

# The Priory Hospital North London




## 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

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

### 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.

# Summary of findings

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.

## Overall summary

We rated the Priory Hospital North London as good because:

- The hospital wards were clean and well-maintained. There was a fully equipped clinic room on each ward which had emergency resuscitation equipment. Medical equipment was serviced and cleaned regularly.
- A risk assessment was carried out on admission and reviewed throughout the patient's stay in hospital.
- There were sufficiently skilled and qualified staff to provide a safe, caring and therapeutic environment.
- There was an extensive programme of therapies including cognitive behavioural therapy (CBT), exposure therapy, music imagery, yoga, self-acceptance groups, relaxation therapy, dialectical behaviour therapy (DBT), mindfulness, anxiety management programmes and medicines. Treatment for addictions followed a 12-step programme with CBT and family therapy.
- There was extensive use of outcome scales to monitor patients' progress.
- Throughout our interviews, staff consistently demonstrated positive attitudes towards the people they worked with. Patients spoke positively about their experiences of staff, care and treatment. A satisfaction survey was completed by patients at the end of their admission. Responses were very positive.
- An extensive menu of healthy food was available for each meal. The menu included dishes that were clearly labelled as being dairy free, gluten free, vegan and free from genetically modified ingredients.

- Staff spoke positively about the way the hospital was managed and consistently told us that they felt supported in their roles. We found a positive attitude that was caring and supportive to patients. Staff spoke positively about team work and mutual support. Staff told us that they valued the opportunities for working and learning together with colleagues at training days and group supervision sessions.
- Staff spoke positively about the hospital director and the ward managers. All staff knew who the hospital director was and said that they were visible and frequently visited the ward.
- Governance of the hospital was provided through the monthly clinical governance meeting. Patients were invited to participate in these meetings.
- The child and adolescent mental health service wards were part of the Quality Network for Inpatient CAMHS (QNIC).

However,

- There were ligature points throughout the hospital. Two bedrooms designated as safer rooms still had significant ligature risks. The patients had unrestricted access to a laundry room which did have ligature points including electric plugs, cables and exposed pipes. This room was not included in the ligature audits.
- There was a high use of temporary staff to cover for staff vacancies.

# Summary of findings

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Good 

# The Priory Hospital North London

## Services we looked at

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

# Summary of this inspection

## Background to The Priory Hospital North London

The Priory Hospital North London is an independent hospital that provides support and treatment for people with mental health needs, obsessional disorders and drug and alcohol addictions. It has 48 inpatient beds. The hospital provides care and treatment for adults and children experiencing acute episodes of mental illness, an inpatient drug and alcohol detoxification, addiction therapy programme, and inpatient care and treatment for adults with obsessional disorders.

Services are provided on the following wards:

- Lower Court is a mixed ward providing care and treatment for up to 27 adults. Patients were either experiencing an acute episode of mental illness, receiving treatment for obsessional disorders or participating in the addictions treatment programme.
- Birch Ward was a mixed ward for up to 13 children and adolescents up to the age of 18 experiencing an acute episode of mental illness.
- Oak Ward was a mixed ward for up to nine children and adolescents up to the age of 18 experiencing an acute episode of mental illness.

The previous inspection of the hospital was on 21-22 January 2015. The hospital failed to comply with the Health and Social Care Act (Regulated Activities) Regulations 2009 as shown below:

### **Regulation 18: Consent to care and treatment**

#### **The provider was failing to comply with Regulation 18**

The provider did not have suitable arrangements in place to ensure they always obtained, and acted in accordance with, the consent of service users in relation to the care and treatment provided for them. We found examples where the person's capacity to consent to an individual decision was not decision-specific.

### **Regulation 9: Care and welfare of people who use services**

#### **The provider was failing to comply with Regulation 9**

The provider had not taken proper steps to ensure that each person using the service was protected against the risks of receiving care or treatment that was inappropriate or unsafe. It had not planned to ensure the welfare and safety of all the people using the service. On Lower Court, bedrooms had not been grouped to achieve as much gender separation as possible. There was no female only lounge.

