential information

Staff, including agency and bank, could access all the information they needed to provide safe care to the patients in their care. The hospital used both paper and electronic records. The electronic record was the primary record, but staff kept a paper copy of key information in case the computer system was unavailable. We did not find any discrepancies between the records.

Medicines management

Staff followed good practice in medicines management (transport, storage, dispensing, administration and medicines reconciliation), and did this in line with national guidance. We reviewed eight drug prescription cards and found that medicines were administered and recorded correctly. Staff recorded room and fridge temperatures and knew what to do if they were not within the correct range.

All patients had consent to treatment forms in place that demonstrated staff had considered the patients ability to agree to their medications. There were side effect monitoring scales available, so staff could identify and act on any side effects from medication. Any risks relating to medication such as allergies or non-compliance were highlighted on the cards and medicines times were colour coded to help reduce errors.

Track record on safety

Good

Specialist eating disorder services

The ward had reported four serious incidents in the 12 months prior to our inspection. The incidents all related to self-harm.

Reporting incidents and learning from when things go wrong

Staff used an electronic form to report incidents, all staff knew what and how to report incidents on the system. Staff discussed incidents in the morning flash meetings, shift handovers and at the weekly multidisciplinary meetings. The provider investigated incidents and any identified learning was discussed at the hospital wide learning from experience meetings and circulated to all staff via emails, meetings and supervision to all staff in the hospital.

Staff were open and honest with the patients and their families. Staff understood their responsibility under the duty of candour and gave the patients and their families a full explanation when things went wrong.

The provider made changes following learning from incidents and often gave additional training. We were given an example of changes following incidents, the provider had stopped using portable radiators to heat bedrooms in the winter and had improved access to temperature controls in bedrooms as the radiator could be used to self-harm.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed three care records during the inspection. All records had up to date care plan and risk assessment present. All care plans were personalised, holistic and the patients had been given a copy. All care plans were recovery focused.

Staff always completed a mental health assessment of the patient on, or soon after, admission. Staff assessed patients' physical health needs on admission and monitored any identified needs as required.

Care plans covered four key areas; keeping safe, keeping healthy, keeping well and keeping connected, all patients had care plans in these areas. Care plans covered all the patients identified needs. Staff regularly reviewed the care plans and updated them when necessary. The hospital were rolling out in house care plan training to all staff, and auditing care plans fortnightly to pick out and themes or trends.

Best practice in treatment and care

The provider offered the care and treatment recommended by the National Institute for Health and Care Excellence (NICE). This included psychological therapies and rehabilitation activities. Group therapy sessions included nutrition, body image concern and self-esteem, cognitive restructuring, independent eating skills and emotional regulation and distress tolerance.

Staff made sure the patients physical health was monitored regularly. All patients had electrocardiogram (ECG) on admission, blood tests daily and their physical observations completed four times a day for the first five days of admission. The hospital had an agreement with a local acute hospital to process the blood results daily. The ward followed the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines to monitor patients' physical health and identify when patients needed transfer to an acute hospital. The ward monitored patients' physical health observations on a Management of Really Sick Patients with Anorexia Nervosa Modified Early Warning Score (MARSIPAN-MEWS) this helped staff to identify concerns with patients' health that may require hospital treatment. The ward manager completed regular physical health audits.

The ward had a dietician who worked closely with the patients and the hospital chef to ensure all patients' nutritional needs were met. The ward follow national guidance on meal times such as patients remaining under supervision in the lounge area for a set period of time after meals. Staff provided education about healthy eating and healthy lifestyles and supported the patients to achieve this.

Staff used recognised rating scales to assess and record severity and outcomes, including the Health of the Nation Outcome Scales (HoNOS), Eating Disorder Examination Questionnaire (EDEQ), Generalized Anxiety Disorder (GAD) and Patient Health Questionnaire 9. We saw that staff used outcomes measures to demonstrate the impact of treatment on patients. For example, when patients began

to gain weight their negative body image and anxiety around this often increased. However, staff used the Generalized Anxiety Disorder (GAD) to demonstrate that overall the patient was less anxious. This allowed patients to see the improvement in their health the weight gain was having.

