Priory Healthcare Limited

The Priory Ticehurst House

Inspection report

Ticehurst
Wadhurst
TN5 7HU
Tel: 01580200391
www.priorygroup.com

Date of inspection visit: 9 December 2020
Date of publication: 05/03/2021

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

Ratings

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

Summary of findings

Overall summary

The Priory Ticehurst House is an independent hospital which provides inpatients mental health treatment to adults and young people. At this inspection, we only inspected the child and adolescent mental health (CAMHS) wards; Upper Court and Keystone.

This was an unannounced, focused inspection and we specifically looked at some aspects of the key questions, 'are services safe and well-led'. We had previously rated both of these key questions as inadequate and still had some concerns because of information we had received from young people and parents about whether services were safe. The purpose of this inspection was to determine if the service was providing safe and good care to young people and whether it had made any of the improvements that we had told it must be made.

The service was previously inspected in September 2019 and December 2019.

Following the September 2019 inspection, we issued a warning notice because the provider did not have effective governance systems in place to assure itself that the environment was safe, that risks were assessed and managed appropriately, that incidents were investigated, and improvements made as a result of findings to ensure care was safe.

We returned in December 2019 and found that the provider had made some improvements to their audit and governance systems and processes relating to risks and incidents and was taking action to reduce environmental risks on Upper Court. We were satisfied that the provider had met the requirements of the warning notice and we therefore lifted the warning notice. However, we found that there was still more to do to ensure sustained and continued improvements. We have been monitoring the service closely since.

We did not rerate the service during this inspection as we only looked at specific key lines of enquiry in the key questions are services safe, effective and well led. Therefore, the previous rating of inadequate remains in place.

We found:

The provider had reviewed all environmental risk assessments, and these were now accurate, up-to-date and appropriate action had been taken to reduce, mitigate or remove risks. The ward environments were safe and Upper Court had been refurbished.

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

The service had improved the way they managed patient safety incidents. 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 young people honest information and suitable support.

There was a comprehensive activity programme in place covering evenings and weekends so young people were kept engaged in meaningful activity.

Summary of findings

There was adequate medical cover for both wards. There was one locum speciality doctor on Keystone ward and Upper Court had a full time Speciality Doctor in situ.

The ward manager that had oversight of both wards was leaving. A new ward manager had been appointed to Upper Court and had recently started and a ward manager had been appointed to take over Keystone ward and was due to start in April. In addition, deputy ward managers had been allocated to both wards

In response to concerns raised by staff and external stakeholders about the ability to deliver safe care to young people the provider had reduced the number of young people it would take on each ward.

Most governance processes operated effectively at ward level and there was generally adequate oversight of performance and risk. There was a framework of the information that was discussed at a senior management and ward level in team meetings to ensure that essential information, such as learning from incidents and complaints, was shared and discussed.

However:

We found that there was a lack of effective oversight of the use of CCTV in young people's bedrooms. Staff did not always provide young people with enough detailed explanation about the use of CCTV and were not seeking consent appropriately. Young people told us that staff told them they needed to have the cameras activated to keep them safe and they were made to feel they had to agree to this. Staff did not discuss the impact on their privacy with them and did not provide alternatives or adjustments. If young people detained under the MHA did not agree to have CCTV activated in their bedroom, the responsible clinician would override this decision saying it was in the interests of the young person's safety". However, this decision-making was not documented, and young people were not part of this decision making.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to The Priory Ticehurst House

The Priory Ticehurst House is situated in East Sussex. It provides mental health services for adults and young people. During this inspection, we only inspected the child and adolescent mental health (CAMHS) wards.

- Keystone ward is a 12-bed mixed-sexed purpose-built psychiatric intensive care unit.
- Upper Court is a 13-bed female only ward. It is a general CAMHS ward that provides assessment and treatment for children and young people with emotional, behavioural or mental health difficulties.

At the time of inspection, both wards had reduced capacity to manage more challenging young people. There were six young people on Upper Court and seven on Keystone.

The Priory Ticehurst House is registered for the following regulated activities:

- Assessment and medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder and injury.

There is a registered manager at the service.

How we carried out this inspection

- The team that inspected the CAMHS services at Priory Hospital Ticehurst comprised of three CQC inspectors, one assistant inspector, two specialist advisors and an expert by experience.
- Before the inspection visit, we reviewed information that we held about the service.
- During the inspection, we reviewed eleven young people's records, observed meetings, interviewed four young people on the wards, spoke with three families, interviewed eight staff, reviewed complaints, incidents and policies.
- You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection

What people who use the service say

Young people who use the service told us that they generally felt respected and involved in their care planning and understood their rights under the Mental Health Act. Young people told us that staff checked in with them after any incidents or aggression on the ward and that staff were supportive and available and often stayed up late with them to make sure they felt safe. Young people felt their physical health was well looked after and medical staff were checking on them. However, young people told us that they felt that having CCTV in their room was invasive and felt they had to agree to having it as they were told this was in their best interests – clinicians would override them if they refused to have CCTV.

Areas for improvement

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

Summary of this inspection

We told the service that it must take action to bring services into line with two legal requirements. This action related to the child and adolescent mental health wards.