The provider is registered to provide care for the following regulated activities:

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

The hospital has a registered manager.

## Our inspection team

The Priory Hospital, North London was inspected by a team consisting of an inspection manager, four inspectors, and a specialist advisor with a professional background in nursing.

## Why we carried out this inspection

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

# Summary of this inspection

## How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked NHS commissioners for their views on the service and invited comments from staff and patients.

During the inspection visit, the inspection team:

- visited all three wards of the hospital and looked at the quality of the environment
- interviewed the ward managers on all three wards

- interviewed staff on the senior management team including the hospital director, clinical services manager, medical director and lead for quality assurance
- interviewed the lead psychiatrist and therapist for obsessional therapies department, general psychiatry, and the addictions treatment programme
- met with 15 members of staff including nurses, health care assistants, psychologists, and the Mental Health Act administrator
- spoke with 14 patients
- reviewed 19 comment cards completed by six patients and eight feedback questionnaires
- reviewed 41 medicines charts
- attended one ward round and two handover meetings
- reviewed 10 patient electronic care records and seven incident reports
- reviewed the statutory documents relating to the detention of seven patients
- looked at a range of policies, audits procedures and other documents relating to the running of the service

## What people who use the service say

We spoke with 14 patients during the inspection. Many patients spoke positively about the staff, care and treatment that they had received, although some of the young people we spoke with felt that some staff could be more supportive.

Patients using acute adult inpatient services on Lower Court said they felt safe. A number of nurses and HCAs were singled out as being particularly caring and helpful. One patient said that staff were good, kind and always

listened to him, although he felt there was not much communication with staff on night shifts. One patient said it would be better if there was an occupational therapist and more access to art therapy.

Patients on the child and adolescent mental health services (CAMHS) wards said that staff were kind, respectful and supportive. They said that the nurses and therapists were interested in working with them and patients felt involved in care planning.

# 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?**

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

- There were ligature points throughout the hospital. Ligature audits on Lower Court showed a high risk rating for the doors, ceiling lights, curtain rails, window fittings and extractor fans. Two bedrooms, designated as safer rooms, still had significant ligature anchor points and no observations panels in the door.
- Patients had unrestricted access to a laundry room on Lower Court which had ligature points including electric plugs, cables and exposed pipes.
- There was a high use of temporary staff to cover for staff vacancies.

However,

- The ward for adult inpatients, Lower Court, was a large, open plan ward with good sight lines and visibility throughout.
- There was a fully equipped clinic room on each ward which had emergency resuscitation equipment. Medical equipment was serviced and cleaned regularly.
- All areas of the hospital were clean and well maintained
- The number of staff on all the wards could be increased by the ward managers when any patients required one-to-one nursing and when there were heightened levels of risk.
- Medical cover was provided by the full-time ward doctor between 9.00am and 5.00pm from Monday to Friday. An on-call doctor provided through a medical employment agency was on site to provide an out-of- hours service.
- A risk assessment was carried out on admission and reviewed throughout the patient's stay in hospital.
- Staff knew how to report incidents.
- A document was produced for staff every two weeks highlighting the action points from investigations of incidents.
- We saw records of four meetings with staff to discuss specific incidents. Each meeting was attended by three to five members of staff who discussed the incident. Action plans were developed for both the specific patient and the ward to prevent such an incident happening again.
- Risk assessments were carried out on admission by a Registered Mental Nurse (RMN) or the ward doctor. These assessments were frequently updated.
- There was good medicines management practice on all wards

