# The Priory Hospital Bristol

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this location | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| 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.

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

# Summary of findings

## Overall summary

We rated the Priory Hospital Bristol as good overall. This was the same rating as the previous inspection in April 2016. We rated the key questions, are services safe, effective, caring, responsive and well-led as good.

The reason for the rating of good overall was as follows:

- The provider managed risks well. The hospital had an up-to-date risk register that highlighted key concerns and had plans in place to manage these. Staff completed regular environmental and patient risk assessments.Managers adjusted staffing levels to meet changing needs, bringing in extra bank and agency staff who were familiar with the wards to cover any shortfall. The hospital ensured all agency and bank staff used were familiar with the wards and had access to the same induction, support and training as permanent staff.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- The provider had clear processes for monitoring and investigating incidents and complaints. The provider also undertook a variety of audits to monitor and improve the quality and safety of the service. Systems were in place to learn from these and improve practice as a result.
- Staff provided a range of care and treatment interventions suitable for patient groups in line with guidance from the National Institute for Health and Care Excellence (NICE). Robust arrangements were in place to meet patients' physical and mental health needs.
- Staff were discreet, compassionate, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.
- The ward managers and senior leadership team provided strong and effective leadership and staff members had confidence in them. Managers within the service promoted an open and honest culture. Staff felt able to raise concerns, report incidents and make suggestions for improvements without fear of consequences. 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 by senior managers and leaders. They were proud to work at the hospital and felt positive about their work and the support they gave patients. The provider recognised staff success within the service through star awards, nominated by other staff members or by patients.

However:

- On the acute wards for adults of working age, care plans were not personalised or collaborative and used generic statements for goals and interventions. Care plans and risk management plans were not updated to reflect progress or change in needs. However, on the long stay/ rehabilitation, child and adolescent mental health and eating disorders wards, patient records were person centred, detailed and up to date. They included comprehensive mental and physical health assessments, with detailed and holistic care plans that included the patients' voice.
- The acute wards for adults of working age were not in a suitable environment for the service, as they did not have adequate space to support treatment and care. The communal room in each of the acute wards did not have anti-barricade doors and were a safety risk due to the limited space and the lack of alternative access to the rooms.
- On the child and adolescent mental health wards, multi-disciplinary working needed to improve to ensure good communication between the different staff meeting the complex needs of the young people using the service. Some staff experienced significant levels of violence and racial abuse from patients in the child and adolescent mental health service. Staff felt the aftercare and support available following these incidents could be improved.
- Staff did not always record that patients were being told of their rights under the Mental Health Act (1983). Not all informal patients were aware of their rights. Some staff were also not clear about their responsibilities under the Mental Capacity Act 2005 and did not see this as part of their role.
- On the acute wards, staff were not aware of the results of clinical audits and where improvements were needed.

# Summary of findings

## Our judgements about each of the main services

| Service | Rating | Summary of each main service |
|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Requires improvement  | Our rating of this core service changed from good to requires improvement from the previous inspection.<br>Our core ratings for caring and responsive went down from good to requires improvement. Our core ratings for safe, effective and well led remained the same and were rated as good.<br>During this inspection we found that patient records were not up to standard as care plans were not collaborative and personalised. Staff also did not update risk assessments regularly.<br>We found the environment was not fit for purpose and that changes needed to be made. The provider made some changes immediately after the inspection, installing a convex mirror to mitigate a blind spot in a corridor on one ward, and also ordered anti barricade doors to the lounge rooms.<br>The service managed vacancies and patient safety incidents well. While audits were taking place, staff were not always clear on the outcome of these and any where improvements were needed. |
| **Long stay/ rehabilitation mental health wards for working-age adults** | Good  | This service was not previously rated at inspection. We rated this core service as good overall.<br>We rated safe, effective, caring, responsive and well led as good.<br>During this inspection we found that patient records were person centred, detailed and up to date. Staff knew their patients well. Physical health monitoring and care were well managed.<br>There was a programme of therapeutic activities from the therapies team for all patients to support with discharge planning. |
| **Child and adolescent mental health wards** | Good  | This service was not previously rated at inspection.<br>We rated this core service as good overall.<br>We rated safe and effective as requires improvement.<br>We rated caring, responsive and well led as good. |

# Summary of findings

| | | |
|---|---|---|
| | | Staff managed incidents well. There were clear risk assessment and management processes in place to manage high levels of incidents in line with the complex young people on the wards. High vacancy rates were managed well through the use of bank and agency staff to ensure consistency of care. Staff were caring and supportive.<br>Communication between the multidisciplinary team and ward staff was not always effective. Some staff experienced high levels of aggression and abuse and felt the aftercare support could be improved. |
| **Specialist eating disorders services** | **Good** | This service was not previously rated at inspection.<br>We rated this core service as good overall.<br>We rated safe, effective, caring, responsive and well led as good.<br>We found care records to be person centred, up to date and holistic. Physical and mental healthcare monitoring and support were well managed. Staff were caring and supportive. Some staff did not understand their responsibilities under the Mental Capacity Act (2005).<br>Patients did not have access to WiFi on the ward. |

# Summary of findings

## Contents

Good

# The Priory Hospital Bristol

**Services we looked at**

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

# Summary of this inspection

## Background to The Priory Hospital Bristol

The Priory Hospital Bristol is an independent hospital registered to provide care and treatment for up to 85 people with mental health conditions.

The hospital admitted patients detained under the Mental Health Act 1983 and provided the following core services:

Long stay/rehabilitation wards.

Acute mental health inpatient units.

Eating disorder service.

Child and Adolescent Mental Health (CAMHS) unit.

The long stay/rehabilitation wards for working age adults adhered to the longer term high dependency rehabilitation model :

- Garden View: a 10-bed female ward for adults with neurodegenerative brain conditions and complex mental health care needs. Garden View was in the process of closing for refurbishment and change of use to an eating disorders ward at the time of the inspection.
- Hillside: a nine-bed mixed gender ward for people who required mental health rehabilitative care.
- Oak Lodge: a 10-bed male ward for people with dementia or huntington's disease and complex care needs. This ward accepted admissions for working age men as well as older men if the patient was appropriate for the care environment.

The acute mental health inpatient units consisted of:

- Redcliffe ward: a 14-bed acute ward for men and women.
- Upper Court: a 10-bed acute ward for men and women.

The specialist eating disorder service was:

- Lotus ward:10-bed ward for men and women who required treatment for eating disorders.

The Child and Adolescent Mental Health (CAMHS) unit was:

- Banksy Ward (Psychiatric Intensive Care Unit) 12 beds (opened Oct 2017)
- Brunel Ward 11 beds (opened in March 2018 as a Tier 4 CAMHS ward).

The hospital is registered to provide the following regulated activities:

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

There is a registered manager in place.

The last comprehensive inspection of The Priory Hospital Bristol was in April 2016.

At the 2016 inspection we rated the service as good overall. We rated effective, caring, responsive and well led as good. However, we rated safe as requires improvement, due to breaches in the safe management of ligature points, risk of absconding and poor infection control procedures.

A warning notice was issued against Regulation 12 due to these concerns. The hospital had failed to meet a previous requirement notice about these issues.

We also issued a requirement against Regulation 12 (safe care and treatment) because of damage to the furnishings of a communal bathroom that prevented proper cleaning, and dirty mats used to cushion patient falls from bed.

An unannounced, focused inspection took place in May 2017 to follow up on the actions the service had taken following the warning notice and requirement notice we issued. As a result of the improvements made by the service, we lifted the warning notice and requirement notice following the previous inspection and re-rated 'safe' as 'good'.

# Summary of this inspection

## Our inspection team

The team that inspected the service comprised three CQC inspectors, an inspection manager, an assistant inspector and two specialist advisors. The specialist advisors were nurses with professional backgrounds in Child and Adolescent Mental Health Services (CAMHS) and eating disorders, Mental Health Act and mental health services for working age adults.

## 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, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- spoke with the hospital director and the clinical director
- looked at 10 staff records from across the hospital
- reviewed a number of accident and incident reports and the lessons learnt from these
- looked at three complaints
- looked at quality assurance audits
- received feedback about the service from external stakeholders
- looked at a range of policies, procedures and other documents related to the running of the hospital and each of the core services
- visited each of the wards and looked at the quality of the environment including the clinic and treatment rooms
- spoke with 27 patients and three carers
- spoke with 42 staff members, including ward managers and deputy managers, consultant psychiatrists, occupational therapists and physiotherapists, dieticians, nurses and health care support workers
- looked at 42 care records of patients and 23 medications records
- attended a patient group meeting, multidisciplinary team meetings, two therapy sessions and a staff handover session
- observed the care and support provided and interactions between people, visitors and staff throughout the inspection.

## What people who use the service say

Patients and carers we spoke with told us:

Regular ward staff were excellent. They listened to patients, were supportive and caring, and went above and beyond to support and advocate for patients.

Some patients felt they were given information and choices and were included in decision making. Others told us they felt decisions had been made by the multidisciplinary team without their input. Some patients

# Summary of this inspection

told us they had not received a copy of their care plan and were not aware of the contents. There were also some patients who did not know their rights under the Mental Health Act 1983 or as informal patients.

Patients told us that escorted leave or ward activities were sometimes delayed on some wards because there were too few staff, although every effort was made to reschedule.

There were some ongoing maintenance problems with some of the showers in the specialist eating disorders ward and a lack of Wi-Fi within the ward and hospital in general, which impacted on the ability to keep in touch with friends and family.

Patients told us that although they generally felt safe and confident that staff would react quickly to safety incidents, there were times when wards could become tense and distressing following incidents. They also told us there was not enough space on the acute wards for working age adults to access quiet areas, socialise, or meet with staff. This led to feelings of tension and claustrophobia.

Some family members we spoke with said staff involved them in the care and treatment of their relative. However, other carers did not feel fully involved or listened to, and were concerned about the lack of partnership working.

Some patients were concerned about the potential impact of raising a complaint, although others had raised complaints and felt things had improved because of this.

# 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:

- The wards were clean, tidy and generally well maintained. Staff followed infection control principles.
- Staff completed regular environmental risk assessments which included a list of ligature points (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation). The risk assessments showed how identified ligature points were mitigated against.
- Managers adjusted staffing to meet changing needs, bringing in extra staff who were familiar with the wards to cover any shortages. Due to high vacancy rates for qualified nurses, the hospital used large numbers of agency and bank staff. Staff vacancies were on the provider risk register and there were ongoing recruitment processes to attempt to fill the vacancies. The hospital ensured agency staff received the same induction, supervision and training as substantive staff.
- Staff were trained and confident in identifying and responding to safeguarding concerns, and knew where to get advice if needed. Staff managed incidents well. The provider had a clear process in place for monitoring and investigating incidents. Systems were in place to learn from incidents and improve practice as a result.
- The provider had systems in place to monitor patient's physical health, and had employed registered general nurses and paramedics to lead on physical health issues across the whole hospital.

However

- Although staff completed risk assessments on admission to the acute wards for adults of working age, risk management plans were not updated and transferred onto the patient care records following further assessment.
- On Redcliffe ward there was a corridor with a blind spot that was not on the risk assessment and was not mitigated against. Following the inspection convex mirrors were put in place to resolve this.
- The communal rooms in each of the acute wards for adults of working age did not have anti-barricade doors and were a safety risk. Following the inspection, anti-barricade doors were ordered to replace the current doors.

# Summary of this inspection

## Are services effective?

Good

We rated effective as good because:

- Patient records were person centred, detailed and up to date in three out of the four services. They included comprehensive mental and physical health assessments, with detailed and holistic care plans that included the patients' voice. There was good evidence of physical health monitoring being carried out.
- Staff provided a range of care and treatment interventions suitable for patient groups in line with guidance from the National Institute for Health and Care Excellence (NICE). Staff used recognised screening tools and rating scales to help them identify issues and to measure progress.
- The service undertook a variety of audits to monitor and improve the quality and safety of the service.
- Managers provided new staff with induction, supervision and appraisal of their work performance. Managers identified learning needs of staff, and provided opportunities to develop their skills and knowledge, including access to training in service related specialisms.
- Staff generally understood their roles and responsibilities under the Mental Health Act (1983), including reading patients their rights, and supporting access to advocates.

However:

- Communication between the multidisciplinary teams and nursing staff, patients and carers on the child and adolescent mental health wards was not always effective.
- Whilst patient records were person centred, detailed and up to date in three out of the four services, this was not the case on the acute wards for adults of working age. Care plans were not personalised or collaborative and used generic statements for goals and interventions. Care plans and risk management plans were not updated to reflect progress or change in needs.
- Staff did not always record that patients were being told of their rights under the Mental Health Act (1983). In addition, not all informal patients were aware of their rights. Consent to treatment status for detained patients was not always recorded on prescription charts.
- The provider had a policy on the Mental Capacity Act (2005) including Deprivation of Liberty safeguards, which staff were aware of and could access through the intranet. However, not all staff understood their roles and responsibilities under the Mental Capacity Act (2005) and did not see this as part of their role.

# Summary of this inspection

## Are services caring?

Good

We rated caring as good because:

- Staff were discreet, compassionate, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.
- Patients were encouraged to give their feedback on the service and the care and treatment they received.

However:

- On the acute wards for adults of working age, staff did not involve patients in development of their care plans and risk assessments. However the patient records on the other wards showed that staff had taken time to get to know their patients. Staff enabled and supported patients to make decisions about their care.
- Some patients on the specialist eating disorders ward did not feel their views were fully considered, particularly in relation to decisions around section 17 leave. At times both patients and carers on the ward felt excluded from the decision-making process during ward rounds.

## Are services responsive?

Good

We rated responsive as good because:

- The hospital was able to refuse new admissions when appropriate to do so. Patients were not moved to alternative wards or hospitals during an admission episode unless it was justified on clinical grounds and in the interests of the patient.
- Staff recognised the importance of consistency and continuity of care for out of area patients. They liaised with local teams and involved care coordinators in decision making and discharge planning.
- Patients' individual needs were met, including their cultural, language and religious needs to ensure the service was accessible to all. The hospital was able to accommodate special dietary requirements.
- Patients knew how to complain or raise concerns. The hospital director reviewed complaints and ensured they were taken seriously, and investigated in line with the formal company policy. The hospital learnt from complaints and shared this learning with staff.

However:

- The acute wards for adults of working age did not have adequate rooms or space to provide suitable ward activities. Therapy was impeded by lack of space. There was no suitable space to meet with visitors or to access quiet areas.

# Summary of this inspection

## Are services well-led?

Good

We rated well-led as good because:

- The ward managers and senior leadership team had the skills, knowledge and experience to perform their roles. They provided strong and effective leadership and staff members had confidence in them. Managers within the service promoted an open and honest culture. Staff felt able to raise concerns, report incidents and make suggestions for improvements without fear of consequences.
- 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 by senior management. They were proud to work at the hospital and felt positive about their work and the support they gave patients. The provider recognised staff success within the service through star awards, nominated by other staff members or by patients.
- There was a commitment towards continual improvement and innovation. Staff had implemented recommendations from reviews of deaths, complaints, and safeguarding. They undertook or participated in audits and acted on the results when needed. The specialist eating disorders service had been accredited under the Quality Network for Eating Disorders (QED) and was due to undergo a reaccreditation process to renew this.

However:

- Although there were systems in place to audit care records and adherence to the Mental Health Act, these had not been sufficient to ensure that care records on the acute wards for working age adults contained personalised, collaborative care plans and that staff were acting in accordance with the Mental Health Act (1983). Some staff were unclear on the outcome of ward specific clinical audits, impacting on the effectiveness of any learning from these.
- Some staff experienced high levels of violence and racial abuse from patients in the child and adolescent mental health service. Staff felt the aftercare and available support could be improved following these incidents.
- Some wards either did not have a local risk register or the risk register had not been updated to reflect current concerns.

# 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 had training in the Mental Health Act (1983) as part of their induction to the service. They had a basic understanding of the Mental Health Act, the Code of Practice and the guiding principles. Staff felt they had sufficient understanding of the Mental Health Act to carry out their roles effectively.

Staff had access to support and advice. They would seek this from the ward manager, other senior staff or the Mental Health Act administrator as needed. Staff also had easy access to local Mental Health Act (1983) policies and procedures and to the Code of Practice.