- The provider must ensure that there is effective governance and oversight of the use of CCTV in young people's bedrooms and that Priory policies are adhered to. Regulation 17 (2) (a) (c) (f)

- The provider must ensure that young people are involved in the decision making about the use of CCTV in their bedrooms and that consent is sought appropriately. Accurate documentation must be kept, and decisions should be reviewed regularly. Regulation 11(1)

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Insufficient evidence to rate	Insufficient evidence to rate	Not inspected	Not inspected	Insufficient evidence to rate	Inadequate
Overall	Inadequate	Good	Good	Good	Inadequate	Good

Inadequate

Child and adolescent mental health wards

Safe	Insufficient evidence to rate
Effective	Insufficient evidence to rate
Well-led	Insufficient evidence to rate

Are Child and adolescent mental health wards safe?

Insufficient evidence to rate

- Keystone and Upper Court wards were safe, well equipped, well-furnished and well maintained. Keystone was a purpose-built ward. Upper Court had been refurbished since the previous inspection and was undergoing further renovations. Daily environmental risk assessments were being completed, audited by the ward clerk and feeding into the clinical governance framework so risks and hazards could be identified and actioned effectively.

- The service had enough nursing and medical staff, who knew the young people and received basic training to keep young people safe from avoidable harm. There was one locum speciality doctor on Keystone ward and Upper Court had a full time Speciality Doctor in situ. The ward manager that had oversight of both wards was leaving. A new ward manager had been appointed to Upper Court and had recently started and a ward manager had been appointed to take over Keystone ward and was due to start in April. The provider had responded to the staff and external stakeholders and had capped the amount of young people on the wards to support the staff managing the high acuity of the young people.

- Staff assessed and managed risks to young people and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme. The wards had one full time occupational therapy assistant for each ward and a full-time occupational therapist covering across the wards. This meant that meaningful activity levels had increased in the evenings and weekends leading to a reduction in levels of incidents. Any gaps in evening activities were being constantly reviewed and opportunities for activity were being introduced.

- Staff understood how to protect young people 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 nurse and doctor for child safeguarding and the teams had a safeguarding lead. Safeguarding logs were in place across the wards and actions were appropriately reported internally, through the clinical governance framework and to organisations outside of the hospital, the young people were also appropriately debriefed following incidents on the ward.

- 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 young people honest information and suitable support. Incidents were reviewed in the monthly clinical governance meeting and the director of clinical services met with the ward manager every week to ensure incidents were reviewed and appropriate actions were taken and followed up.

Inadequate

Child and adolescent mental health wards

Are Child and adolescent mental health wards effective?

Insufficient evidence to rate

- The wards were using Care Protect CCTV in bedrooms, communal areas, corridors and lounges to support the safety of the young people and staff. However, there was a lack of effective processes for assessing capacity to consent and for gaining informed consent from young people. There was a lack of documentation showing when best interests' decisions were in place when young people were unable to consent. Young people were not told that they would not be disadvantaged if they didn't consent and were led to believe that they must consent. If young people refused clinicians would override this but there was a lack of accurate recording of why this had been done. Some young people told us they were not happy to be monitored in their bedrooms but agreed in the end as they were told it would keep them safe and that there was no choice.

Are Child and adolescent mental health wards well-led?

Insufficient evidence to rate

- 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 young people and staff. The new ward managers and deputy ward managers had been recruited from other CAMHS services and had experience of the practices of the priory hospital group. Plans had been put in place to cover the consultant cover for the wards. There was one locum speciality doctor on Keystone ward and Upper Court had a full time Speciality Doctor in situ. Out of hours cover was provided by an onsite doctor available seven days a week.

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.

- In the previous inspection, the staff had felt that the provider was not listening to their concerns about the high numbers of young people on the wards, the risk those young people were presenting and their lack of ability to provide safe and good care to them. The provider had responded to the staff and external stakeholders and had capped the amount of young people on the wards to support the staff managing the high acuity of the young people. Staff felt happy and positive about their roles and that the management had been supportive to staff during the COVID pandemic.

- The provider had improved most governance processes within the hospital. The service had implemented learning from experience meetings where incidents were discussed, and themes identified and rolled out to the staff teams through staff meetings. The wards were holding monthly 'quality walk arounds' which was a peer review from another ward manager where the manager carried out an inspection of the ward. Audits were in place and were being managed at ward level and feeding into the hospital governance framework.

However:

Inadequate

Child and adolescent mental health wards

- We found that there was a lack of effective oversight of the use of CCTV in young people's bedrooms. In addition, staff were failing to follow Priory policy. Staff were not providing young people with sufficient information about the use of CCTV to allow them to make informed decisions to consent. Clinicians would also override decision where young people did not want CCTV used in their bedrooms but the reasons for the decisions to override the young people's wishes were not clearly documented. Governance processes had not picked this up.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that there was effective governance and oversight of the use of CCTV in young people's bedrooms and that Priory policies were adhered to.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider did not ensure that young people were involved in the decision making about the use of CCTV in their bedrooms and that consent was sought appropriately. Accurate documentation was not kept, and decisions were not reviewed regularly