**Requires improvement**



# Summary of this inspection

## Are services effective?

### We rated effective as good because:

- Patient records demonstrated good practice in showing a holistic approach to care and evidence of physical health assessments.
- Comprehensive assessments of patients' physical and mental health were completed shortly after admission and were updated throughout the patients' time at the hospital.
- There was a strong emphasis on the use of therapies for all patients.
- Therapies included cognitive behavioural therapy (CBT), exposure therapy, music imagery, yoga, self-acceptance groups, relaxation therapy, dialectical behaviour therapy (DBT), mindfulness, anxiety management programmes and medicines. Treatment for addictions followed a 12-step programme with CBT and family therapy.
- There was extensive use of outcome scales to monitor patients' progress.
- Nursing handovers took place twice a day at the start and end of each shift. There were also handovers each morning between the nursing and therapy teams.
- Staff said that they met every two weeks for group supervision and group dialectical behavioural therapy (DBT) sessions. They said that incidents were discussed in these meetings.
- We reviewed the statutory documents relating to the detention of patients and found them to be filled out correctly, up to date and stored appropriately.
- There was a record on each file to show that the patient had been informed of their rights under the Mental Health Act 1983 (MHA) when they were first detained, when there were changes to the section of the MHA under which they were detained, and routinely thereafter.

However,

- Supervision records showed that one-to-one supervision sessions across the hospital were not taking place consistently

Good



## Are services caring?

### We rated caring as good because:

- Throughout our interviews, staff consistently demonstrated positive attitudes towards the people they worked with.
- Patients were positive about the care and treatment they received.
- Patients were allocated a named nurse who they met with each week.

Good





# Summary of this inspection

- Patients told us that staff engaged with them well and developed an understanding of their needs quickly.
- A satisfaction survey was completed by patients at the end of their admission. Responses were very positive.
- Patients met with their named nurse each week to discuss their care and treatment. Ward rounds took place each week.
- Community meetings took place each week for general psychiatry patients, patients with obsessional disorders and patients on the addictions treatment programme.
- An advocacy service visited the hospital once a week. This service was provided by the National Youth Advocacy Service (NYAS). A leaflet for the service was available on the ward giving full contact details and stating that an advocate visited the ward each week.

However,

- Attendance at community meetings was low.

## Are services responsive?

**We rated responsive as good because:**

- Patients were not admitted to the wards to beds allocated to patients who were on leave.
- On Lower Court the furniture had been arranged to ensure that there were quiet areas. There were also facilities for patients to meet with visitors in private.
- Patients had unrestricted access to a small kitchen at all times to make snacks and hot drinks.
- Wards were well equipped. All patients on Lower Court had their own bedroom with ensuite facilities. Clinic rooms were clean, well maintained and well equipped. On Lower Court there was a therapy room and a large activity room. Patients on the child and adolescent mental health service (CAMHS) ward had access to a well-equipped art room and education room.
- An extensive menu of healthy food was available for each meal. The menu included dishes that were clearly labelled as being dairy free, gluten free, vegan and free from genetically modified ingredients.

Good



## Are services well-led?

**We rated well-led as good because:**

- Staff spoke positively about the way the hospital was managed and consistently told us that they felt supported in their roles. We found a positive attitude that was caring and supportive to

Good



# Summary of this inspection

patients. Staff spoke positively about team work and mutual support. Staff told us that they valued the opportunities for working and learning together with colleagues at training days and group supervision sessions.

- Staff spoke positively about the hospital director and the ward managers. All staff knew who the hospital director was and said that they were visible and frequently visited the ward.
- Governance of the hospital was provided through the monthly clinical governance meeting. Patients were invited to participate in these meetings. The minutes of these meetings were distributed across the staff team.
- The obsessional therapies department was one of very few services in the country that provide in-patient treatment for obsessional disorders.
- The child and adolescent mental health service wards were part of the Quality Network for Inpatient CAMHS (QNIC).

# 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.

The hospitals systems supported the application of the Mental Health Act and its Code of Practice. Detention

paperwork was filled in correctly, was up to date and was stored appropriately. There was a Mental Health Act administrator based on site. Staff knew how to contact them for advice when necessary.