Patients had access to information about independent mental health advocacy. This information was given as part of the welcome pack on arrival to the ward, and was displayed in communal areas. An independent mental health advocate (IMHA) visited the wards regularly.

Staff were made aware of the need to explain patients' rights to them to ensure they understood their legal position and rights in respect of the Mental Health Act, but there was not always recorded evidence that this had been done. While the service regularly carried out audits to ensure people were being told their rights and this appeared to be effective in most cases, we found some records where this had not been recorded as having consistently been done.

Staff were aware of the need to obtain consent to treatment and we saw evidence of consent being recorded in patient records. Where patients were unable to consent to treatment, we saw evidence of second opinions being sought and best interest outcomes recorded. However, the consent status was not clearly documented on all the prescription charts we looked at during the inspection.

Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this had been granted. This was sometimes postponed or delayed due to staff shortages.

Staff stored copies of patients' detention papers and associated records correctly, and so that they were available to all staff that needed access to them.

The hospital displayed notices to tell informal patients that they could leave the wards freely. We also saw evidence of a contract drawn up with an informal patient to clarify what the expectations were on the ward and their rights as an informal patient. However, some informal patients told us they were unaware of their rights, and staff told us this wasn't routinely documented for informal patients.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in the Mental Capacity Act (2005) through e-learning (online training) as part of their induction. Staff understanding of the Act and their roles and responsibilities was variable. Some staff we spoke with demonstrated a good understanding and were confident in their knowledge of least restrictive practice. However, some staff were confused about how the Mental Health Act (1983) and the Mental Capacity Act (2005) worked together. They were unclear about how the Mental Capacity Act (2005) needed to be put into practice on the ward, and what their role was in applying this.

At the time of the inspection there were four patients on the long stay/rehabilitation ward for whom Deprivation of Liberty Safeguards (DoLS) authorisations had been requested. The safeguards are a process the provider must follow if they believe it is in the person's best interest to deprive them of their liberty to provide care and they lack the mental capacity to consent to this, but have not been detained under the Mental Health Act.

# Detailed findings from this inspection

The provider had a policy on the Mental Capacity Act (2005) including deprivation of liberty safeguards, which staff were aware of and could access through the intranet. Staff knew where to get advice from regarding the Mental Capacity Act (2005).

Mental capacity to consent to treatment was assessed and recorded on care records by the consultant. This was reviewed at each ward round, and more frequently if needed. We saw evidence of time and decision specific capacity assessments and evidence that staff had supported patients to be involved in decision making. However, not all wards were completing mental capacity assessments or documenting best interest decision making processes for patients lacking capacity to make decisions about their care unrelated to their treatment under the Mental Health Act (1983).

Staff discussed mental capacity at admission and during the multidisciplinary team meetings. We saw evidence of best interest meetings with clear rationales and with attendance of family where possible in patient care records.

All staff in the Child and Adolescent Mental Health (CAMHS) service who had not completed training in Gillick competency were booked to complete this in the two months following the inspection. Staff awareness on the ward was improving following this training. Gillick competence is a term used to determine whether a child (under 16 years of age) is able to consent to his or her own care and treatment, without the need for parental permission or knowledge.

## Overview of ratings

Our ratings for this location are:

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Acute wards for adults of working age and psychiatric intensive care units** | Requires improvement | Good | Requires improvement | Requires improvement | Good | Requires improvement |
| **Long stay/ rehabilitation mental health wards for working age adults** | Good | Good | Good | Good | Good | Good |
| **Child and adolescent mental health wards** | Good | Requires improvement | Good | Good | Good | Good |
| **Specialist eating disorder services** | Good | Good | Good | Good | Good | Good |
| **Overall** | Good | Good | Good | Good | Good | Good |

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

Requires improvement

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

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

Requires improvement

### Safe and clean environment

Staff completed regular risk assessments of the care environment. Staff completed and regularly reviewed ligature and environmental risk assessments. They were aware of the environmental risks and knew how to mitigate against these. The service had acted to mitigate risks by removing ligature anchor points and replacing them with anti-ligature furniture and fittings.

All areas of the ward could not be viewed from one central point and the service had installed mirrors to remove any blind spots. However, on Redcliffe ward there was one corridor with a blind spot and the service had not identified this on their risk assessment. Although there was a CCTV camera recording the area, the recording for this could not be viewed by nursing staff and therefore did not mitigate the risk. Following the inspection, convex mirrors were installed to rectify this.

Both wards were mixed-sex and complied with Department of Health guidance on eliminating mixed-sex accommodation.

Males and females were allocated individual bedrooms with en-suite facilities. Females had access to a female only lounge on each ward. However, due to a lack of meeting rooms on the ward these were often used to hold meetings and 1:1 sessions.

The doors to the female lounge were not anti-barricade. This was a concern due to the confined space and no alternative access to the lounge, meaning a patient could barricade themselves or others into the room. The ward staff were aware of this but the service had not identified actions to mitigate this risk. Following the inspection, the senior management team ordered anti-barricade doors.

Staff on Redcliffe ward had easy access to alarms and patients had easy access to nurse call systems. Staff and patients on Upper Court had access to alarms and a nurse call system.

All ward areas were clean, had good furnishings and were well-maintained. Housekeeping staff kept cleaning records up to date and these demonstrated that the ward areas were cleaned regularly. Housekeeping staff attended the wards daily to make sure they were kept clean. Patients told us that housekeeping staff kept communal areas clean and that maintenance issues were resolved in a timely manner.

Staff adhered to infection control principles, including handwashing. There were posters displayed above hand basins describing good handwashing techniques and basins were accessible in clinic rooms and toilets.

We visited the clinic room on both wards, which were clean and well maintained. Nurses and housekeeping staff completed daily cleaning of the clinic and medical equipment. Nurses checked emergency equipment and medications weekly and replaced any items as necessary.

### Safe staffing

Both wards had vacancies for registered nursing staff, and ward managers used locum registered nurses to ensure there were enough skilled staff to cover absences and

vacancies. The ward managers told us that they had a full complement of healthcare assistants for each ward. Managers responded to changing risk levels and patient need on the wards by using agency and bank nursing staff to maintain safe staffing levels.

When bank and agency nursing staff were used, those staff received an induction and were familiar with the ward. The ward managers block booked regular agency nurses to ensure continuity and consistency for patients. Regular nursing staff and patients told us that agency staff took the time to get to know patients and ward procedures to ensure that there was no impact on the care provided.

The service used a provider-wide safer staffing ladder to identify the number of staff required for each shift. On both acute wards for working age adults the required staff on a day shift was two registered nurses and two healthcare assistants. During a night shift there was one registered nurse and two healthcare assistants. We reviewed the shift rotas and spoke with staff who told us that the correct number of staff were working each shift.

Nursing staff told us that they could request more staff in response to increased acuity or risks on the ward. The service had also allocated an extra member of staff for each patient on enhanced observations, such as 1:1 nursing observations. Nursing staff told us that they were aware of the process to request more staff and had found this to be effective.

Although there was a system in place to request more staff in response to a change in the dynamics of the ward, the nursing staff told us that when there were four staff working on a shift, they often felt understaffed and unable to facilitate leave, staff breaks, and activities while keeping the ward safe. Staff told us on occasion this had led to a short delay in organising escorted leave or ward activities. Patients stated that they sometimes had to wait to access their leave off the ward with a member of staff. However, these activities were rarely cancelled as the staff could request support from other wards to make sure the activity took place later in the day.

The senior management team discussed individual ward staffing levels during morning flash meetings and were able to allocate a 'floating' (not allocated to a specific ward) member of staff to help manage shortages of staff and facilitate patient leave requests and staff breaks.

There were enough staff on the ward to carry out physical interventions safely and staff could summon further support from other wards through use of the staff alarms.

Staff had received and were up to date with appropriate mandatory training, with all mandatory training having a minimum of 85% compliance across the hospital. This included 95% of staff having completed basic life support training and 86% having completed Prevention Management of Violence and Aggression (PMVA) training.

There was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency. Both wards had an allocated consultant psychiatrist who provided medical cover on the ward five days a week. A resident medical officer was available at all times and able to provide medical advice and assistance out of hours. The resident medical officer attended the ward to complete admission paperwork and assessment for patients. This was done within one hour of admission, unless an emergency prevented the medical officer from doing so. We saw evidence from a sample of patients admitted to the wards to confirm that the majority were seen within the hour timeframe.

**Assessing and managing risk to patients and staff**

Nursing staff completed and updated risk assessments for each patient. The multidisciplinary team reviewed these risk assessments at least weekly and used these to understand and develop management plans for these risks.

We reviewed seven care records in relation to risk management. All patients had a risk assessment completed on admission and a comprehensive screening tool had been used to identify relevant historical and current risks. Staff developed a generic 'keeping safe' care plan on admission to manage risk. Individualised and changing risks were documented and considered as part of the multidisciplinary review and risk management plans agreed. The nursing staff were aware of these plans and the individual risks for each patient. However, these management plans were not transferred on to the nursing 'keeping safe' care plans and interventions to make them personalised.

Individual client risk issues were discussed by clinical staff during twice daily handovers, multidisciplinary weekly reviews and senior management morning meetings.

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

Requires improvement

The service had a policy in place for the observation of and engagement with patients. Nursing staff completed observation and engagement in line with this policy.

Nursing staff minimised their use of restrictive interventions. Use of restrictive interventions was on an individual basis and all staff followed best practice and the Mental Health Act (1983) when restricting patients' freedoms.

Nursing staff were trained in prevention and management of violence and aggression (PMVA) and breakaway techniques. Staff used restraint only after de-escalation had failed. Nursing staff told us that their training did not include any techniques to restrain a patient lying down and that they had been trained to disengage if a patient fell to the floor to reduce risk of positional asphyxiation (when a person is prevented from breathing adequately due to the position of their body). This was part of the provider policy. Training was given in standing, seated or recovery positions only as staff did not restrain patients lying down either in prone (face down) or supine (on their back) positions.

Nursing staff completed an individual risk assessment prior to patients utilising any leave from the ward. This included an assessment of the patient's mental health and was documented in the care records.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. The use of rapid tranquilisation varied on the wards, dependent on the patient group and complexity.

Nursing staff were aware of the physical health risks following administration of rapid tranquilisation and reported that this was only used as a last resort.

Nursing staff used a physical health monitoring form with pharmacy guidelines for physical assessment and visual observations at least four times every hour following administration of rapid tranquilisation. Staff confirmed the regularity and discontinuation of these in agreement with the ward doctor.

Neither ward had a seclusion room and staff did not use any form of seclusion or segregation as an intervention.

Staff recognised and responded to deterioration in patients' health. The consultant psychiatrist was available five days a week to discuss any changes. The resident medical officer was available to assess patients out of hours. The nursing staff could arrange GP appointments at the local walk in centre following any deterioration in physical health and the consultant psychiatrist made contact with the local general hospital to support any urgent physical health needs. We saw evidence of nurses responding to a deterioration in an individual's mental health and increased risk behaviours. The service had organised a Mental Health Act assessment and increased nursing observations to manage the patient's changing presentation.

The hospital had recently become smoke free and staff adhered to best practice in implementing a smoke-free policy. Patients were offered nicotine replacement therapy as required.

Informal patients knew they could leave at will. There were signs displayed on locked doors to inform them of this.

**Safeguarding**

Staff knew 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 able to identify types of abuse and identify the patients on the ward who specific safeguards had been put in place for. We saw evidence of staff identifying and responding to safeguarding concerns within the care records. Safeguarding was part of a standing agenda for multidisciplinary weekly reviews.

All staff we spoke with were aware of the safeguarding leads for the hospital and knew how to seek advice from them. Nursing staff told us that they could report safeguarding concerns to managers and the local authority.

Staff followed safe procedures for children visiting. Children were not allowed on the wards. Visits with children took place in the main reception building.

**Staff access to essential information**

Not all agency staff had access to essential information contained within the electronic care records. Regular nursing staff told us that agency staff could only view care records via their logins and accounts. Although the management team had provided some regularly booked agency staff with a login to the care records, these were not accessible to all relevant staff working on the wards. This

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

Requires improvement

meant that some staff on the wards were unable to easily access essential information such as risk assessments and management plans, continuous daily records and care plans.

**Medicines management**

Staff followed good practice when storing, giving and recording medication. Registered nurses were administering medication and completing records in line with national guidance from the Nursing and Midwifery Council. One registered nurse took responsibility for administering medication for each shift.

Registered nurses were required to complete medicines management training and be signed off as competent by an experienced nurse before administering medication without supervision.

We reviewed all the prescription charts from both wards. The doctors demonstrated safe practice in prescribing. A pharmacist visited the ward weekly and completed medicines management audits. Medical staff could view the audit through an online system. We viewed a recent audit which nursing staff and the doctor had acted on and provided responses to.

Medical staff reviewed the effects of medication on patients' physical health regularly and in line with NICE guidance. The ward doctor reviewed effects of medication for patients prescribed high dose antipsychotic medication within the weekly patient review.

**Track record on safety**

The service reported no serious incidents on either ward in the previous 12 months.

**Reporting incidents and learning from when things go wrong**

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Incidents were reported through an electronic recording system and reviewed by senior management. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Staff told us that lessons learned were shared through team meetings, emails and posters which were displayed in the nursing office. Incidents were analysed and discussed by the senior management team during clinical governance meetings.

We were given an example of changes that had been made following an investigation into a recent incident. This included changes to the observation levels and escort procedures for patients attending activities away from the wards, to improve safety for patients.

Staff understood the duty of candour. When things went wrong, staff apologised and gave patients honest information and suitable support. Nursing staff provided debriefs and one to one time for patients following any incidents.

Staff were provided debrief sessions and group reflective practice to support them following serious incidents. Staff told us that these sessions took place as required and were led by a psychologist which they found useful.

## 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**

A resident medical officer completed a comprehensive mental and physical health assessment of every patient on, or soon after, admission. However, this assessment did not feed into the nursing care plans.

The nursing care plans were not personalised or collaborative and used generic statements for goals and interventions.

Nursing staff completed four care plans on admission, focused on mental health, physical health, keeping connected, and safety. We viewed seven care records across both wards. In all the records, nursing staff had developed all four care plans soon after admission. However, the care plans did not link with identified needs from nursing assessments and the multidisciplinary team ward reviews.

Nurses reviewed care plans by adding a comment, but did not show any progress with the care plan. Where these reviews had identified new individualised needs, these were not used to update interventions and goals and make them personalised.

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

Requires improvement

Four of the care records included care plans which identified interventions and goals which were out of date or did not apply. This included identifying section 17 leave as a goal for patients who had already been utilising this.

Following the inspection, additional training to address this was provided to nurses on the acute wards for working age adults, and the senior management team put in place additional audits of care plans to ensure these issues had been addressed.

Staff checked patients' physical health on admission, using the Modified Early Warning System (MEWS) tool to monitor and record patient health. Staff repeated this daily unless there was a need to increase this due to a deterioration in the patient's health.

Staff monitored patients who were withdrawing from substance misuse using the clinical opiate withdrawal scale (COWS). Patients were given substitute medications to support detox such as methadone and subutex programmes as recommended in NICE guidelines. A trained addictions therapist also offered group and one to one sessions to support.

The multidisciplinary team reviewed patients' care and progress in a weekly ward round. The documentation of these reviews included a detailed and holistic review of the patients' progress and needs and agreed actions.

**Best practice in treatment and care**

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions were those recommended by, and were delivered in line with, guidance from the National Institute for Health and Care Excellence (NICE). These included Psychosis and Schizophrenia in adults: prevention and management (2014) and Depression in Adults: recognition and management (2009). The psychologist for both wards provided psychological therapies such as cognitive behavioural therapy, mindfulness, and dialectical behavioural therapy skills. The doctor prescribed within British National Formulary guidance and NICE guidelines.

The psychologist attended the ward on two days and provided one to one therapies and group sessions. Access to group therapies was dependent on need and risk assessment.

Staff used recognised rating scales to assess and record severity and outcomes. This included the Health of the Nation Outcome Scale.

Staff told us that they were aware that clinical audits and quality walk-rounds took place but they were unaware of the outcome of these and were not assigned responsibilities for completion of action plans. Ward managers completed care records and infection control audits and took responsibility for completion of the associated action plans.