The provider conducted clinical audits (including physical health, Mental Health Act and care plan audits), to understand how they were performing and identify ways to improve the quality of the service. Staff on the wards were involved in carrying out the audits. There were daily quality checks carried out by ward manager to check the quality of the care provided.

Skilled staff to deliver care

The team had access to the full range of professional needed to meet the needs of the patients. There was a consultant psychiatrist, nurses, occupational therapist, dietician, healthcare assistants, psychologists and social workers. The provider had a contract for pharmacy and a pharmacist visited the ward on a weekly to complete audits and offer advice and training to staff.

Staff had the right experience and qualifications to work with this patient group. The Priory Group has a four-day course covering eating disorder and the hospital providers a one-day course on the subject led by the dietician and a health assistant with 20 years' experience in the clinic area. All staff including agency and bank were given an appropriate induction which includes supernumerary time and completing eating disorder competencies. The ward has compiled an induction to Skylark ward booklet for staff that provided all the key information about eating disorders. Appropriate staff were trained to in the use of naso gastric tubes for feeding patients.

Managers provided supervision to staff in line with the providers policy and in the 12 months prior to our inspection 92% of staff had received supervision monthly. The ward offers group supervision every month with the ward psychologist. The percentage of staff that had had an annual appraisal in the year before the inspection was 98%. Appraisal were reviewed, against the agreed goals, every six months. The ward manager used supervision and appraisals to identify the training needs of staff. The provider offered specialist training when it was needed. The provider would make a financial contribution towards training when it was not seen as essential but would be beneficial to the role.

There were regular team meetings.

We reviewed staff records and saw that managers took action quickly when there was poor staff performance, developing support and training plans.

Multi-disciplinary and inter-agency team work

Staff held regular and effective multidisciplinary meetings. The staff team involved the patients in the meetings. Staff had found that patients were not always confident in the meetings, so they introduced a form for the patients to complete that described their week in words. Staff found this enabled patients to express their feelings about their care easier. The staff would explain why decisions were made to the patients.

Staff had handover meetings between each shift and had a daily flash meeting. Staff shared information about any changes to the patients' needs, risk and incidents across the hospital.

The staff team on Skylark including senior managers, reported having good working relationships with their colleagues. They had good links with external agencies including the local acute hospital and local authority. The ward staff invited patients care coordinators and families to multi-disciplinary meetings to keep them up to date and to plan for discharge.

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

Training on the Mental Health Act was mandatory at the hospital and training was being provided on the day of our visit to Skylark. Training compliance on the day of our inspection was 87% for clinical staff. Staff we spoke with had a good understanding of the Mental Health Act and the Code of Practice.

The provider had developed appropriate policies and procedure around the use of the Mental Health Act that staff could access. A Mental Health Act administrator offered support to staff and they knew how to contact them.

Good

Specialist eating disorder services

Staff would referred patients to an independent mental health advocate (IMHA) when appropriate or if the patient requested it. There was leaflets on the ward explaining the role of advocates, when they would visit the ward and they could access one.

Staff regularly met with patients to discuss their rights under the Mental Health Act and in line with the code of practice. The hospital management team could audit this electronically and reminders sent to staff when patients were due to have their rights explained.

Patients were given access to Section 17 leave (permission for patients to leave hospital) when appropriate and staff planned shifts to ensure they use it.

There were copies of the patient's detention papers and other Mental health Act paperwork on their electronic record. The original copies were kept in the Mental Health Act administrator's office.

Good practice in applying the Mental Capacity Act

All ward staff completed mandatory training in the Mental Capacity Act. At the time of our inspection 86% of clinical staff were compliant.

Staff appeared to have a good understanding of the Mental Capacity Act and we saw examples in the patients records where they had considered capacity to consent to treatment and staff stored copies of Capacity and Consent to Treatment records within each patients' medicine chart folder.

There had been no applications for deprivation of liberty safeguards made in the past six months prior to inspection, but there was evidence that staff had discussed this in patients records.

The provider had a policy on the Mental Capacity Act, including deprivation of liberty safeguards. Staff were aware of the policy, how to access it and where to get advice.

Where patients lacked capacity, staff made decisions in their best interests with full explanations and rationale for decision recorded.

The ward monitored the use of Mental Capacity Act and this was audited as part of the hospital monthly quality walk rounds.

Are specialist eating disorder services caring?