Training on the Mental Health Act and the Mental Capacity Act was covered as part of the mandatory training. Detained patients had their rights under the Mental Health Act explained to them routinely.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act 2005 (MCA) awareness training was delivered to all staff as part of the mandatory training programme. Eighty-nine percent of staff across the hospital had completed this mandatory training.

There were no applications for authorisation to deprive patients of their liberty under schedule A1 of the MCA between 1 July 2015 and 31 December 2015, and there were no patients deprived of their liberty under this schedule at the time of the inspection.

# Detailed findings from this inspection






## Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Good	Good	Good	Good	Good	Good
<b>Overall</b>	Requires improvement	Good	Good	Good	Good	Good

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

Good 

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

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

Requires improvement 

### Safe and clean environment

- Lower court was a large, open plan ward with good sight lines and visibility throughout. Bedroom doors were solid with no viewing panels.
- A ligature point audit had been carried out for each bedroom. These audits showed a high risk rating for the doors, ceiling lights, curtain rails, window fittings and extractor fans. Plans to address these risks included the installation of covers to prevent access to ropes on sash windows, removal of door stops and ensuring risk assessments for each patient were carried out and changes communicated across the staff team. Two bedrooms had been designated as safer rooms with reduced ligature points. However, the television brackets in these rooms were still a ligature risk. The patients had unrestricted access to a laundry room with did have ligature points including electric plugs, cables and exposed pipes. This room was not included in the ligature audits that we received.
- This was a mixed sex ward with 10 male bedrooms, 12 female bedrooms and 5 'flexible' bedrooms that could be used for male or female patients. All bedrooms were large, well-furnished and had ensuite facilities. One corridor with 10 bedrooms was designated as a female only corridor. This area also accommodated a well furnished female only lounge. There were two further

female bedrooms at the end of a corridor with four flexible bedrooms. No patients had to pass through rooms occupied by the opposite sex to reach toilet and washing facilities.

- There was a fully equipped clinic room. A defibrillator was kept in the ward office. Emergency equipment was checked on a daily basis and a monitoring chart was signed by staff to show that these checks had been carried out.
- There was no seclusion room at the hospital.
- All areas of the ward were very clean, well maintained and had a high standard of furnishing.
- Equipment was clean and well maintained. We found that the portable appliance test labels were out of date on the ECG machine and the suction machine on the resuscitation trolley.
- There was a call button in each room for patients to alert nurses that they needed assistance. Personal alarms were provided for all staff conducting enhanced observations. These were kept in a locked box in the ward office. The log book for signing out these alarms had not been updated since 2015. We were told that alarms were tested daily but these checks were not documented.

### Safe Staffing

- Established staffing levels were set by a staffing 'ladder' system. This required two nurses to be allocated to the ward at all times and for the number of health care assistants (HCAs) to vary according to the number of patients. Two HCAs would be allocated to the ward if there were less than 15 patients, rising to an allocation of four HCAs if the ward had its full complement of 27

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

Good 

patients. Additional HCAs would be allocated to each patient on enhanced observations. On the day of the inspection there were three nurses and four HCAs on duty.