**Skilled staff to deliver care**

The team included the full range of specialists required to meet the needs of patients on the ward. This included registered nurses, doctors, consultant psychiatrist, occupational therapists and a psychologist. Staff were experienced and qualified and had the right skills and knowledge to meet the needs of the patient group.

The service provided a robust induction for new staff which included two weeks of mandatory training and one week working as a supernumerary member of staff on the ward. Staff told us that the induction was comprehensive and equipped them with skills needed to meet the needs of the patient group.

Managers provided staff with supervision and appraisal, and ensured that staff had access to regular team meetings. Both ward managers had developed 'supervision trees' to ensure all staff were allocated a supervisor. Ward managers logged supervision on the provider online learning academy and were able to identify when staff were due supervision and appraisals. Nursing staff told us that they could easily access clinical and informal supervision. The ward psychologist also facilitated a weekly reflective group for staff. Nursing staff reported that this group was useful and took place as planned. All staff had completed their appraisals.

We viewed staff meeting minutes for Upper Court ward. These meetings were well attended and took place regularly. Ward managers organised nursing cover for the ward from other wards to ensure staff could attend.

Staff could access specialised training through the provider academy. Two healthcare assistants from Redcliffe ward

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

Requires improvement

had recently accessed training to become registered nurses. Ward managers also ensured that other opportunities to develop staff skills were easily accessible, such as phlebotomy training.

**Multi-disciplinary and inter-agency team work**

Staff held regular and effective multidisciplinary meetings. This included weekly ward round reviews for patients, daily shift handovers and a morning flash meeting for senior members of the multidisciplinary team. These meetings included discussion of patient progress, care planning, risk assessment, incident review and discharge planning. Staff told us that multidisciplinary team working was effective on both wards. Staff felt that the team worked collaboratively and everyone felt confident to express their views and that these were listened to.

Both wards had positive working relationships with local bed managers and a bed manager attended ward reviews for patients using local trust contracted beds. Nursing staff kept in contact with patients' community teams and involved community teams and care coordinators in discharge planning and care pathway approach meetings. When necessary, this included communicating through conference calls.

**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. Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act. Staff knew who their Mental Health Act administrators were.

Some patients told us that they were unaware of their rights under the Mental Health Act. We viewed 12 care records for detained patients and found that paperwork to document the reading of patients' rights had not been completed. Informal patients told us they were unaware of their rights. Staff told us informal patients were told of their right to leave the ward verbally and via a sign on the door, but they did not document these rights.

The consent status for detained patients' medication was not documented on all the prescription charts, as the section for this had not been completed by the prescriber. Nurses administering medication could therefore not confirm whether patients were consenting to medication at the time of administration and would need to access the individual patient care records to assure themselves of this. This information could be accessed on the electronic care records. However, not all agency staff could access the care records to view this information before administering medication.

**Good practice in applying the Mental Capacity Act**

Staff supported patients to make decisions on their care for themselves. They understood the service policy on the Mental Capacity Act (2005) and assessed and recorded capacity clearly. For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. The care records on both wards included reference to consideration of capacity where appropriate. Capacity to consent was discussed and documented as part of admission and multidisciplinary team ward reviews.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, culture, and history. Staff had included family members views in decision making as part of best interest meetings.

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

Requires improvement

**Kindness, privacy, dignity, respect, compassion and support**

Staff treated patients with compassion and kindness. Patients told us that staff respected their privacy and dignity during their interactions and when carrying out nursing care. Patients we spoke with said staff treated them well and behaved appropriately towards them.

Staff were available to provide support when patients needed it and engaged in regular one to one sessions with patients. Patients were unsure who their named nurses were but felt able to approach all members of staff for support. Patients also said that staff would approach them to offer support or informal chats throughout the day.

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

Requires improvement

Patients felt safe on the wards and confident that staff would react quickly to safety incidents but stated that the ward could become tense and distressing following incidents.

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

Patients knew how to report any concerns or complaints and had been informed of the complaint procedures.

Staff understood individual needs of patients, including their personal, cultural, social and religious needs. Staff supported patients to access places of worship and invited religious leaders to visit patients where appropriate. The service also kept religious items, such as prayer mats and the Quran, which patients could use in their bedrooms. Staff sought to confirm patient preferences and needs during the admission process.

The service had clear confidentiality policies in place that were understood and adhered to by staff. Clients were informed of these policies and consent was requested regarding sharing of information with family and other professionals.

**Involvement in care**

Patients told us they could not recall a process to inform and orient them to the ward, although staff confirmed that this should take place. Patients were unclear on why they were in hospital and what the service offered as part of their admission. Patients were unsure which facilities, activities and therapies were available to them. The documentation of the admission process in patient files was unclear and incomplete.

Staff did not involve patients in development of their care plans and risk assessment. Patients did not know who their named nurses were and six of the seven care records did not include patient views. Patients told us that they were unaware of the content of their care plans and had not received a copy. There was a checkbox within the electronic care records to confirm that patients had been offered a copy of their care plan. In four out of the seven care records this checkbox had not been filled in.

However, patients did feel involved in ward round reviews and decision making in relation to their treatment, care pathway and discharge planning. Patients told us they felt able to approach all members of the clinical team to discuss their treatment and needs, and confident that their views would be listened to.

Staff gave examples of effective ways they had found to communicate with patients with communication difficulties, this included writing things down, accessing interpreters and using communication cards.

Both wards organised weekly community meetings which patients could attend and give feedback on the service they received. Patients could also suggest ideas to improve the service through this forum.

Staff ensured that patients could access advocacy. An independent advocate attended the ward regularly and was available to patients. There were advocacy information leaflets displayed on the walls of the wards.

Staff informed and involved families and carers appropriately and provided them with support when needed. With patient consent, carers and families were invited to ward reviews and were kept involved regarding care and decisions through telephone contact with nursing staff.

Although carers and families were encouraged to visit patients, there were limited rooms for visits to take place and therefore these took place off the ward. Visits with children took place in a separate reception building. Detained patients relied on leave to enable them to attend family visits. Staff took appropriate steps to ensure patients could access this leave off the ward.

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

Requires improvement

**Access and discharge**

On Redcliffe ward there were 11 of 13 beds occupied. On Upper Court ward there were nine of 10 beds in use. Occupancy for the previous year had been 80% for Redcliffe and 71% for Upper Court. Average length of stay was 18 days for Redcliffe and 20 for Upper Court.

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

Requires improvement

The service accepted referrals for out of area patients and worked with their local team to transfer them back to a bed in their local area as soon as one was available. The service also had contracted beds with a local NHS trust and kept these beds available for their use at all times.

In the previous year there had been 86 out of area patients who were over 50 miles from their usual residence. The staff recognised the importance of ensuring consistency and continuity of care for out of area patients. Staff liaised with local teams throughout patient stays and involved care coordinators in decision making.

The service had a triage nurse who was not based at the hospital to consider referrals. The aim of this was to ensure that patients were placed as close to the home areas as possible and to reduce the workload of nurses on shift, to enable them to spend more time with patients on the ward rather than liaising with care coordinators arranging admission.

Nursing staff reviewed referral paperwork but told us that any decision to refuse a patient would be discussed by the senior management team, who would then make the decision. Nursing staff told us that they did not always agree with the senior management team's decision. The management team made a decision based on whether they could meet the patient's needs taking into account acuity and current patient mix.

The hospital would decline any admissions where they did not feel they could meet the patients' needs.

If patients were granted overnight leave there would always be a bed available when they returned from leave.

Patients were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. If a bed was found in a patient's local area, the nursing team would liaise with staff on the new ward to confirm current treatment and care plans, to ensure continuity of care.

Staff planned for patients' discharge, including good liaison with care coordinators. The clinical team involved local teams in patient care via telephone conferences, and invited care coordinators to ward reviews. Nursing staff ensured patients preparing for discharge had been allocated a community care coordinator and invited community teams to attend a discharge meeting. Discharge planning was completed in liaison with patients' community teams.

When patients were moved or discharged, this happened at an appropriate time of day.

Nursing staff could refer patients to more intensive environments if required. Nurses told us they could request a bed on psychiatric intensive care units (PICU) within patients' local area, if required. Staff told us that they did not experience difficulties identifying beds on a PICU, when a patient needed to move.

**Facilities that promote comfort, dignity and privacy**

The premises were not suitable for the service being provided. Neither ward had adequate rooms and space to support treatment and care. The communal area on both wards was used as a lounge, kitchenette and dining room. The rooms were too small for more than a few patients to use at one time. Patients therefore had to take their meals to their bedroom or eat their meals in the main hospital dining room if they were assessed as safe to leave the ward, as there was not enough space for all the patients to use the dining table.

Nursing staff told us that their ability to provide on-ward activities and therapies was impeded by the lack of space. There were no activity rooms or quiet areas on the wards. There was a small female lounge with a two-seater sofa on both wards. However, patients and staff told us that this room was occasionally used for one to one sessions and therapies due to there not being enough meeting space elsewhere on the ward. There was no space to meet with visitors and visits therefore took place off the ward in a separate building.

Patients told us there was not enough space to access quiet areas, socialise, or meet with staff and this led to feelings of tension and claustrophobia.

The clinic room was small and physical health examinations took place in patient's bedrooms.

Patients had their own bedrooms with en-suite facilities. Redcliffe ward had recently been extended with new bedrooms. These bedrooms were larger than the older bedrooms and purpose built.

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

Requires improvement

Outside space was not easily accessible. Patients assessed as safe to leave the ward could access the grounds area. Patients without leave could access the courtyard with a member of staff. Patients and staff told us that there was sometimes a delay in making staff available to support access to the outside.

Patients could make hot drinks and snacks throughout the day and night in the kitchenette area in the lounge.

Following the inspection, the hospital reviewed the environmental concerns raised. Redcliffe ward was changed to a male ward, enabling the female lounge to be used as additional communal space. Plans were also made to move Upper Court ward to a more appropriate ward on site. It is expected that this work will have taken place by July 2019, allowing for additional works to ensure the new ward will be appropriate for an acute setting.

**Meeting the needs of all people who use the service**

The service had made adjustments for disabled patients by ensuring easy access to the premises. Although the service could accept referrals for patients in wheelchairs, staff reported that the limited space on Upper Court would make mobility difficult.

Managers ensured that staff and patients had easy access to interpreters and/or signers.

Patients said that the service catered for their dietary needs. Patients said that food was high quality and it was possible to make specific requests and order alternative menu options.

Staff ensured that patients had access to appropriate spiritual support.

**Listening to and learning from concerns and complaints**

There was a complaints policy in place and clients and staff were aware of the process for complaints. The service treated concerns and complaints seriously, investigated them, learned lessons, and shared these with all staff. The ward managers discussed learning from complaints as part of staff meeting agendas.

The wards gave information on how to make a complaint during the patient induction to the ward and information was provided on the ward noticeboards. Patients told us that they felt comfortable to approach staff with any concerns or complaints and that staff would respond appropriately to these. Staff told us that they would initially try to resolve patient's issues where possible and refer these on to their managers. Patients could raise complaints through the community meeting and received feedback from this.

Over the previous 12 months Redcliffe had received three complaints and Upper Court had received four. Redcliffe had also received eight compliments and Upper Court 21 compliments.

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

Good

**Leadership**

Ward managers had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed.

Patients and staff told us that leaders were visible in the service and approachable for patients and staff. Ward managers were based on the ward and staff and patients could approach them for support at all times.

Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care.

**Vision and strategy**

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The provider's leadership team had successfully communicated these to the frontline staff on the wards. Through staff meetings, staff had the opportunity to contribute to discussions about the strategy for the acute service, especially where this was changing. Ward managers had the same opportunities during senior management team meetings.

**Culture**

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values

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

Requires improvement

Staff could request and access leadership development opportunities through the provider online academy.

Staff felt respected, supported and valued. Staff were happy in their roles and reported good working relationships with other members of the team. The teams worked well together and staff told us that the team was effective and efficient.

Staff felt positive and proud about working for the provider and their team.

The service had a whistleblowing policy which was available on the intranet. Staff felt able to raise concerns without fear of retribution and knew how to access the whistleblowing policy.

**Governance**

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

Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding referrals at the service level. Bulletins and posters had been disseminated via emails and displayed on the office walls. Staff were aware of recent lessons learned across the provider's services and had implemented the recommendations.

Staff were unclear on the outcome of ward specific clinical audits and were not involved in completing the action plans following these. Ward managers addressed any poor performance identified during audits as part of clinical supervision.

Despite managers carrying out audits of patient care records, care plans were generic and not person centred. Managers were also not ensuring that nurses were acting in accordance with the Mental Health Act (1983) and documenting patients' rights.

**Management of risk, issues and performance**

Although ward managers maintained, and had access to, the risk register at ward level, the risk register for Redcliffe ward was out of date and did not reflect ongoing concerns raised by staff during our inspection.

**Engagement**

Staff and patients had access to up to date information about the work of the provider and the services they used. This included forums such as community and staff meetings, alerts and bulletins displayed on the walls and on the provider intranet.

Patients and carers had opportunities to give feedback on the service they received through community meetings, ward reviews and feedback on discharge.

**Learning, continuous improvement and innovation**

The provider recognised staff success within the service through star awards, nominated by other staff members or by patients. The awards were based on how staff had demonstrated the provider visions and values. During the inspection a staff member was presented with an award and recognition of their work from the hospital clinical director.

# Long stay/rehabilitation mental health wards for working age adults

Good

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

## Are long stay/rehabilitation mental health wards for working-age adults safe?

Good

**Safe and clean environment**

The wards were clean and tidy with fixtures and fittings in a good condition. The wards had an environmental risk assessment in place which included a list of ligatures. The risk assessment showed all ligatures identified were mitigated against. Staff were aware of the environmental risks and knew how to mitigate against these.

The wards complied with the Department of Health guidance on eliminating mixed sex accommodation by ensuring the only mixed gender ward had separate male and female sleeping and bathroom areas and a separate lounge for women.

The service had contracts with outside agencies to service and repair medical equipment. Equipment such as hoists, stand aids and wheelchairs in the wards had been recently serviced and cleaned. Records showed that this was carried out regularly. Some equipment was allocated to individuals and these were noted with the patient's name. This helped to ensure patients were not at risk of cross contamination.

The wards adhered to infection control principles. There were appropriate handwashing facilities and alcohol gel dispensers available for staff. This helped staff to maintain safety and cleanliness. The hospital employed domestic, housekeeping and maintenance staff to carry out immediate work within the service. Cleaning records were in place to ensure that all areas of the hospital were regularly cleaned. Cleaning records showed that staff had completed the required tasks in line with these requirements. Spillages and body fluids were cleaned up immediately by domestic staff. Infection control audits were carried out regularly and any identified actions were completed in a timely manner.

All areas to which patients had access had nurse call systems. This included bedrooms, bathrooms, dining areas and activity rooms. All staff that went into ward areas carried personal alarms and these were used to summon help if staff felt they needed urgent assistance.

The wards did not have a seclusion room and patients were not secluded in any other rooms within the hospital.

There was a clinic room on each of the wards. We checked each of the clinic rooms and found they were all clean and tidy with adequate space available. Emergency equipment and drugs were easily accessible and well organised. Regular checks were carried out on the emergency equipment to ensure it was in working order and there was nothing missing or past its expiry date. Staff checked and recorded temperatures of all clinic rooms and clinical fridges daily.

**Safe staffing**

The ward had an high annual staffing turnover of 29.4%, with 15 staff leaving the service over the year before the inspection. This was as a result of a number of internal transfers within the hospital, as well as staff leaving for relocation or to access additional study or career development opportunities.

# Long stay/rehabilitation mental health wards for working age adults

Good

Sickness levels in the service were also high, at 15.7% on Garden View, 39.6% on Oak Lodge and 31.9% on Hillside. There had been some long term sickness in the teams due to personal staff circumstances.

The service managed this through the use of regular agency staff to fill any gaps. These staff were subject to the same interview, induction and training as permanent staff members, and were placed on regular shifts to support consistency of care.

The service was fully staffed for healthcare assistants at the time of the inspection, and were continuing to try and recruit nursing staff to fill vacancies.

The hospital employed registered mental health nurses, registered general nurses, healthcare assistants, a psychiatrist, occupational therapist, speech and language therapist and a physiotherapist.