Outstanding ☆

Kindness, privacy, dignity, respect, compassion and support

All interactions we witnessed between staff and the patients were caring and respectful. Staff were made aware of phrases they should not say to patients. For example, staff should not compliment patients on how they are looking as this can have a negative effect on the patients' body image. Staff could compliment each other or visitors to the ward as it remained important that the patients remained connected to the wider world.

Staff discussed treatment options with patients and asked for feedback at the weekly community meeting. We saw that patients were able to question practices on the ward. For example, the patients questioned why they needed to remain in the dining area at meal times for 20 minutes. Staff explained that this was because research has shown this helps patients with distress tolerance. Staff shared the research with patients so that they had the same evidence base to consider as the staff team. Patients told us that this helped them to understand their treatment and make complying with it easier.

Patients told us that they felt safe on the ward and the staff treated them well.

Staff we spoke with understood the needs of the patients on the ward and how the team was meeting them. Senior staff used the handover meetings to informally assess and remind staff of key competencies. There were competency flash cards on the ward around areas such as treatments, safeguarding and the Mental Capacity Act. Senior staff would select a topic at random and then ask the team questions about the subject. This acted as a reminder to staff and identify possible training needs for the team.

The staff told us they would be happy to raise concerns about how the patients were being treated.

Staff kept information about the patients on a secure computer system, when information was a paper copy it was kept in locked offices and information boards were closed when rooms were accessed by other patients.

Good

Specialist eating disorder services

Involvement in care

A healthcare assistant met all new patients and showed them around the ward. All patients were given a patient information booklet that covered basic ward information like meal and laundry times and had information about the treatments available to patients. There was also a folder on the ward that gave patients information about the staff. For example, favourite film, book, likes and dislikes. Staff told us that sharing information about themselves helped to develop a therapeutic relationship with the patients. Staff showed the patient around the ward when they were admitted and introduced them to the other patients and staff. The hospital kept the patients up to date with any changes via a newsletter.

We saw evidence that patients were involved in planning their care and this was recorded in the care plans we reviewed. Patients views were clear and documented in language they would use. All the patients had a copy of their care plan and this was recorded in the care record. Patients were encouraged to keep a daily journal to capture their thoughts and feeling of their care. This included self-monitoring of dietary intake and associated thoughts and feelings which is recommended in the Eating Disorders, recognition and treatment NICE guidelines.

The patients were always invited to attend their multidisciplinary team meeting and staff gave them the opportunity to express their opinion about their care. Patients were encouraged to complete the 'my week in words' document to highlight what had gone well and what need to improve.

Staff encouraged the patients to give feedback on the service. They held weekly meetings, which we attended, for the patients to give their suggestions about the service. We saw that the staff listen and respected the patients views and responded to suggestions from patients. For example, the ward had 'you said we did' posters which identified changes the service had made. Patients asked for a board game which had been provided. The patients and had also asked for agency staff not to do medication in the morning as it sometimes made them late; staff had explained why they could not always make this happen but would speak to agency staff about making sure they had enough time. There was a mutual expectations meeting, that allowed patients and staff to explain what they expected from each other.

Staff involved families and carers in the patients care appropriately. Staff invited families and carers to multidisciplinary meetings and CPA (care programme approach) meetings. The consultant would speak directly with families and carers. The ward was always looking for ways to improve family involvement in care as the patient's success after discharged relied on the family understanding the patient's condition and how they could support them. They were currently looking at how they could securely share information with families about care planning so they, with the patient's permission, could input into the care planning process.

In addition to the quarterly carers meeting held at the hospital by the social worker the ward had a monthly carers meeting that was held by the occupational therapist and dietician. There was a carers newsletter. The ward had arranged for a carers' education day at the hospital where staff would offer education and advice to carers around meal support, understanding eating disorders and strategies to use at home.

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

(for example, to feedback?)

Good

Access and discharge

All referrals to the ward came via national network so the hospital did not take any direct referrals. The hospital was involved in a national weekly admissions meeting. There was a clear exclusion criterion, and staff would only admit patients whose needs they could
meet. The multidisciplinary team completed a risk assessment prior to admission to ensure the patients were suitable for the service. The ward staff refused admissions if they felt the patient's needs could not be met.