- The ward manager was a Registered Mental Nurse and covered short periods of up to four hours when additional staff were required on the ward. In the three months from 1 October 2015 to 31 December 2015, bank and agency staff had been used to cover 167 shifts as a result of sickness, absence or vacancies. A full complement of staff had not been provided on the ward on 10 occasions during this period.
- The overall staff turnover rate for the hospital was 48%. Overall sickness for the hospital was 5%.
- The hospital had identified that recruitment of nurses was a challenge. Overall staffing levels for the ward were 10 nurses and 15 HCAs. There were two vacancies for qualified nurses.
- The same bank staff worked on the ward regularly and were familiar with the patients, routines and layout of the hospital. Some permanent staff worked additional shifts as part of the hospital's bank of staff. Some agency staff were placed on three month contracts to cover for staff vacancies. On the Saturday prior to our inspection, one nurse was on leave and one was off sick, meaning that there were no permanent nurses on duty during that shift. The ward manager considered such a situation to be very rare. One patient commented that ratio of permanent staff to bank staff was good and that there was always a member of staff that she knew on each shift.
- Within each shift plan, a qualified member of staff was allocated to the communal areas of the ward at all times.
- Medical cover was provided by the full-time ward doctor between 9.00am and 5.00pm from Monday to Friday. An on-call doctor provided by a medical employment agency was on site to provide an out-of-hours service. The clinical director oversaw the induction of agency doctors and assessed their suitability for the role before they were accepted to work at the hospital. An on-call consultant was also available out-of-hours.
- In February 2016, 81% of staff nurses and 80% of HCAs were fully compliant with the requirements for mandatory training. Compliance rates across the hospital had risen to over 90% for the hospital for all courses by May 2016.

Assessing and managing risks to patients and staff

- There were no facilities for seclusion of patients at the hospital.
- There were seven incidents of restraint involving five patients between 16 August 2015 and 15 February 2016.
- A risk assessment was carried out on admission on all four of the patient records that were reviewed. Three of the four records classified the patient as being at high risk. These risk assessments were regularly updated although the level of detail in these updates was variable. Risks identified were typically either suicide, absconding, or deliberate self-harm.
- The hospital was introducing the RATE (risk assessment training and education) risk assessment training programme for all staff.
- An audit of safeguarding incidents between January and December 2015 had been carried out by the clinical services manager. The audit found that 25 safeguarding incidents had been reported during this period compared to 14 in the previous year. This increase was attributed to increased awareness due to training and ongoing conversations about safeguarding. Information about safeguarding, including the hospital's policy, were displayed on a notice board.
- Medicines were stored securely in designated cupboards and medicine trolleys. The medicine storage areas were clearly labelled in the locked clinic. Controlled drugs (CDs) were stored and managed appropriately. The CDs were checked each day by two registered nurses. The pharmacy service was provided by an external organisation. A regular pharmacist visited the hospital each week, reviewed all the drug charts and conducted regular audits of the clinic rooms.
- Patients were allowed visitors under the age of 18 if the visit took place in the designated family room. Visits were booked in advance. Children were not allowed into patients' bedrooms or the main areas of the ward. Patients were permitted to walk around the grounds with visiting children. For patients on the addictions treatment programme, visits were discussed with the multi-disciplinary team and formed part of the care plan. We noted there had been an untoward incident involving someone visiting a patient in the patient's bedroom and staying after normal visiting hours had

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

Good 

ended. The staff had been unaware of this. This incident was discussed with the staff team and the team agreed to be more vigilant in checking when visitors left the ward.

## Track record on safety

- There were six incidents recorded as serious incidents requiring investigation between 25 January and 12 November 2015.

## Reporting incidents and learning from when things go wrong

- Staff told us they knew how to report incidents. Incidents were reported on an electronic record. These reports were reviewed by the hospital director and clinical services manager and discussed in a meeting with clinical leads and senior managers held twice each week. Ward managers were responsible for follow up actions.
- In the year from 1 April 2015 to 31 March 2016 there were 31 incidents recorded. The highest categories of incidents were absconding, self-harm and violence, each with four entries.
- A document was produced for staff every two weeks highlighting the action points from investigations of incidents. However, this document appeared very brief. It did not include any details of the incidents so it was difficult to understand the context of the action points outlined in the document.
- We saw records of four meetings with staff to discuss specific incidents. These meetings took place between January and April 2016. The incidents involved a serious attempt by a patient to injure themselves, a visitor staying in a patient's bedroom beyond visiting hours, and a patient absconding.
- Each meeting was attended by three to five members of staff who discussed the incident and developed plans for both the specific patient and the ward in general to prevent such an incident happening again. Plans for improvement including monitoring the arrival and departure times of visitors, recognising the unpredictability of patients, and increasing risk assessments. Positive interventions by staff were recognised and validated within these meetings.