The staffing levels (called "ladders" by the provider) on each ward were one or two qualified and up to four healthcare assistants during the day, and a minimum of one registered nurse and up to three healthcare assistants at night. These were varied according to the number of patients and their dependency levels. The managers discussed staffing levels at the morning meeting each day to ensure that staff and patients were safe on the wards. Where patients were on enhanced observations or had an increased care need, additional staff were included in daily figures.

When agency or bank staff were used, the service tried to use staff that were familiar with the running of the wards and its patients to ensure continuity of care. Bank and agency staff were required to participate in the induction process to ensure they were familiar with the provider's policies and procedures.

All patients within the wards had a named nurse. Patients had regular reviews with their named nurse and staff recorded what care had taken place.

Staff were visible on all wards. We saw staff spent time supporting patients with daily activities, engaging them in discussions and spending time on a one to one basis.

Staff told us there were regular organised activities both in the hospital and outside. We looked at the activities timetable and saw that there was a varied activity programme. Staff told us that activities were rarely cancelled due to staff shortages. Section 17 escorted leave was rarely cancelled as there were sufficient staff on duty to ensure that leave could go ahead as planned. Section 17 leave is the legal means by which a detained patient may leave a hospital site.

The wards had a dedicated consultant psychiatrist who worked in the hospital throughout the week. The psychiatrist worked across all the wards and conducted weekly ward rounds with other members of the multi-disciplinary team. Out of hours arrangements were in place to ensure staff could access medical help if needed. In addition, staff could contact the on-call director out of hours if there was a need for help or advice.

There was a programme of mandatory training that staff were required to undertake. Staff were also required to complete training in the Mental Health Act (1983) (95% compliance across the hospital), Mental Capacity Act (2005) (92% compliance) and deprivation of liberty safeguards (92% compliance), as well as safeguarding adults and children training, and a range of other essential training courses relevant to the service. All the mandatory training had a compliance rating above 85% across the hospital. Staff also had access to monthly continuing professional development opportunities delivered internally on the wards.

The managers we spoke with told us they monitored staff compliance with mandatory training to ensure it had been completed.

**Assessing and managing risk to patients and staff**

We looked at the care records of nine patients and found they were detailed and person centred. Staff completed individual risk assessments for each patient on their admission to the hospital and carried out regular monthly reviews. Additional reviews were carried out if patients had been involved in an accident or incident, or if staff noticed a change to a patient's presentation.

Staff ensured there were no blanket restrictions in place. Restrictions to patients were limited to the least possible. Any restrictions that were in place were highlighted in care records. For example, patients were not able to leave the hospital alone due to concerns that they may be at risk if they left without supervision.

# Long stay/rehabilitation mental health wards for working age adults

Good

Patients had access to wards through locked doors within a staffed reception area. Informal patients could leave the ward at any time. However, an immediate risk assessment would be carried out by a member of staff.

All staff at the service were trained in the use of restraint. The service managed actual and potential aggression using a positive behaviour support approach. Staff had not used rapid tranquilisation on any of the wards in the year before the inspection, and restraint had not been used over the previous six months. Policies on the use of restraint and rapid tranquilisation ensured any use would be in line with the Mental Health Act Code of Practice. The wards did not have a seclusion room and did not use seclusion. Staff told us patients were not restricted to their room and we found no evidence to suggest this practice ever occurred.

**Safeguarding**

All staff working at the hospital were required to complete safeguarding training for adults at risk of abuse. Compliance for this was at 90% across the hospital. Staff also completed child safeguarding training.

Staff on the wards we spoke with were aware of their responsibilities in relation to safeguarding and knew how to make safeguarding referrals. The ward managers told us they had a good relationship with the local authority. The provider had a safeguarding policy in place and all staff were aware of how to access this.

**Staff access to essential information**

Staff had access to an electronic care records system but patient records were currently paper based. Each patient had a folder of information which included relevant information such as family history, health records, risk assessments and care plans. Care plans were well maintained and up to date, and were stored securely in nursing offices on individual wards. All care staff could access patient records when required. We reviewed three folders from each ward and found all the information was clear, up to date and relevant. Staff we spoke with told us that they found the records easy to use and informative.

**Medicines management**

We checked the provider's arrangements for the management of medicines on the wards. The provider's policy covered all aspects of medicines management. We found that medicines were stored securely and were only accessible to authorised staff. There were appropriate arrangements in place for the disposal of medicines waste. We checked the arrangements for the storage of medicines which required refrigeration and found staff monitored fridge temperatures in line with national guidance. We reviewed nine medicines charts overall and found staff kept accurate records of the treatment patients received. We reviewed consent to treatment documentation and found medicines were prescribed in accordance with the provisions of the Mental Health Act (1983) in all cases.

The provider had systems in place to monitor patient's physical health. In all the records we looked at physical health monitoring had been completed. Every patient had a variety of risk assessments specific to physical health care which were completed monthly to inform potential treatment. The provider had employed registered general nurses to lead on physical health issues across the whole hospital, including wound management, diabetes, epilepsy care and healthy lifestyle choices and education.

**Track record on safety**

The wards used an electronic incident reporting system to record all incidents. Hillside reported four serious, four moderate and 94 minor incidents in 2018. Oak Lodge reported eight serious, 10 moderate and 88 minor incidents. Garden View reported 10 serious, 17 moderate and 146 minor incidents during 2018.

A safeguarding incident that did not reach the threshold for further investigation by the local authority would be considered a serious incident within this system. The serious incidents also included patient deaths of natural causes, and incidents of whistleblowing that were investigated internally and by outside agencies and found not to be of concern.

**Reporting incidents and learning from when things go wrong**

The hospital used a paper based reporting system and all staff could report and record incidents using this system. Incident report forms were reviewed and signed off by the hospital director to investigate and clarify any lessons learned. Incidents were logged and uploaded onto the provider's governance database and reviewed in daily meetings, weekly multi-disciplinary team meetings and again in the ward rounds. Monthly analysis was completed for each ward and for the hospital, with a further review during divisional governance meetings.

# Long stay/rehabilitation mental health wards for working age adults

Good

Staff we spoke with were clear about what should be reported and were able to give examples. Staff were aware of the forms they needed to complete to report incidents and what information they should record. Staff and patients were debriefed after incidents to allow for discussion and support. There was a clear process in place for the monitoring and investigating of incidents.

Staff were given feedback from investigations and were told of lessons learned through team meetings and supervisions. Staff we spoke with told us they were given information about outcomes of investigations and lessons learned were shared, not just in the hospital but also to other services within the group.

## Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

### Assessment of needs and planning of care

We reviewed the care and treatment records of nine patients.

All admissions to the hospital were planned. Before admission staff visited the prospective patient and carried out a comprehensive pre-admission assessment. Assessments included physical health needs as well as mental health and were used as a basis for patient's care plans.

The care and treatment records we reviewed were person centred, detailed and up to date. Each patient had access to individual activity programmes to work towards increased independence and discharge to the community or an alternative care setting.

All the care plans had risk assessments and risk management plans in place and had been completed in accordance with the care plans. Each patient had a "this is me" section at the front of their records. This provided the reader with a photograph, a resume of the person's likes, dislikes and family history. In addition, there was a patient snapshot summary for each ward which provided temporary staff with a good introduction to each patient.

Staff regularly reviewed care plans and risk assessments. We found that reviews were carried out if there were changes to patient's individual needs.

Where possible patients and their families participated in the creation of care plans. If patients were unable or unwilling to participate, staff noted this in the record but continued to encourage participation. Where patients were happy to have family involvement, we saw evidence of family input into care plans and patient's history.

When patients were transferred to other services, patient records were copied and passed on to the new team.

### Best practice in treatment and care

Staff used recognised screening tools and rating scales to help them identify issues which may have an impact on patient health. For example, we saw evidence of staff using the Malnutrition Universal Screening Tool (MUST) to help them monitor nutritional intake, Waterlow score to monitor tissue viability, and the model of human occupation screening tool to measure functional ability.

There was good evidence of physical health monitoring being carried out. Patients had regular physical health checks. The frequency of these was determined by any physical health concerns, and were carried out more regularly for patients with increased physical needs.

Physical health was monitored and recorded on the national early warning score (NEWS). Patients had regular weight checks, nutritional reviews, tissue viability checks, choking assessments and general observations. In addition, the hospital ensured patients were registered with a local GP, dentist and chiropodist, all of whom visited the service regularly.

The wards employed a number of physical health and dual trained nurses to reflect the health needs of the patients on the wards and employed a GP service to offer support for patients' physical health needs.

Staff also had additional training for physical health needs such as wound care training, and linked in with the GP and district nursing teams on an ongoing basis for advice and support as needed.

The therapies team on the wards led an activity programme for each patient to work towards increased independence and discharge to the community or an alternative care setting.

# Long stay/rehabilitation mental health wards for working age adults

Good

The therapies team had put together a ten pin bowling team and took patients to a local ten pin bowling alley as an activity and to support community reintegration. They worked with patients to help develop and maintain life skills and activities of daily living including cookery activities. Patients were also supported to access animal therapy within the community.

The service undertook a variety of audits to monitor the quality and safety of the service. There was a clinical audit programme in place that included care plans, nutritional audit, capacity assessments and best interest document audits.

The results of audits were shared in clinical governance meetings and with staff working in the service. It also allowed managers to identify common themes and make changes where necessary.

**Skilled staff to deliver care**

The wards employed a wide range of staff including registered general nurses, registered mental health nurses, occupational therapist, healthcare assistants, physiotherapist, speech and language therapist and an external pharmacist who attended the hospital to carry out medicines audits and medicines reconciliation. Patients also had access to a weekly one to one psychology session.

Staff employed were experienced and qualified to carry out their roles. Before starting work at the service, staff were required to provide suitable references and to have disclosure and barring checks carried out.

All staff working in the hospital were required to participate in induction. This included information on the policies and procedures that were in place both nationally and locally.

Staff were required to have regular supervisions and appraisals. Staff appraisal rates were 85%. Supervisions were carried out a minimum of six times a year with appraisals completed annually. If needed, supervisions could be increased to ensure staff were receiving help and support when required. All staff had received an appraisal within the last 12 months.

The ward managers told us they felt confident to deal with poor performance. Where there were concerns about a staff member's performance there was advice from the human resource department and the option of increased supervision to assist them.

**Multidisciplinary and interagency team work**

Staff held weekly ward rounds on all three wards. Each patient had a multidisciplinary ward round every two weeks. Those attending included the consultant psychiatrist, nurses, senior healthcare assistant, psychologist and occupational therapist. The care records showed evidence of multidisciplinary working.

Handover meetings occurred twice a day on all three wards, once in the morning and once in the evening at the changeover of staff.

Staff told us they were clear about the roles and responsibilities of visiting NHS professionals in delivering patient care. Examples given were advice from specialist staff over tissue viability or palliative care. A general practitioner from a local practice attended the hospital every week and visited the wards on rotating basis each week.

Staff we spoke with told us there were good working relationships with external stakeholders. This included the local authority safeguarding team, local pharmacy, and commissioners.

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

At the time of our inspection the staff working in the hospital had completed their mandatory training in the Mental Health Act (1983). Records confirmed that 90% of staff had received training on the Mental Health Act across the hospital.

Ward managers told us that they were contacted by Mental Health Act administrators to check on any admissions and collected the detention paperwork. We saw evidence that original detention papers were stored safely in a locked filing cabinet.

Information on the rights of patients who were detained was displayed on wards. Staff were aware of the need to explain patients' rights to them to ensure they understood their legal position and rights in respect of the Mental Health Act.

Staff were aware of the need to receive consent to treatment and we saw evidence of consent being recorded in patient records. Where patients were unable to consent to treatment, we saw evidence of second opinions being sought and best interest outcomes recorded.

# Long stay/rehabilitation mental health wards for working age adults

Good

Patients were informed of their rights when they were admitted to hospital and monthly after that. We saw evidence of staff informing patients about their rights and at further times if the patients did not appear to understand these. Patients were further advised of their rights if there were changes in their treatment or if there were changes to their Mental Health Act status.

**Good practice in applying the Mental Capacity Act**

At the time of our inspection 92% of staff working in the hospital had completed training in the Mental Capacity Act (2005). Staff we spoke with demonstrated a good understanding of the Act and were confident in their knowledge of least restrictive practice.

At the time of the inspection there were four patients for whom applications had been made for a Deprivation of Liberty Safeguard authorisation. The safeguards are a process the provider must follow if they believe it is in the person's best interest to deprive them of their liberty to provide care, they do not have the mental capacity to consent to this, and are not detained under the Mental Health Act.

We saw good evidence of capacity assessments in patient care notes. We looked at nine sets of records and all had capacity assessments. We found that the capacity assessments were decision specific and we saw evidence that staff had assisted patients to make decisions.

Staff told us that relevant best interest meetings took place for patients that lacked capacity. We saw evidence of this in patient care records. Best interest meetings had a clear rationale and patient's families or relevant others attended where possible.

## Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

**Kindness, privacy, dignity, respect, compassion and support**

Staff engaged with patients in a way that was respectful and caring. Staff spent time carrying out activities with patients and providing emotional support where patients appeared concerned or distressed. Staff told us that they enjoyed working with patients and showed they were passionate about their care. Some staff told us they were feeling sad about the closure of Garden View ward, and would miss the patients they had developed strong relationships with.

Patient care records showed staff had taken time to get to know their patients. Care plans demonstrated that staff had used the knowledge gained to complete patient histories.

There was a good staff presence on all wards and staff demonstrated a good understanding of patients' needs and understood individual's care plans.

Patients were offered a variety of appropriate activities. An activities co-ordinator planned group and individual activities throughout the week and weekends. Staff working at the service supported patients to carry out activities. Staff in the service encouraged patients to remain active and joined in with activities where possible.

**Involvement in care**

We reviewed the care records of nine patients and found they included evidence of orientation to the ward on admission.

Where patients had been able to participate in their care planning and risk assessments, we found they contained patient's comments and identified preferences. We saw care plans showed evidence of interventions patients found helpful.

Patients who were found to lack capacity to make decisions about their care were still involved in the care planning process. Where patients had difficulty with communication we saw records contained information about how patients communicated and what methods staff used to help them.

Patients were encouraged to give their feedback on the service and the care and treatment they received. The service used annual surveys, comments boxes and meetings to gather information relating to the running of the service. In addition, there were regular meetings in the service for patients, families and carers.

Patients had access to advocacy. There were regular visits on a Tuesday and at other times by arrangement by the

# Long stay/rehabilitation mental health wards for working age adults

Good

advocacy service. Access to the Independent Mental Health Advocate (IMHA) was also available as required. We saw posters displayed across the hospital advertising advocacy services.

**Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?** (for example, to feedback?)

Good

**Access and discharge**

The wards took referrals from anywhere in the country and did not have a catchment area. Occupancy rates were 85% on Hillside, 60% on Oak Lodge and 60% on Garden View. Patients admitted to the wards had care needs which reflected the longer term high dependency rehabilitation model.

Hillside worked to a recovery focused, person centred model. They aimed to promote independence to support patients to move into community supported living. The expected length of stay on Hillside was six months to two years.

Garden View supported patients with neurodegenerative brain disorder as well as enduring mental health problems. The patients on the ward had complex physical health and mental health needs that often prevented them accessing alternative placements. The ward provided slow stream (more long term) rehabilitation, aiming to reintegrate patients back into the community where this was possible. The ward also worked with end of life patients where appropriate.

Patients on Oak Lodge also had complex care needs due to degenerative conditions (deteriorating illnesses), and the ward also offered end of life care pathways where appropriate. The ward provided dignified long term care for patients with complex needs, which could not be met in nursing or residential care settings.

For most patients on Oak Lodge or Garden View wards, admissions were viewed as long-term placements. The therapies team led an activity plan for all patients working towards discharge. In the year before the inspection, the average length of stay for patients who had been discharged during that time was 118 days for Hillside, 22 days for Garden View, and 259 days for Oak Lodge.

The average length of stay for patients on the long term and rehabilitation wards at the time of the inspection was 174 days.

All patients on the rehabilitation unit were monitored by the relevant commissioners to ensure the admission remained appropriate to their needs.

There were no delayed discharges in the year before the inspection, but with the planned closure of Garden View there had been a couple of delays in waiting for spaces to be available in the alternative accommodation patients were moving to.