The average length of stay for patients in the 12 months before the inspection was 123 days. Staff started planning for the patients discharge as part of the care programme approach and engaged with local teams to support this.

The average level of occupancy in the last 12 months was 94%, as beds were managed nationally the hospital did not hold a waiting list. The service did not admit patients in to

the beds of patients on leave. The service would could admit patients as soon as it was agreed and would admit patients the same day. Discharges or moves to other services were planned to take place at an appropriate time of the day.

If necessary, the service moved the patients to a service that was able to manage higher levels of risk, they had good links with the local acute hospital. There was one patient who was classed as a delayed discharge this was due to commissioners finding an alternative placement.

Staff supported patients when they were discharged to a new service. For example, staff would work with supported living services to ensure they have the skills needed to support the patient. For example, staff provided training on eating disorders and offered telephone support to the provider and patient.

The facilities promote recovery, comfort, dignity and confidentiality

All patients had single on en-suite bedrooms and could personalise them as they wished. For example, putting up posters and bring items from home. patients had access to secure storage for on the ward.

The was a full range of rooms available to the patients and staff including a clinic room, lounge, and quiet room. There was enough space for patients to have therapy and one to one session.

The patients were allowed mobile phones and chargers to make private calls. Patients were risk assessed on admission and if there was a ligature risk the patient would not be allowed the charger until it was assessed as safe.

The patients could access the hospital grounds. However, there was no direct access to the outside as the ward was on the first floor. Patients may be put on bed rest if they had a very low BMI when first admitted. Access to the ward was by stairs and staff had to use an emergency evacuation chair if patients were not able to use the stairs.

Patients' engagement with the wider community

The ward had links with the local recovery college which helps support patient with education and employment. Staff supported patients to use the college and with any education or employment opportunities they accessed. Staff also supported and encouraged patients to access the local community for social and therapeutic activities.

During are visit we saw staff facilitate an activity for the patients. Staff told us that by asking the patients to suggested activities in the community it reduce any anxiety associated with it. For example, staff supported a meal out suggested by the patients.

Staff actively encouraged patients to keep in contact with families and other important people. Patients told us that staff always made families welcome on the ward and arrange for them to take leave in the grounds or wider community when they visited. The patients would spend time at home on leave as part of their treatment and discharge plan.

Meeting the needs of all people who use the service

The ward was based in a grade 2 listed building which limited the amount of building work the service could carry out. The had installed ramps to enable access to the main building but the only access to Skylark was via stairs. Patients with mobility needs would have to use the emergency evacuation chair to access the ward. The hospital was able to supply information in languages other than English and could provide information to meet other communication needs to advise them about their rights, complaint process and treatments.

Staff supported the patients to keep contact with families and other important people. Parents we spoke to told us they were always welcome on the ward and staff would arrange for them to take their loved one on leave in the grounds or wider community when they visited.
The patients would spend time at home on leave as part of their discharge plan.

The hospital provided food to meet different spiritual and cultural dietary needs.

Spiritual support was available to patients. Staff would support patients to places of worship or invite spiritual leader to the ward.

Listening to and learning from concerns and complaints

In the 12 months prior to the inspection there had been no complaints about Skylark ward. There had been no withdrawn complaints and the hospital director told us that all complaints would be investigated. The ward had received 33 compliments during the same period.

Good

Specialist eating disorder services

The patients told us they knew how to complain. The ward manager aimed to resolve complaints locally and within 24 hours of the patient making the complaint.

Staff knew how to handle complaints and ensured the patients were protected when they did complain. The patients told us they were happy to complain and felt safe to do so.

Complaints were investigated, and managers gave staff feedback on the outcomes and any agreed actions, from other wards. Managers reviewed the outcomes of complaints and agreed any lessons to be learned during the learning from experience meetings. The findings from these were shared with staff at meetings and via email.

Are specialist eating disorder services well-led?

Good

Leadership

The leadership team on Skylark ward had the knowledge and experience to carry out their roles. The ward leadership understood the goals aims of the service and could explain how they aimed to offer good quality care. The staff team was fully committed to the aims of the service.

Leaders, including members or the hospital senior leadership team, were visible on the ward. The ward manager completed a daily quality check on the ward and the hospital director and clinical lead visited the ward daily and made themselves available to patients and staff.