**Facilities that promote comfort, dignity and privacy**

The wards had sufficient facilities to promote dignity and privacy. Garden View was located on the ground floor, arranged around an enclosed garden. The two upstairs wards, Oak Lodge and Hillside, also had gardens. All wards had an office, bedrooms, lounges, quiet room and a large kitchen diner. The wards had access to a therapy kitchen and a portacabin where they could support patients with life skills activities. The wards also had the facilities to take patients out to local community activities, including weekly ten pin bowling. The hospital had a therapy team who offered a programme of activities to the service.

On Oak Lodge and Garden View, patients could have an individualised bedroom door and in addition patients were able to personalise their bedrooms if they or their carers wished.

There was a visitor's room off the ward in the main building with access to tea and coffee.

Patients could store property securely if they wished. All patients had access to lockable storage in their bedrooms where they could store personal or valuable possessions.

Food was cooked fresh on site each day. There was always a variety of choices and specialist diets were well catered for.

Patients could access food and drinks when they wanted them, although some patients, due to medical need, had to have assistance.

# Long stay/rehabilitation mental health wards for working age adults

Good

### Meeting the needs of all people who use the service

The wards were set out over two floors. Access to the first floor was via stairs or lift, allowing patients with mobility issues to access all areas. All rooms throughout could be accessed by patients or visitors in wheelchairs.

All patients had bedrooms with en-suite facilities which were accessible for patients with mobility problems. Rooms had been adapted to suit the needs of individuals. For example, we found rooms had soft furnishings to help prevent the patients injuring themselves due to regular seizures and falling.

The wards had emergency evacuation equipment, ensuring patients who needed assistance would be able to leave the hospital in an emergency. Personal emergency evacuation plans were in place for patients.

Throughout the wards we saw notice boards which gave patients and carers information on a range of subjects including local advocacy services, patient rights, information about the Care Quality Commission and making a complaint. Fact sheets relating to detention under the Mental Health Act were accessible to patients and carers.

The hospital was able to accommodate all dietary requirements. Patients' dietary needs were assessed, including preferred foods, any medical needs in relation to diet and religious, spiritual and cultural requirements. Patients were given food choices at meal times as appropriate, and staff could provide an alternative.

Patients' individual needs were met, including their cultural, language and religious needs. A chaplain visited the ward each week and patients could request visits from different faiths. Staff also wore dementia friendly name badges on the wards.

### Listening to and learning from concerns and complaints

The wards had received one complaint in the last year. Staff worked with potential complainants to resolve these informally before the formal process was required.

Complaints information was available both on notice boards and within the patient information pack, which was shared with relatives. Monitoring and feedback about complaints was a standing item for the hospital governance group.

The hospital director reviewed all complaints and ensured they were investigated in line with the formal company policy. Complaints were taken seriously and the hospital director ensured that patients were encouraged to give feedback.

## Are long stay/rehabilitation mental health wards for working-age adults well-led?

Good

### Leadership

Leaders had the skills, knowledge and experience to perform their roles. Staff we spoke with had confidence in the managers and the leadership they showed the teams. They had a clear understanding of the services, and could explain how the teams worked to provide good care, while supporting patients to function to the best of their ability and preparing patients for discharge to alternative placements where appropriate.

Managers and their deputies were visible in the service and approachable for both patients and staff. Staff felt that the ward managers were pivotal in holding the respective teams together. Ward managers would regularly work within the clinical teams to keep in touch with them up to date over clinical practice.

Leadership development opportunities were available for staff who wished to progress within the service.

### Vision and strategy

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 and the ward managers had communicated the provider's vision and values to their staff. The teams felt the visions and values linked well to how they were working.

Staff were positive about the hospital director and the senior management team within the hospital. They told us that they were approachable and they felt supported by their managers.

# Long stay/rehabilitation mental health wards for working age adults

Good

The provider recognised staff success within the service through star awards, nominated by other staff members or by patients. The awards were based on how staff had demonstrated the provider visions and values.

**Culture**

The staff we spoke with were positive about working at the hospital. They told us they felt able to raise concerns, report incidents and make suggestions for improvements. They were confident their line managers would listen and act on them. Staff could describe the whistleblowing process and the whistle blowing policy.

Staff morale was very good and all the staff we spoke with had a clear commitment to their roles. Staff told us they felt supported and valued by local management and peers.

Staff were provided with opportunities for development within their roles. This included specialist training, lead roles and the support to complete a registered nurse conversion course.

Managers within the service promoted an open and honest culture. All staff had received training on their responsibilities under the duty of candour and additional information was available on the intranet.

**Governance**

The ward managers were clear about the process for highlighting any significant risks and ensuring the hospital director could include these on the hospital risk register as there were no ward risk registers.

Ward managers collected data monthly on performance and sent this to senior managers. These included audits on care plans, risk assessments, incidents and complaints. The organisation monitored manager's completion of audits.

Senior managers had systems to ensure that staff complied with mandatory training and attended clinical supervision and annual appraisals. They monitored complaints and incidents across the service and these were investigated where appropriate.

The wards were all reliant on the continued use of locum agency staff. The provider had ongoing recruitment campaigns to bring in more staff and at the time of the inspection all support worker posts had been filled. All locum staff were familiar with the wards, having worked there before. They were also able to access the same support as permanent staff.

The managers of the three wards said they had enough time and autonomy to manage effectively. The managers had the support of a full-time ward clerk who they shared.

Regular team meetings were held allowing staff discuss concerns, take part in educational or clinical supervision, debrief following incidents and to learn from the issues.

**Management of risk, issues and performance**

Environmental risk registers contained issues highlighted by the team. The key risks were ligature points on the wards and there were risk management strategies in place to mitigate these.

The hospital had protocols in place for major incidents and business continuity in case of emergencies.

We did not find any examples of financial pressures compromising patient care.

Staff had access to systems that recorded information and submitted data to senior managers, informing the governance framework. The hospital had procedures in place to ensure that information was efficiently managed and policies, procedures, and management accountability structures provided a governance framework for the monitoring of information management across the service.

Information governance training was mandatory for all staff directly employed at the hospital.

The ward managers had access to systems to support them in their management role such as mandatory training figures, staff sickness and absence figures.

Staff made notifications to external bodies as required.

**Engagement**

Patients and carers had opportunities to give feedback on the service they received through community meetings and feedback questionnaires. Managers and staff had access to this feedback which they shared at team meetings in order make any changes.

Senior managers of the hospital engaged with external stakeholders, such as commissioners and the local safeguarding teams.

**Learning, continuous improvement and innovation**

The wards did not participate in any accreditation or peer review schemes.

# Long stay/rehabilitation mental health wards for working age adults

Good

Staff took part in audits and research where appropriate.

Staff described plans for various quality improvement initiatives and how they were working to improve the experience of the patients who entered the service. An example was the development of a sensory group for patients with communication difficulties. All innovative ideas and quality improvement plans were supported and encouraged by senior managers at the hospital.

Good

# Child and adolescent mental health wards

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

## Are child and adolescent mental health wards safe?

Good

### Safe and clean environment

Staff members in both wards ensured that the premises, including the seclusion room, were safe for the young people. The managers had completed ligature and environmental risk assessment on the premises in 2018. A dedicated staff member walked around in the corridors on 15 minutes observations to ensure they could respond quickly if needed. Staff were aware of the environmental risks and knew how to mitigate against these.

The service had premises that were well maintained. Nurses had hand held alarms so staff could alert others if they needed assistance. Children and young people had nurse call alarms in their bedrooms. The premises had surveillance cameras in communal areas and occasionally in bedrooms if young people were assessed as high risk of self-harm. Clinicians always sought their consent in line with the service policy for use of the cameras.

The seclusion room allowed clear observation, two-way communication, had toilet facilities and a clock.

Therapy rooms and all communal areas were clean and appeared well maintained. We reviewed the most recent cleaning records and they were up to date, complete, and filled in correctly.

Staff members from both teams controlled infection risk well. Staff adhered to infection control principles including handwashing. There were signs on the wards instructing how to wash hands correctly.

Both teams ensured that clinic rooms were well-equipped. Temperatures of all clinic rooms and clinical fridges were checked and recorded daily. In both clinic rooms the medications in the medicine cabinets were checked by the nurse in charge weekly and the pharmacist. Grab bags for emergency medication were available in all in clinic rooms and fridge temperatures recorded appropriately. They were easily accessible and well organised. The staff team checked emergency equipment daily to ensure they were in working order and there were no medicines exceeding the expiry dates.

### Safe staffing

The managers ensured that both teams had enough staff with the right qualifications, skills, training, and experience to keep young people safe and provide the right care and treatment. The current staff complement included mental health nurses, occupational therapists, psychologists, junior doctors, pharmacist and consultant psychiatrist.

The service determined the staffing levels on each ward. For example, In Banksy ward the establishment level for nurses was 11 and healthcare assistants 44. The number of nurse vacancies was 9.9 and healthcare assistants was 24. In Brunel ward the establishment level for nurses was five and healthcare assistants 13. The number of nurse vacancies was 1.3 and there were no healthcare assistant vacancies. In the last three months in Brunel ward 197 shifts were covered by agency staff and seven by bank staff. The overall annual turnover was 30% and 22 staff left in the last twelve months.

Both the teams had a high vacancy rate, particularly qualified nurses. The service actively tried to recruit staff. For example, they organised recruitment drives, advertised regularly and approached universities. The staff acknowledged that they were understaffed but recognised both the managers and the senior team were doing everything to recruit new staff. The staff vacancies were on the risk register and there was an ongoing recruitment drive.

The service used high levels of regular bank and agency staff to fill any vacancies. Currently the wards used agency staff daily. Managers risk assessed each ward at the daily meeting. They discussed the staffing needs of the wards and could adjust staffing levels if they needed. For example, they had additional staff for one to one observations or to facilitate leave. Staff members ensured that a qualified nurse was present in communal areas of the ward at all times.

Providing good quality, safe care for the young people on the wards was very challenging in light of the complex needs of some of the young people. This had contributed to the high staff turnover and vacancy rates. However, the service were managing this well with ongoing work to recruit and retain staff and the continued use of regular agency staff who were familiar with both the wards and young people. This meant that, despite the vacancies, the ward were able to provide consistent care on the wards.

During the inspection, the hospital provided updated staffing figures that confirmed that the majority of the Brunel healthcare assistant vacancies had been filled. Banksy had also filled their healthcare assistant vacancies and recruited additional staff over and above the planned number of staff.

A dedicated consultant psychiatrist worked in the hospital throughout the week and conducted weekly ward rounds. Young people had regular access to a psychiatrist. The consultant on Banksy at the time of the inspection was a long term locum, and the service were in the process of recruiting for a permanent consultant. A permanent consultant has been appointed since the inspection, and is due to start within the next few weeks. The consultant on Brunel ward had been a permanent member of staff since May 2018.

There was sufficient medical cover day and night on both wards. On both wards, there were good cover arrangements in place for leave and absence of doctors. A doctor could attend quickly in the event of a medical emergency. The on-call director was available out of hours for additional help or advice.

Staff members and young people told us that escorted leave or ward activities were sometimes cancelled because there were too few staff, although they said every effort was made to reschedule.

Most staff, including managers, told us that there were enough staff to carry out physical interventions such as restraint and seclusion. This often involved utilising trained staff from other wards. This was always risk assessed to ensure other wards were also safely staffed.

The wards could also access additional staff members if needed for young people who were on increased observation levels. The senior management team discussed individual ward staffing levels during morning flash meetings and were able to allocate a 'floating' (not allocated to a specific ward) member of staff to help manage any shortages of staff. Staff on both wards were positive about the responsiveness of staff from other teams.

In both teams there were plans for emergencies. Managers ensured that there were clear cover arrangements for sickness, leave, and vacant posts to ensure the safety of the young people. The sickness rate for both wards service was high at 12% for Brunel ward and 46% for Banksy ward in 2018. However, these rates included some long-term sickness. In the two months before the inspection sickness levels had decreased by in the region of 20%.

The compliance for mandatory and statutory training courses at 2018 was 91%. The electronic rota system automatically told the team managers when a staff member's training was due for renewal. Managers completed performance reports for the service and forwarded this information onto team leaders to discuss with staff.

**Assessing and managing risk to patients and staff**

Staff undertook a risk assessment of every young person on admission and following any incident where the risk could change. Risk was assessed at every multidisciplinary meeting. Staff members received training in the

assessment and management of risk which they told us they found useful. Staff on the wards were very aware of the high level of risk for many of the young people, particularly on Banksy ward.

Staff members discussed high risk young people in clinical meetings, ward rounds, reflective practice sessions and multidisciplinary meetings. The staff recorded these discussions in the individual clinical records. As part of the local observation policy, staff handed over any concerns to the next person carrying out the observations at the end of the shift.

Staff were given handover sheets with detailed incident information as part of a handover at the start of each shift. All incidents were shared as part of a wider daily meeting with all senior management to ensure oversight of any issues and to follow up on any actions to be taken to manage risks.

Risk assessments were updated regularly and risks including potential triggers for young people, were known to all staff spoken with. Risks were also discussed and debriefs given by either the psychologist or nurse in charge following any incidents. Information was then shared with the wider multidisciplinary team and during daily senior management meetings. Incidents were followed up at monthly incident review meetings, and any themes or learning points shared with all staff following this. Commissioners were notified of incidents and updated on monthly incident audit results.

Risk assessments were evident in all eight case files we reviewed. Staff completed a risk assessment at admission and then updated these when the risk changed. Staff completed a monthly risk assessment audit. The team were 100% compliant with the completion of risk assessments.

The staff teams ensured that collaborative crisis plans could be accessed by families, and teams. The governance lead monitored the completion of crisis plans and staff teams were aware of the need to ensure crisis plans were completed.

The young people had a list of items they could not have on the ward to ensure their safety.

Staff members had developed good personal safety protocols, including lone working practices, and carried personal alarms.

The manager and senior management team monitored all restraints and rapid tranquilisation that took place either on the ward or in the seclusion room as each was well documented in line with their policy and procedures. They stated that if they identified particularly high number of restraints, a report was provided for the governance group. This initiated a quality improvement project for reducing violence and aggression.

In the month before the inspection there were 19 restraints on Banksy ward and 16 uses of rapid tranquilisation. On Brunel ward there were 11 restraints and three uses of rapid tranquilisation.

Nursing staff were trained in prevention and management of violence and aggression (PMVA) and breakaway techniques. Staff used restraint only after de-escalation had failed. The hospital policy was that restraint was only to be used as a last resort, and no staff were to use prone (face down) or supine (laying down) restraint, and so this was not part of the training given to staff. Training was given in standing, seated or recovery positions only. Staff were also taught breakaway techniques that were only used if it was safe to do so.

There were no prone or supine restraints of young people on the wards.

Following the use of rapid tranquilisation, staff monitored the young person's physical observations in line with the provider's policy by staff who offered any support to the young person as needed, including a debrief with them. Staff were also debriefed. The staff team completed risk assessments, updated new care plans and completed a report to governance group and commissioners.

In the clinic room, in line with the prevention and management of disturbed and violent behaviour policy, were three posters with algorithms about the use of rapid tranquilisation. These also outlined the steps to be taken before rapid tranquilisation, for example de-escalation techniques or use of as required medication. Staff we spoke with understood and followed the policy. Following any use of rapid tranquilisation nursing staff used a physical health monitoring form with pharmacy guidelines for physical assessment and visual observations at least four times every hour.

Staff ensured records about young people's seclusion were well maintained and accurate. For example, there was evidence of two hourly nursing reviews and

multidisciplinary reviews. Young people refused physical observations quite frequently so staff ensured movements and breathing observations were completed. If there were concerns about a deterioration in young people's physical health staff would seek further assistance from medical professionals as needed. If a young person showed signs of deterioration then staff would use planned restraint to manage any risk and complete physical observations following the observation and engagement policy.

There had been no instances of long-term segregation over 2018. One instance had occurred in August 2017. This was the only time this had happened within the service as this was considered a last resort option. This took place to ensure the safety and wellbeing of the young person, and was the least restrictive option available until an alternative placement was identified by commissioners.

**Safeguarding**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or adult at risk from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and organisational. Staff members understood how to protect children and young people from abuse and the service worked well with other agencies to do so.

All staff spoken with knew about their safeguarding policy and could tell us how to make a safeguarding alert and when it was appropriate to do so. Records confirmed that 85% of staff had completed adult safeguarding training and Level 3 child protection training. There was a plan in place to ensure the other staff received the training quickly. This was checked by the managers of each individual team who then reported compliance to the service managers. The team had good links with the local safeguarding board.

Managers monitored the number of safeguarding referrals they made. Staff completed an incident form when each safeguarding referral was made. These were monitored by the senior management team.

There were no serious case reviews related to the service in the last 12 months.

**Staff access to essential information**

Staff members kept both paper and electronic records of young people's care and treatment. The information had recently been reviewed and all staff had been trained to ensure information was consistently kept in the same place in the electronic recording system. All staff could access the electronic records. Staff said they found the records accessible and informative. However, agency staff did not all have access to the records because they were not give the login codes. This included healthcare assistants who had worked at the wards longer than some of the substantive staff. During the inspection the senior manager arranged for all staff to have codes to access the information system.

**Medicines management**

The service had systems in place to ensure young people's medicine management was safe.

The service regularly reviewed the effects of medication on young people's physical health in line with guidance from the National Institute for Health and Care Excellence (NICE). There was a pharmacy review of young people's medication charts daily by pharmacists.

We reviewed seven medicines charts. These were accurate and well maintained. Records included consent to treatment documentation.

**Track record on safety**

There were seven serious incidents on Banksy ward. The type of incidents included violence towards staff and police, young people swallowing parts from broken equipment and self-harm using a blade and violent behaviour. In Brunel there were two incidents. These included a young person who absconded from escorted leave and threatened to jump from motorway bridge.

The service provided a detailed report of incidents in the wards. In Banksy ward there were 118 in the twelve-month period up to July 2018. In Brunel ward there were 27. The number of incidents that included restraints of the young people was 29 in Banksy and 11 in Brunel. None of these restraints were prone (where a young person is face down on the floor).

**Reporting incidents and learning from when things go wrong**

Staff managed incidents well. They recognised incidents and reported them appropriately.

They had received training on how they could report incidents on the electronic reporting system. They could explain what to report and how they would do this.

Good

# Child and adolescent mental health wards

Managers on the wards investigated incidents thoroughly. Managers completed a monthly report for senior managers and commissioners as part of their quality monitoring. These were analysed by the governance lead and discussed at governance meetings and trends were identified and acted upon. For example, they identified that using the hospital grounds was an area where incidents occurred so they reviewed the times they were used.

The staff teams implemented changes to practice after an incident in 2017 where a young person absconded whilst with staff in the grounds during an early evening walk. The learning included the introduction of new policy and procedures about the timing of walks.

In Banksy ward the staff team changed the policies around searches of young people and ordered specialist equipment to ensure that blades could not be taken onto the ward.

There was a weekly incident meeting with managers to review all incidents.

Staff members were always offered a debrief session after each incident.

## Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

### Assessment of needs and planning of care

Staff members had access to up to date, accurate and comprehensive information on children and young people's care and treatment.

Staff completed a comprehensive mental health assessment of the young people in a timely manner. Of the 12 care records examined, all had a doctor's assessment which detailed a mental health examination as well as physical health examination. There was also a nurse assessment. Within the admission assessments there were stated goals and objectives to be worked on collaboratively with the young person. All care plans were reviewed and updated.

Staff developed care plans that met the needs identified during assessment. Each young person had four care plans, some had an additional weight monitoring care plan. Out of the 12 sets of care plans, 11 were personalised, holistic and recovery orientated. The one whose care plans were not personalised showed documented attempts to engage the young person with those care plans. In each file there was information about young people's use of coloured bands to indicate how they were feeling.

Staff members ensured crisis plans were consistently completed. The managers monitored completion and monthly data showed that compliance was good across the team.

### Best practice in treatment and care

Staff members provided care and treatment based on national guidance and evidence of its effectiveness. There were care pathways in place that showed current National Institute for Health and Care Excellence (NICE) guidance for staff to follow. Evidence seen in the care files confirmed that the team followed NICE guidance when prescribing medication and in relation to psychosis and depression in children and young people.

Staff members monitored young people's physical health care on admission and throughout their episode of care and treatment. The specialist doctor monitored physical health care.

The staff teams monitored the effectiveness of care and treatment and used findings to improve them. The service ensured analysis of outcome measures to inform service development. Staff used recognised rating scales to assess and record severity and outcomes, for example Health of the Nation Outcome Scales (HoNOS) and Children's Global Assessment Scale (CGAS). These were evident on both Banksy and Brunel ward. Staff spoken with felt it was a useful measure of how the young people felt they benefitted from the care and treatment they received whilst on the wards.

Staff ensured young people had care plans in relation to their food and hydration needs.

Clinical staff in both teams participated in a variety of clinical audits. For example, they completed audits on care plans, medication errors and self-harm.

### Skilled staff to deliver care

The multi-disciplinary team comprised of skilled and qualified consultants, junior doctors, nurses, nursing

assistants, family therapists, occupational therapists, psychologists, healthcare assistants and pharmacists. Staff said they mostly worked well together. But within the multidisciplinary team (MDT) there were some tensions and poor communication between staff. Staff also spoke of tensions on the ward after the morning MDT meeting when information about the new plans for the young people was not communicated quickly and led to inconsistent care. Some staff spoke of feeling undermined.

All staff including agency staff were required to undertake the induction for new starters as well as a local ward-based induction process. Ward managers told us that all staff, including bank staff and volunteers, received an induction and training when joining the service.

Staff on both wards had received training in working with challenging behaviour. They also had weekly skill set meetings/reflective practice where training was delivered. This covered a range of areas, such as risk assessments and care planning or any area staff wanted to have more information.

The managers provided staff with regular appraisals and managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development). In teams clinical and managerial supervision was combined. At the time of inspection, the rate of supervision and appraisal for the wards was on average around 75%.

The consultant supervised the junior doctor monthly. They told us they found this useful.

The managers across all teams ensured that staff had access to regular team meetings, morning briefing meetings, skill sets and handovers to share information and develop learning.

**Multidisciplinary and interagency team work**

There were a variety of multidisciplinary team meetings (MDT). There were weekly multidisciplinary meetings which nurses, consultant psychiatrists, psychologist, family therapists, occupational therapists, and social workers attended. There was also the ward round with consultant psychiatrist and/or junior or doctor, family therapist's social worker. In addition, there was a weekly risk meeting to discuss incidents.

We observed an MDT meeting. Young people were invited into the meeting after the team members had discussed the young person's current treatment plan and risks. Discussions included the young person's capacity to make decisions, the involvement of other agencies and services and service such as family therapy that the team could offer. Decisions were then made collaboratively with the young person.

However, staff were mixed about communication in these meetings. A variety of staff expressed concerns. Staff in focus groups felt communication between the MDT and the nursing staff needed improving. Liaison with outside services like community team and schools was good, they had developed relationships with the eating disorder services.

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

In 2018, overall 91% of the workforce had received training in the Mental Health Act (1983).

Staff members understood their roles and responsibilities under the Mental Health Act (1983) Code of Practice (2015). We reviewed Mental Health Act paperwork for young people on both wards and found most of them to be in order and stored so they were accessible to all staff who required them. We saw evidence of audits taking place of the paperwork on all wards, and these were effective in most cases. For example, young people were regularly informed of their rights and any leave was actioned and recorded appropriately.

**Good practice in applying the Mental Capacity Act**

Staff members understood their roles and responsibilities under the Mental Capacity Act (2005). In the files we reviewed, there was evidence of consideration of capacity and consent where this was appropriate. Staff ensured young people gave consent to treatment and this was recorded in their records.

Mental Capacity Act (2005) training took place at induction and was ongoing throughout the year. The figures for staff attending the training was 91%. There was a Mental Capacity Act policy and staff knew who to approach if they needed support or advice. Staff discussed young people's mental capacity at the multidisciplinary meetings.

All young people had mental capacity assessments and there was evidence of best interest decisions in the event of a young person lacking capacity to make a decision about their care and treatment.

Good

# Child and adolescent mental health wards

All staff were booked to receive training in Gillick competencies in the next two months, and staff awareness on the ward was improving. Gillick competence is a term used in medical law to decide whether a child (under 16 years of age) is able to consent to their own medical treatment, without the need for parental permission.

## Are child and adolescent mental health wards caring?

Good

### Kindness, privacy, dignity, respect, compassion and support

Staff members cared for the children and young people with compassion. All the interactions we saw between them and the staff members were kind, respectful and showed an understanding of the young people's needs. For example, they created 'do's and don'ts' posters that outlined things that staff and other young people could avoid doing or saying to prevent upset. For example, not discussing diets in front of the young people.

All young people or carers we spoke with said staff listened to them and were supportive and caring. The majority of young people gave us positive feedback about the staff teams.

The teams respected the young people's confidentiality, they had soundproofing in interview rooms and used lockable bags to carry any information outside the office.

### Involvement in care

Staff members involved young people and those close to them in decisions about their care and treatment. The staff team ensured young people were involved in their care planning, risk assessments and decisions about their care. All young people spoken with told us staff members described treatment options and gave them choices. Staff involved young people in care planning and risk assessment. We saw evidence of their voice, wishes and goals in the care plans and risk assessments.

If a young person requested a change to their care, this was discussed by the multidisciplinary team as part of the ward round, before inviting the young person into the meeting to discuss. We saw decisions were made collaboratively with the young person with clinicians explaining carefully each option they had and the reasons why they thought a particular course of treatment was in their best interests.

Staff encouraged young people to give feedback on the service in the weekly community meeting. The young people's survey was very accessible as it was in pictorial form with happy faces and sad faces. The results of the survey were written up into a report and informed the "you said we did" board. The young people fed back concerns about the food and the service changed parts of the menu to include more yoghurts and fruit.

Young people had access to advocacy services. There was evidence in all care files that staff regularly discussed and arranged an advocate for them.

Young people were involved with the recruitment of staff in all teams. They formed part of the recruitment process for new clinical staff in 2018.

Staff encouraged young people to attend their review meetings and staff met with them to design a care plan together. The majority spoken with said they attended reviews. All young people had copies of their care plan. Both young people and staff were positive about their collaborative approach.

There were regular visits by the Independent Mental Health Advocate (IMHA). We saw posters displayed across the hospital advertising advocacy services.

Staff members involved families in the care of the young people as appropriate. For example, family members we spoke with said staff involved them in the care and treatment of their relative. Young people told us they felt included in the decision-making process. The manager phoned them after any incident or change to the young person's care and treatment. The psychologist was starting a weekly carers group that carers said they would find useful.

Good

# Child and adolescent mental health wards

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

Good

**Access and discharge**

The wards took referrals from anywhere in the country so did not have a catchment area. Occupancy rates were 79% on Banksy ward and 98% on Brunel ward. The average length of stay on Banksy ward was 64 days and 131 days on Brunel ward in the twelve months up to July 2018. Leaders were mindful of the complexities of the young people on the wards and took this into account when considering new admissions.

There was one young person experiencing a delayed discharge on Brunel ward and two on Banksy wards. The young people on Banksy ward were awaiting placements. These included being on the waiting list for low secure accommodation. Staff at Banksy ward were proud that the majority of young people were discharged home from the ward.

The ward manager and members of the multidisciplinary team met regularly and focused around barriers to discharge and what actions could be taken to reduce these. This helped staff identify and remove barriers to discharge.

Staff worked closely with community teams to facilitate discharge. For example, the social worker for the wards attended the MDT meeting and worked with community teams to offer ongoing support.

Staff supported young people during referrals and transfers between services.

Staff planned together with young people for their discharge following their admission to the wards.

Staff told us that accessing the psychiatric intensive care unit was not difficult. The Brunel manager that they managed acutely unwell young people without transfer to the psychiatric intensive care unit so transfer was rare.

**Facilities that promote comfort, dignity and privacy**

Young people could personalise bedrooms. For example, they displayed posters they had made.

Staff and young people had access to a range of rooms and facilities to support the treatment and care being provided across the wards, such as clinic rooms, meeting rooms, activity rooms, communal areas and gardens. All wards had designated treatment rooms, lounges and chill-out rooms to support young people to relax

Both wards had access to quiet family and visiting rooms to ensure that young people maintained relationships with family, children and friends.

The wards had good occupational therapy input. They offered daily schedules of activities on and off the ward. These included art, cookery, exercise games, and mindfulness. On both wards young people only had activities scheduled from Monday to Friday and decided their own weekend activities with the support of staff. The occupational therapist and psychologists had developed an imaginative and flexible programme to suit the individual needs of the young people. For example, they had identified that the needs of young men, who were often in the minority, were not fully met as there was no gym. They investigated an outdoor activity programme with boxing exercises and looked into utilising boxing opportunities in the community. One described the activities as 'brilliant' with the staff trying to get them off the ward as much as possible

Staff ensured that young people had access to education, and these were tailored to the interests of the young person. These were either on the ward or in the educational site. Young people spoke positively of the way the teachers supported them individually or in groups.

Young people did not have access to their mobile phones. However, the staff were trialling the use of phones without internet access in accordance with individual risk assessments. Wards provided private space where young people could make private telephone calls if required.

Young people generally told us that the food was good and they could make hot drinks and have snacks day and night. Food was cooked fresh on site each day. There was always a vegetarian choice.

The team helped children and young people to access employment, and training opportunities. They supported young people, particularly those out of area, to maintain contact with families and friends. The education team had

strong links with the young people's schools in the community. Young people we spoke with were very positive about the way the team enabled them to maintain these links.

**Meeting the needs of all people who use the service**

Both wards were on ground floor for wheelchair access and had adapted bedrooms.

The waiting areas and corridors in the wards contained information leaflets about local services and medication. Information leaflets about the service were not provided in a range of formats, but they could be accessed on request. Information included how to access counselling and substance misuse services, contact advocacy and how to make a complaint.

Staff had access to interpreters and were currently using one to assist them communicate with a young person.

Children and young people had access to a wide range of food to meet their spiritual and cultural needs. For example, halal food was readily available.

In Banksy ward there was a multi faith room for the children and young people to use alone or with their families and carers.

**Listening to and learning from concerns and complaints**

The two wards received four complaints in 2018. One of these was not upheld, two were partially upheld and one was under investigation. None were referred to the Ombudsman.

All staff treated concerns and complaints seriously, investigated them and learnt lessons from the outcomes. The theme of the majority of complaints were from carers around communication between staff and carers. The manager phoned carers to discuss their concerns. These were addressed with the staff involved. Young people reported they were happy with the outcomes.

In addition, a carer group was being set up so carers could raise any concerns directly with the staff. Any formal complaints about the service management were dealt with and investigated by the managers or with support from the senior management team.

Staff told us they spoke about how to make a complaint at their first meeting with a young person. Information on how to make a complaint was displayed in all the waiting rooms. This included information about the role of independent advocacy in complaints. Young people and carers told us they knew how to complain and were confident that the staff would act upon them.

Learning from complaints was shared at monthly governance meetings and at weekly reflective learning forums, team meetings and handovers.

The staff team on Banksy and Brunel ward received 58 compliments during the last 12 months up to July 2018. The compliments were mostly about staff kindness.

## Are child and adolescent mental health wards well-led?

Good

**Leadership**

The ward managers and the senior leadership team had relevant experience to carry out their role. They provided clear leadership and staff members were confident in their ability to provide an environment where safe care and treatment could be safely delivered to the young people

The teams knew who the senior managers in the service were, and told us that they visited the teams. All staff spoke positively about the increased presence of senior managers and welcomed their visits.

There were leadership training opportunities for the staff members to develop their skills as managers. For example, one ward manager was in an acting up role.

**Vision and strategy**

All staff knew and understood the service visions and values and applied them to their work. Staff spoke positively about senior management in the service. Staff from both wards gave feedback about services at team business meetings.

Staff could explain how they were working to deliver high quality care within the budgets available. All managers completed a benchmarking document (a document that compared their performance with other teams in terms of waiting times, outcomes and discharge) for both the service and commissioners.

Good

# Child and adolescent mental health wards

**Culture**

All the staff we spoke with felt positive about working for the service. They could approach managers without concern. Staff morale was good in the teams although they stated they often felt understaffed. However, they were confident that the leadership team was doing everything it could to employ new staff. Agency staff at focus groups, who had worked there since the ward opened, felt integrated in to the team.

Other staff spoke of the high levels of violence and racial harassment they suffered from the young people and the detrimental effect on their wellbeing. Staff felt the aftercare could be improved when they were on sick leave following these incidents.