The provider offered leadership training opportunities. The provider offered course via the NHS leadership academy course and the Priory academy and local university.

Vision and strategy

All staff we spoke to understood and were committed to achieving the provider's vision and values.

Staff could express their view about the future direction of the service. The provider had a "Your Say" meeting had the opportunity to contribute to discussions about the strategy for their service. Staff could also provide feedback via these meetings. Patients and carers were encouraged to give feedback about service development.

Staff understood and explain how they delivered quality care with the resources they had available.

Culture

Staff felt that supported by managers from all levels of the hospital. Staff told us their opinions were respected by the leadership team and that they responded to their needs. Staff told us that managers priority was patient safety.

Staff told us they knew how to raise concerns and were confident that the managers would listen and respond to them. Staff knew where to find the whistle-blowing policy if they needed it.

Managers dealt with poor performance and we saw examples of where they had followed the providers policies to help staff address their performance issues.

Managers address career development in appraisals and agreed and set goals to help staff achieve this. The hospital senior leadership team offered mentoring to staff who were identified as being potential future leader within the service. Staff told us that the mentoring help them to focus on who to develop their leadership skills.

The was a staff awards scheme to recognise staff achievements and hard work. The hospital also wrote to staff, identified as giving a little extra, and thanked them for their hard work. The hospital organised social events for the staff team to thank them for their service. For example, a summer BBQ. The hospital organised events for the patients and staff to attend such as a monthly quiz, themed lunches and BBQs.

Governance

There was strong governance on Skylark ward and throughout the hospital. Governance processes ensured the ward followed the providers policies and kept patients safe, provided them the correct treatment and that the service learnt when things went wrong.

There was a clear process in place so that information was shared with staff at ward level including learning from incidents. There was a clinical governance meeting monthly attended by staff from all wards. The were key performance indicators that the ward reported on which included supervision and training compliance, sickness monitoring, incidents and medicines management. The leadership team shared learning across the hospital.

Staff took part in clinical audits and acted on the results.

Good

Specialist eating disorder services

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand, monitor, and reduce or eliminate risks. They ensured risks were dealt with at the appropriate level. Clinical staff contributed to decision-making on service changes to help avoid financial pressures compromising the quality of care.

Information management

The service collected reliable information and analysed it to understand performance and to enable staff to make decisions and improvements. The information systems were integrated and secure.

Engagement

The service engaged well with patients, staff, equality groups, the public and local organisations to plan and manage appropriate services. It collaborated with partner organisations to help improve services for patients.

Learning, continuous improvement and innovation

The hospital was accredited by the Quality Network for Eating Disorders (QED) which works with services to assure and improve the quality of services treating people with eating disorders and their carers. The QED is provided by the Royal College of Psychiatrists.

The hospital was part of the local care commissioning groups New Care Models, which aim to bringing patients closer to home help them maintain better connections with their families and friends and reduce the length of stay.

The site was currently following the Safe Wards model to improve safety on the ward.

Outstanding practice and areas for improvement

Outstanding practice

- Calm cards were attached to all the medicine cards, to remind staff of what actions they should take before they used as required medication.
- Staff shared research with patients on the eating disorder ward to help them understand their treatment.
- Leaders on the eating disorder ward used flash cards to test staff competence and identify additional training.
- The eating disorder ward had organised a carers education day to help them support their loved one.
- The hospital held mutual expectation meetings to allow patients, young people and staff to agree rules.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that there is a process in place to ensure clinic room equipment is disposed of when out of date. Regulation 12: Safe care and treatment.
- The provider should ensure that the process on the acute ward for disposing of controlled medication and recording is robust to prevent further errors. Regulation 12: Safe care and treatment.
- The provider should ensure that staff on the acute ward are assessing and recording mental capacity assessments on a decision specific basis as and when it is appropriate to do so. Regulation 12: Safe care and treatment.
- The provider should ensure that all care plans are recovery focused and personalised to each patient and young person. Regulation 9: Person-centred care.
- The provider should ensure all staff understood young people's right to leave the ward. Regulation 13: Safeguarding service users from abuse and improper treatment.
- The provider should ensure there is enough activity for young people at weekends. Regulation 9: Person-centred care.
- The provider should ensure all young people and patients can make calls in private. Regulation 10: Dignity and respect.

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.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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