Following the focus groups, the managers had agreed a new system where information from MDT meetings was relayed directly to the staff on duty. They said they would consider ways they could work with the staff and young people to address potential racial abuse on the wards.

Staff spoke very positively about the supportive and innovative teamwork within their teams. They were positive about the culture and were positive about the impact of the service manager and managers who worked hard with the teams to set up and develop the new service. Staff members in the focus group stated they valued the support from the managers, the employee of the month schemes and the reflective practice sessions. Young people were very positive about the wards and called them a place of hope.

Staff were proud about the work they did. Staff felt that the organisation listened to and acted upon ideas like the introduction of the new care plans.

In the last year there were no cases where staff were suspended, or placed under supervision. The manager stated they received good support from the human resources team. Some staff felt the aftercare service could be improved if they were off work through injury. Staff gave us several examples where they had been supported to move to other teams if they decided working on the children and young people's wards was not for them.

All staff told us there was not overall a bullying culture in any of the teams. They knew how to raise concerns without fear of victimisation and knew how to use the whistle-blowing process if they had concerns. Staff gave us examples when they had used the whistleblowing process.

The managers ensured staff were competent for their roles. Staff members received sufficient regular one to one managerial supervision to assist them to provide care and treat young people safely.

**Governance**

The governance systems were sufficient to ensure the safe care and treatment of the children and young people.

Both wards had introduced systems to check the team's performance and make changes when necessary. Staff had implemented recommendations from reviews of deaths, complaints, and safeguarding alerts. They undertook or participated in audits, such as care plan audits, and acted on the results when needed. They understood arrangements for working with other teams, both within the provider and externally, to meet the needs of the young people.

Senior managers had systems to ensure that staff complied with mandatory training and attended clinical supervision and annual appraisals. They monitored complaints and incidents across the service and these were investigated where appropriate.

The wards were all reliant on the continued use of locum agency staff. The provider had ongoing recruitment campaigns to bring in more staff, and at the time of the inspection all support worker posts had been filled. All locum staff were familiar with the wards, having worked there before. They were also able to access the same support as permanent staff.

The managers of the three wards said they had enough time and autonomy to manage effectively.

The managers had the support of a ward clerk. Both managers stated they would welcome additional time and this was being reviewed by the service.

Regular team meetings were held allowing staff discuss concerns, participate in educational or clinical supervision, debrief following incidents and to learn from the issues.

**Management of risk, issues and performance**

Good

# Child and adolescent mental health wards

The service had a clear system for identifying risks. The service kept a risk register on the electronic reporting system. The ward managers could escalate risks to the risk register. Staff spoken with were aware of what they had on the risk register and what the service had in place to address the risk. For example, staffing in both wards were on the register and there was a plan in place to address this.

All staff were trained in clinical risk and use of the electronic reporting system. The service had plans for emergencies such as adverse weather which were known to all the team.

Overall staff were very positive about the organisation and in relation to their ownership of the risk register. They had confidence in the senior team to address risks.

The service had a systematic approach to continually improving the overall quality of its service. Both the team managers and the service managers could access a business performance report on the electronic system. These were shown to us at the inspection and discussed in staff meetings.

Staff completed data from the wards for their own governance groups, to monitor the work they did and implement change, and for commissioners. There was a governance framework for the analysis and monitoring of information management across the service.

All staff members completed information governance training as part of their mandatory training.

Young people's records were confidential and required information system logins. Some staff did not have access to these records but this was rectified at the inspection.

The ward managers had access to systems to support them in their management role such as staff performance and absence figures.

Staff made notifications to external bodies when necessary and these were logged and monitored by governance groups.

**Engagement**

The teams engaged well with young people and their families. They listened to feedback from the young people, and made changes as a result. For example, following feedback from the community meeting they recently ordered new equipment for the garden, made contact with boxing clubs and extended their outdoor programme.

The service used surveys, community meetings, one to one meetings and the complaints procedure as formats to pick up the young people's experience of the service. For example, staff ensured young people's cultural food needs were met by meeting with the catering managers and cook to devise the menu.

**Learning, continuous improvement and innovation**

The service was new and had not been awarded an accreditation. The service was not undertaking any research or involved in any innovative practice.

Good

# Specialist eating disorder services

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

## Are specialist eating disorder services safe?

Good

### Safe and clean environment

Staff completed environmental risk assessments. These were reviewed every six months, or more frequently as appropriate. Where staff could not see all parts of the ward due to the layout, there were convex mirrors to mitigate any risks. There were potential ligature risks (places where a cord or rope could be tied for self-harm or strangulation) on the ward. These were on the ward risk register. Staff were aware of the risks, and mitigated against these by ensuring all patients were thoroughly risk assessed for access to each patient area. The ward also did not admit people assessed as a high risk of suicide. If the risk increased the team would consider whether a referral to an acute ward would be more appropriate.

The ward admitted both males and females, although there were only females on the ward at the time of the inspection. The ward complied with Department of Health guidance on eliminating mixed-sex accommodation.

Ward areas were clean with good furnishings. There were some maintenance problems with the showers, and some patients had needed to use other patients' showers due to theirs not working. This had been reported to maintenance but patients told us this had not yet been resolved.

Staff adhered to infection control procedures, including handwashing.

The ward did not have a seclusion room.

Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff maintained equipment well and kept it clean.

### Safe staffing

Managers calculated the number and grade of nurses and healthcare assistants required using a provider-wide safer staffing 'ladder'. This took into account the number and complexity of patients (for example those who needed one to one support) and identified how many staff and of what grade were needed. The ward manager regularly monitored and reviewed staffing levels.

In the past year, nine staff members had left, an equivalent of almost half of the staffing team. Of those staff who left, a number had left to access additional training and career progression. Some of those staff had since returned to the ward to work bank shifts. No concerns were raised about working conditions from those who left the ward, and this was supported by the staff members who had returned to work bank shifts on the ward. The ward had 3.8 full time equivalent nurses with 1.5 full time equivalent vacancies, and 10.9 full time equivalent health care assistants, with 2.4 full time equivalent vacancies.

During the inspection, we were given updated staffing information to show that the healthcare assistant vacancies had been filled, with the service recruiting more staff than vacancies, allowing for extra staff to cover sickness or leave.

The ward manager adjusted staffing levels to take into account the needs on the ward. When needed, the manager used agency and bank staff to maintain safe staffing levels.

The same agency staff were used regularly, and had access to the same induction, training and supervision as permanent employees, and so were able to provide consistent care despite not being permanent staff members.

The ward manager worked a clinical shift on the ward once a week so she could maintain her clinical skills. This also helped to monitor the ward environment and oversee the staff.

A qualified nurse was present on the ward at all times.

Staffing levels allowed patients to have regular one to one time with staff. Staff would stop what they were doing to put the patients first when appropriate and safe to do so.

There were enough staff to carry out physical interventions (such as observation and restraint) safely, and staff had been trained to do so. Restraint was used rarely on the ward.

There was sufficient medical cover for the ward day and night, and a doctor could attend the ward quickly in an emergency. The ward had a locum full time consultant and a part time staff grade doctor (four days per week), with resident medical officer (RMO) cover out of hours. Senior managers were in the process of recruiting a permanent consultant after having had different locum consultants over the previous few months.

Staff had received and were up to date with appropriate mandatory training.

**Assessing and managing risk to patients and staff**

We looked at seven patient records, all of which had thorough and up to date risk assessments. Staff completed a risk assessment of every patient on admission and updated this regularly, including after any incidents or significant change. Staff used a standard risk assessment used across all the provider services.

Staff carried out risk assessments before any leave took place. Patients completed a contract with the ward, and a mini mental state examination (MMSE) was carried out. Patients who went on home leave had a crisis plan in case of difficulties while away from the ward.

Staff followed policies and procedures for use of observation (including to minimise risk from potential ligature points) and for searching patients. A healthcare assistant took overall responsibility for security on each shift. Staff applied restrictions on patients' freedom in line with their treatment plan, although patients did not always feel that this was fully explained to them. The ward had clear notices of banned and restricted items, and included this information in patient welcome packs.

The ward had implemented a smoke free policy from January 2019 and were working with patients to ensure this was effective. Patients were offered nicotine replacement therapy. Two staff were smoking cessation leads on the ward. Patients whose section 17 leave (permission to leave hospital while detained under the Mental Health Act 1983) had been restricted or withdrawn, and were unable to leave the grounds to smoke or use vapes, found this particularly difficult.

Staff restricted leave if there were concerns for the individual patients' physical health and general wellbeing. Patients raised concerns about the process for withdrawing section 17 leave. They felt that the decision to grant leave was more focused on whether they had met weight targets than whether it was beneficial for them to leave the ward. Any restrictions were discussed with patients.

Informal patients could leave at will. There was a sign by the ward exit letting patients know this. A contract had also been drawn up with an informal patient to let them know their rights and expectations while on the ward. This was in response to a complaint related to informal patients not knowing their rights.

Restraint was used only after de-escalation had failed as a last resort. When this was used, it was done to prevent self-harm or for forced nasogastric (NG) feeding. In the three months before the inspection, restraint was used on three occasions, for NG feeding and when a patient was self harming to prevent them from further injury.

When used for NG feeding, the restraint was assessed as a planned intervention, using appropriate techniques. The ward had a specific feeding room that was used for this purpose. Staff did not use prone restraint.

Staff used rapid tranquilisation on occasions and followed National Institute for Health and Care Excellence (NICE) guidelines. There was a rapid tranquilisation policy in place and monitoring forms were added to observation records to ensure appropriate recording and follow up checks following pharmacy guidance.

**Safeguarding**

Good

# Specialist eating disorder services

Staff were trained in safeguarding and knew how to identify adults and children at risk of, or experiencing abuse. Staff raised any concerns with one of the safeguarding leads for guidance (one of whom was the ward manager). They made referrals to the local authority when appropriate, with support from one of the leads if needed.

Staff followed safe procedures for visiting children. No children under 16 were permitted on the ward, a separate area in the main hospital was used for these visits.

**Staff access to essential information**

Staff used a combination of paper and electronic records, with master copies of all paperwork stored on the electronic system. All information needed to deliver patient care was available in an accessible format to relevant staff (including agency staff who had logins to the system) when they needed it. However, we did speak with a recently employed member of staff who did not yet have access to the computer system.

**Medicines management**

Staff followed good practice in medicines management (transport, storage, dispensing, administration, medicines reconciliation, recording, disposal). A nurse on each shift took overall responsibility for medicines management. The ward manager and pharmacist assessed and signed off as competent all staff working with medicines, working to the Nursing and Midwifery Council (NMC) Code of Conduct for medicines. The ward manager audited medicines on a weekly basis. A pharmacist also visited the ward regularly to audit medicines and had oversight of all medicines on the ward.

**Track record on safety**

There were 108 incidents on the ward in the past year, 81 of which were minor and 11 moderate, with 16 incidents recorded as serious.

The ward was able to demonstrate their process for investigating and responding to incidents, including highlighting good practice, lessons learnt, and an action plan for putting lessons learnt into practice.

Staff completed incident reports on an electronic system, documenting the incident in patient records, and completing a serious incident initial investigation within 24 hours. The ward then completed further 72 hours documentation and a team incident review form. Staff and patients were de-briefed and the relevant external agencies notified. All serious incidents were reviewed at a monthly meeting and learning shared with all services in the hospital.

**Reporting incidents and learning from when things go wrong**

Staff knew what incidents to report and how to report them.

There were systems in place to ensure staff had feedback from investigation of incidents, both internal and external to the service. Managers brought information from hospital flash meetings, monthly incident review meetings and lessons learnt notifications, which they shared with staff, either in team meetings or through team group chats.

There was evidence on the ward where changes had been made because of feedback. For example, staff received additional training in their induction around infection control safety following an incident on the ward.

Staff were debriefed and received support after any incidents on the ward.

## Are specialist eating disorder services effective?

(for example, treatment is effective)

Good

**Assessment of needs and planning of care**

We looked at seven care records on the ward and found these to be of a good standard. Staff completed a comprehensive mental and physical health assessment of the patient in a timely manner at, or soon after admission.

Staff developed thorough care plans that met the needs identified during assessment. They were personalised, holistic and recovery orientated, with a clear focus on the patient's own goals and outcomes. The service aimed to encourage a culture of encouragement rather than punishment for not meeting targets. Weight targets were agreed through discussion and negotiation with the patient. However, patients did not all feel this was the case, and felt that some members of the multidisciplinary team were too focused on a rigid target weight gain as a measure of success.

Good

# Specialist eating disorder services

Staff checked patients' physical health on admission and on an ongoing basis, using the Modified Early Warning System (MEWS) tool to monitor and record patient health. All physical observations were checked and recorded on an ongoing basis to ensure staff could identify any deteriorations in physical health. Staff repeated this daily or more frequently as needed in line with any increased concerns or deterioration in the patient's health.

Staff updated care plans regularly to reflect any changes in needs or circumstances.

**Best practice in treatment and care**

Staff provided a range of care and treatment interventions suitable for the patient group. The interventions included those recommended by and delivered in line with guidance from the National Institute for Health and Care Excellence (NICE). This included the use of Maudsley Anorexia Nervosa Treatment for Adults (MANTRA, a specialist eating disorders therapy programme), regular assessment and monitoring of physical health (with patients having physical observations at least twice daily), and patients having at least once weekly one to one psychological therapy sessions.

Staff ensured that patients had good access to physical healthcare and ongoing monitoring of health to ensure any deterioration was identified and followed up. There was a focus on supporting patients to live healthier lives, through dietary advice and guidance and smoking cessation schemes for example.

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

Staff were involved in ongoing clinical audit, and quality improvement schemes such as the Quality Network for Eating Disorders (QED) accreditation scheme.

The ward manager encouraged positive risk taking. While the ward had a list of banned and restricted items, they reviewed this regularly. Sweeteners were recently reintroduced as an item that patients could access with monitoring from staff after previously being a banned item. This was seen as a less restrictive alternative that enabled staff to support patients with appropriate use of sweeteners while giving them an increased dietary choice.

**Skilled staff to deliver care**

The team included the range of specialists required to meet the needs of patients on the ward. There was a full-time consultant and a part time staff grade doctor, a part time dietician, registered mental health and general nurses, an occupational therapist, two part-time psychologists and an assistant psychologist, alongside a range of healthcare assistants. The ward also had access to a social worker one day per week.

The therapists had a range of specialisms including body image therapy and cognitive behavioural therapy (CBT). Healthcare assistants on the ward also included psychology students, and a third-year student nurse in training. The ward also had one nurse prescriber. There was no ward clerk at the time of the inspection.

Managers ensured new staff had induction, supervision and appraisal of their work. The ward manager ensured that staff had access to monthly team meetings. This included agency staff, who had access to the same support as permanent staff members. Supervision was given through monthly one to one clinical supervision and group supervision and reflection. Staff attended quality improvement meetings, and the ward had a recent away day.

Each staff member had an allocated supervisor, and was given guidance around the expectations and responsibilities around supervision, as well as a supervision contract. Staff had supervision with their allocated supervisor when they worked a shift with them, and rosters were completed to facilitate this. Staff told us this didn't always work well if the shift was particularly busy and they sometimes had difficulty fitting this in at the planned times. However, at the time of the inspection all staff were up to date with their supervision. Staff also had annual appraisals, which the ward manager used to identify the learning needs of staff, and provide them with opportunities to develop their skills and knowledge. They met with each staff member to discuss their future goals and career path. Some staff had gone on to undertake their nursing training.

The ward manager ensured that staff received the necessary specialist training for their roles. All staff on the ward had access to specialist eating disorder training, some of which was provided by the ward manager on a rolling basis to ensure all staff were able to attend.

Five of the seven nurses on the ward had been trained and assessed as competent in the insertion of and feeding by nasogastric (NG) tube. The remaining two nurses were due to complete this training at the end of February.

Staff also had access to a six week face to face specialist eating disorders course. Four nurses on the ward and half of the healthcare assistants had completed this specialist training. Further training was booked for April 2019 when the remaining three nurses, who were more recent employees, would be attending.

There was a file on the ward with up-to-date research and evidence based practice examples which staff were encouraged to read.

There was a clear process for responding to any performance issues, and the manager was able to evidence how previous issues had been dealt with appropriately and efficiently.

**Multidisciplinary and interagency team work**

Staff held regular and effective multi-disciplinary meetings. They shared information about patients at handover meetings within the team (for example, between shifts). A handover sheet with key information was also prepared for each patient as part of this process.

The team had effective working relationships with other teams both within and outside the organisation. They involved care coordinators in care planning meetings and discharge planning, and sought advice from external agencies such as the local authority safeguarding team as appropriate.

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

Staff had training in the Mental Health Act as part of their induction to the service, and had a basic understanding of the Mental Health Act, the Code of Practice and the guiding principles. Staff felt they had sufficient understanding of the Mental Health Act to carry out their roles effectively.

Staff had access to support and advice on implementation of the Mental Health Act (1983) and its Code of Practice. Staff sought support from the ward manager or other senior staff and the Mental Health Act administrator as needed.

Staff had access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had access to information about independent mental health advocacy. This information was given as part of the welcome pack to the ward, and was displayed in communal ward areas. An independent mental health advocate (IMHA) visited the ward regularly.

Patient rights under the Mental Health Act (1983) were presented and explained and repeated. However, this was not always recorded. Staff carried out regular audits to ensure patients were told their rights. We found some records where this had not been consistently done.

Staff ensured that patients could take Section 17 leave (permission for patients to leave hospital) when this had been granted. There were times when the right to take Section 17 leave had been rescinded. Patients told us the reason behind this was not always clear, and they were concerned that decisions were made on the basis of weight targets, rather than overall benefits of accessing leave. Staff risk assessed all Section 17 leave on an individual basis and discussed this with patients.

Staff stored copies of patients' detention papers and associated records correctly so that they were available to all staff that needed access to them.

The service displayed a notice to tell informal patients that they could leave the ward freely. We also saw a contract that had been drawn up with an informal patient to clarify what the expectations were on the ward and what their rights were as an informal patient.

**Good practice in applying the Mental Capacity Act**

Staff were trained in the Mental Capacity Act (2005) through e-learning (online training) as part of their induction. Some staff were confused about the interface between the Mental Health Act (1983) and the Mental Capacity Act (2005). They were unclear about how the Mental Capacity Act needed to be put into practice, and what their role was in applying this.

There were no deprivation of liberty safeguards applications made on the ward in the 12 months before the inspection. However, the ward manager was clear on the processes and responsibilities if an application needed to be made.

Good

# Specialist eating disorder services

The provider had a policy on the Mental Capacity Act (2005) including deprivation of liberty safeguards, which staff were aware of and could access through the intranet. Staff knew where to get advice from regarding the Mental Capacity Act (2005).

If staff were uncertain about a patient's mental capacity they would seek advice from either the ward manager or the consultant.

Mental capacity to consent to treatment was assessed and recorded on care records by the consultant. The multidisciplinary team reviewed this at each ward round, and more frequently if needed.

We did not see evidence in the care records of consideration of whether a mental capacity assessment or best interest decision was needed for patients who may have lacked capacity to make decisions other than consent to treatment.

## Are specialist eating disorder services caring?

Good

### Kindness, privacy, dignity, respect, compassion and support

Staff attitudes and behaviours when interacting with patients were discreet, respectful and responsive. Staff gave patients help, emotional support and advice at the time they needed it. Patients were generally complimentary about the support they received from staff and said that staff treated them well. Patients felt they could trust staff they worked with regularly and that they had built a good rapport with appropriate boundaries.

Patients also felt that staff advocated well for them when they needed this support.

There were however some concerns raised by patients about feeling as if Section 17 leave was withdrawn due to not meeting expected weight outcomes. This led to some patients feeling that their physical health needs related to their eating disorder were given priority over their emotional and other needs. Staff made decisions about Section 17 leave on the basis of individual risks related to patients' physical and emotional wellbeing.

Staff generally understood the individual needs of patients, including their personal, cultural, social and religious needs. Some staff showed a clear understanding of the impact of past experiences on current care needs, and could demonstrate how they took this into account while caring for patients. For example, they were mindful of past experiences of trauma and how this could affect a person who is being restrained for feeding.

### Involvement in care

Staff used the admission process to inform and orientate patients to the ward and to the service. All patients were given a welcome pack and shown around the ward. The welcome pack included the ward aims and philosophy, what to expect, family and carer support, and a list of banned and restricted items, as well as information on how to complain and how to access advocacy support.

Staff involved patients in care planning and risk assessment. We saw evidence of patient voice, wishes and goals in the care plans and risk assessments.

If a patient requested a change to their care, this would be discussed by the multidisciplinary team as part of the ward round, before inviting the patient into the meeting to discuss. Patients told us they felt decisions were made before they joined the meeting.

Staff enabled patients to give feedback on the service they received through feedback questionnaires, community meetings and one to one sessions.

Staff enabled patients to make advance decisions about their care. We saw evidence of these discussions and how people wanted their care needs to be met in the care plans.

Staff ensured that patients could access advocacy support if they wished to do so.

The ward had a carers education group programme but this was not running at the time of the inspection due to the staff member being on extended leave. However, there were plans for this to start up again.

There were plans for a member of staff on the ward to become an allocated carer's lead and for families to be invited into the ward for education sessions.

Good

# Specialist eating disorder services

Carers were invited to care reviews and their needs included in patient care plans. However, we were given feedback on inspection that communication with carers was not always effective, and some carers felt they were not fully included as part of the care team.

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

(for example, to feedback?)

Good

### Access and discharge

The ward frequently admitted out of area patients due to the specialist nature of the service and lack of similar units in different areas of the country. The ward was mindful of this and tried to limit the number of out of area patients where possible.

The referral process had changed in recent months, to a more central system where all specialist eating disorder referrals were received and triaged at a central point, before making direct referrals to the ward. This meant the ward had less oversight and input into the triage and assessment process of patients and there was a greater risk of inappropriately placed patients on the ward.

The ward also received private referrals.

The ward had formal exclusion criterion for people who were at high risk of ligatures and self-harm due to the environmental risks on the ward. Referrers were aware of these criteria.

The ward was able to refuse new admissions when appropriate to do so. We were given an example of a male patient being on the waiting list for admission. Due to the need to give him a bedroom away from the female patients, the ward delayed the admission as this bed was occupied by an unwell female patient. It was felt that moving this patient against her wishes would be more harmful than the male patient waiting for a brief period of time before admission. However, the male patient was monitored to ensure that if his presentation deteriorated and he needed a more urgent admission, this may need to outweigh the female patient's wishes.

There was always a bed available for patients on their return from leave.

Patients were not moved to alternative wards or hospitals during an admission episode unless it was justified on clinical grounds and in the interests of the patient.

When patients were discharged, this happened at an appropriate time of day.

In the year before the inspection, the average length of stay was 96 days. Any delayed discharges were generally due to looking for alternative accommodation or placements on discharge.

Staff planned for patients' discharge, including good liaison with care coordinators.

### Facilities that promote comfort, dignity and privacy

Patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. They had access to their bedrooms during the day. The rooms were only locked if patients were on leave or if there was a serious risk to their physical health. Patients could have a key to their room if they wished.

Patients could personalise their bedrooms. Bathroom doors in the rooms were sometimes locked as part of a care planned intervention due to concerns around purging behaviour.

Staff and patients had access to a range of rooms and equipment to support treatment and care, including clinic and treatment rooms, and therapy rooms. There were quiet areas on the ward and a room where patients could meet visitors. Patients could make a phone call in private, and were able to use their own mobile phones to do so. Patients could also use their phones for the internet, however, the reception in the ward was poor, and patients either had to go to the main building for a slightly better Wi-Fi connection, or use their own personal phone data allowances.

Patients had access to outside space, but had to leave the upper floor ward to access this.

The food was of a good quality and patients could access foods for specialist dietary requirements. However, the correct food choices were not always brought from the main kitchen and some people we spoke with were concerned that their specific dietary needs were not catered for or considered. Patients would have their meals

brought up to the ward where they would eat in the ward kitchen and dining room under supervision. Later in their admission patients could go to the kitchen in the main hospital for their food.

Patients could use the ward kitchen for drinks. Snacks were available at set times as part of specialist meal plans. The main fridge was locked during the day to enable close monitoring of meals and snacks, but patients had access to a patient fridge for drinks.

Staff ensured that patients had access to education and work opportunities. Patients on the ward had been supported to attend university or college during their admission.

Staff supported patients to maintain contact with their families and carers. However, some patients (particularly those placed out of area) found it harder to stay in touch with their families when they were unable to use information technology to do so (via skype or facetime) due to the poor internet connection on the ward.

**Meeting the needs of all people who use the service**

The service made adjustments for disabled patients. They had an accessible bedroom for patients who had mobility problems, and would refer to the ward occupational therapist or the hospital physiotherapist based in the rehabilitation wards for any equipment needs.

Staff ensured patients could obtain information on treatments, local services, patients' rights, how to complain and so on. Each patient had a welcome pack with information and access to an advocate who visited the ward regularly.

The ward could access information leaflets in other languages or in easy read format if this was needed, and had access to interpreters or signers if this was needed.

Patients had a choice of food to meet the dietary requirements of religious and ethnic groups within the confines of their specific eating plan.

Staff ensured that patients had access to appropriate spiritual support on the hospital site.

**Listening to and learning from concerns and complaints**

Patients knew how to complain or raise concerns. All patients were given this information as part of their welcome pack on arrival at the ward and there were notices on display on the ward telling people how to complain. There was also the opportunity for patients to raise any concerns or complaints through the community meetings held on the ward.

In the year before the inspection, there were five reported complaints against the service, one of which was partially upheld. No complaints were referred to the Ombudsman. The ward also received 30 compliments.

Staff received feedback on the outcome of investigations of complaints and acted on the findings.

## Are specialist eating disorder services well-led?

Good

**Leadership**

Leaders had the skills, knowledge and experience to perform their roles. Staff and patients were confident in the ward manager. They had a clear understanding of the service, and could explain how the team was working to provide high quality care. However, some patients raised concerns as to whether all senior members of the multidisciplinary team had the background knowledge in eating disorders to effectively support and meet their holistic needs.

Leaders were visible in the service and approachable for both patients and staff. Staff felt that the ward manager was the person who held the team together. Senior managers had visited the ward, and the ward manager worked a clinical shift on a weekly basis to keep in touch with the ward team and dynamics, as well as ensuring up to date and current clinical skills and practice.

Leadership development opportunities were available for staff who wished to progress within the service.

**Vision and strategy**

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 and the ward manager had successfully communicated the provider's vision and values to the frontline staff. The team felt the visions and values represented how they were working.

Good

# Specialist eating disorder services

The team had their own vision of how they worked, aiming to promote the best possible outcomes for patients, to work with them as a team, encouraging and supporting positive risk taking, and promoting a life for patients outside of their eating disorder.

**Culture**

Staff felt respected, supported and valued by the ward management. They were proud to work in the team and felt positive about their work and the support they gave patients. It was important to the team to feel they were doing a good job, and they were keen to show us this. Staff described themselves as a happy and strong staff team, who could manage the stress of the job within their team, despite working in a complex and specialist environment.

Staff felt able to raise concerns without fear of consequences. They knew of the whistleblowing process and how to use this.

Staff appraisals included a focus on career paths and aspirations. The ward manager was keen to ensure that all staff had a designated career path to work towards, and supported staff development wherever possible.

The provider recognised staff success within the service through star awards, nominated by other staff members or by patients. The awards were based on how staff had demonstrated the provider visions and values. During the inspection a staff member was presented with an award and recognition of their work from the hospital clinical director.

**Governance**

The ward had clear systems and processes in place to ensure the ward was safe and clean, that staff were trained and supervised, patients were assessed and treated well and incidents were reported and learnt from.

The ward was reliant on the continued use of locum agency and bank staff. There were ongoing rolling recruitment campaigns to bring in more staff. All non-permanent staff could access the same support as permanent staff, while ensuring all locum staff were already familiar with the ward, having worked there before.

There was a clear framework of what needed to be discussed at handovers on the ward and at team meetings, to ensure that essential information for patient care, and for learning from complaints and incidents, was shared and discussed.

The ward used Commissioning for Quality and Innovation national goals (CQINs) to report on the ward outcomes to NHS England.

The ward participated in local clinical audits and acted on the results when issues were identified.

**Management of risk, issues and performance**

The ward risk register contained issues highlighted by the team. The key risk was ligature points on the ward. There were however clear risk management strategies in place to mitigate these risks.

Staff had gone above and beyond during recent adverse weather that could have impacted on the safe running of the service. Staff worked additional or longer shifts to cover for those staff who were unable to make it in to the ward due to the difficult driving conditions.

There were no examples of financial pressures compromising patient care.

Staff had access to the equipment and information technology needed to do their work and the ward manager had access to information to support her with the management role. This included information on the performance of the service, 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 as needed.

**Engagement**

Patients and carers had opportunities to give feedback on the service they received through one to one sessions, community meetings and feedback questionnaires. Managers and staff had access to this feedback, and could use it to make improvements.

Senior leaders engaged with external stakeholders, such as commissioners.

**Learning, continuous improvement and innovation**

Good

# Specialist eating disorder services

Staff were given the time and support to consider opportunities for improvements and innovation within the service, and were encouraged to share any ideas.

The ward had been accredited under the Quality Network for Eating Disorders (QED) scheme since 2014. The QED works with services to assure and improve the quality of services treating people with eating disorders and their carers. Through a comprehensive process of review, their aim is to identify and acknowledge high standards of organisation and patient care, and support other services to achieve these.

The re-accreditation process, due at the end of 2018, had been delayed by the QED due to staffing issues. The ward was in the process of preparing for this at the time of the inspection.

The provider had plans to relocate the ward to an alternative ward in the hospital, which was currently in the process of closing for refurbishment, and the ward manager had requested that the re-accreditation be delayed until the ward moved.

The ward team continued to have ongoing links with QED to improve their practice. The ward manager had an additional role as part of the QED accreditation team, visiting other wards to review and accredit them. The manager attended specialist eating disorder conferences, and brought back examples of good practice to develop and improve the ward.

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider MUST take to improve

- The provider must ensure that patients on the acute ward for working age adults are involved in the development of their care plans and that these are person-centred.
- The provider must address the lack of space and insufficient facilities on the acute wards and ensure these are fit for purpose.
- The provider must ensure the doors to lounges on the acute wards are anti-barricade and all blind spot area risks are mitigated.
- The provider must ensure effective communication between the multidisciplinary team and the staffing team on the child and adolescent mental health wards to ensure effective care and risk management.

### Action the provider SHOULD take to improve

- The provider should ensure that patients on the acute wards for working age adults are provided information and orientated to the ward in a way that they understand.
- The provider should ensure patients are aware of their rights under the Mental Health Act (1983) and this is documented.
- The provider should ensure consent status for treatment is recorded on prescription charts and this information is easily accessible to nurses administering medication.
- The provider should ensure that staff are clear on the outcome of ward specific clinical audits to ensure effective learning.
- The provider should ensure that all agency and locum staff working on the wards can access electronic patient records independently.
- The provider should ensure that patients on the specialist eating disorder wards are fully involved in discussions around section 17 leave, and are clear on the reasons for not granting or withdrawing leave.
- The provider should ensure that staff on all wards have a clear understanding of Mental Capacity Act (2005) and the implications for their practice, and that staff on the Child and Adolescent Mental Health wards complete Gillick competency training.
- The provider should ensure appropriate support is in place for staff who experience violence or abuse during the workplace.
- The provider should ensure patients on the eating disorders ward have access to the internet.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

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

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment<br>The acute ward premises were not fit for purpose. The wards did not have sufficient facilities and available rooms to meet patient needs, causing the environment to be overcrowded.<br>The lounge doors were not anti-barricade and there was a blind spot in a corridor on Redcliffe ward.<br>This was a breach of regulation 15 (1), (c). |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 9 HSCA (RA) Regulations 2014 Person-centred care<br>The provider had not ensured that patients on the acute wards were involved in the development of nursing care plans and that these were individualised and met their needs and preferences.<br>This was a breach of regulation 9 (1), (a) (b) (c). |

| Regulated activity | Regulation |
|---|---|
| Assessment or medical treatment for persons detained under the Mental Health Act 1983<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>The provider had not ensured that communication with the multidisciplinary team on the Child and Adolescent Mental Health wards was effective enough to ensure safe care and risk management.<br>This was a breach of regulation 12 (2), (a). |