## 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

- Overall patient care records demonstrated good practice in showing a holistic approach to care and evidence of physical assessments.
- Comprehensive assessments of patients' physical and mental health were completed shortly after admission and were updated throughout the patients' time at the hospital. Initial assessments were completed by either a doctor or a registered nurse. All these records included up-to-date care plans. Most of these care plans were personalised and recovery orientated, with evidence that a copy of the care plan had been given to the patient. Some patients had care plans for specific aspects of their care, such as an observations care plan. One care plan included a request for the patient's intake of food and drinks to be included in the observations record. Patients were allocated a named nurse who they met with each week. Patients were also allocated an associate nurse who was familiar with their care and treatment and would be available for them if their named nurse was not on duty.
- Progress notes, care plans, and assessments were stored on an electronic patient record, secured by passwords. All staff had access to these records. Observation records were paper based and stored in the nursing office. The observation records were completed regularly.

## Best practice in treatment and care

- There was a strong emphasis on the use of therapies for all patients. On admission, patients were assessed by a therapist and a programme of therapy was created to meet their individual needs. Medicines tended to be minimised to help patients engage with their feelings in a therapeutic setting, particularly for patients on the addictions treatment programme.

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

Good 

- Therapies for patients admitted to the general psychiatry part of the ward usually involved cognitive behavioural therapy (CBT) and medicines. Treatment for obsessional disorders involved CBT, exposure therapy, music imagery, yoga, self-acceptance groups, relaxation therapy and some medicines if required. Treatment for addictions followed a 12-step programme with CBT and family therapy. Therapy took place in groups and one-to-one sessions. Dialectical behaviour therapy (DBT) and anxiety management programmes were also available.
- One of the junior doctors explained that patients received a full psychiatric and physical examination on admission, including blood tests. We reviewed four patient records and found evidence of a physical examination on admission for all of them. Whilst patients are on the ward, doctors carry out physical assessments and treat patients for minor injuries and illnesses. If a patient has a more serious health problem they are taken to the general hospital nearby.
- A dietitian visited the ward every Wednesday.
- Health of the Nation Outcome Scales (HoNOS) are used to measure improvements in the health and social functioning of patients during their admission. A summary of HoNOS scores showed that all patients were assessed against the HoNOS scale on admission and on discharge. Some patients also had an additional assessment during their admission. The department for patients with obsessional disorders used the Yale Brown Obsessive Compulsive Inventory as the main measure of outcomes. These outcomes are measured on admission, discharge and three months after discharge. The Florida Obsessive Compulsive Inventory, Appearance Anxiety Inventory, and the Specific Phobia of Vomiting Inventory were used to assess patients' progress on a weekly basis. Patient Health Questionnaire Nine (PHQ9) was also used on a weekly basis to measure depression and anxiety.

## Skilled staff to deliver care

- The multidisciplinary team included nurses, health care assistants, two junior doctors and seven consultant psychiatrists. Therapy was provided by the three teams of therapists covering general psychiatry, addictions treatment programmes and OCD. Each therapy team had a designated Head of Therapy. There were no social workers allocated to the ward. A pharmacist visited the hospital once a week.
- All new staff took part in an induction programme covering orientation to the ward environment, safety, risk and observation policy and professional conduct. All permanent staff had an initial induction period of six months.
- The Priory Group policy states that every member of staff working in direct contact with patients will have access to regular supervisions which will focus on reflecting on practice, supporting, guiding, and coaching. On Lower Court we found that 16 staff who had been employed throughout the period from November 2015 to April 2016 had supervision, on average, every seven weeks. One employee had only had two supervisions sessions during this time due to annual leave and sickness. Attendance at fortnightly group supervision session tended to be low with between one and three staff present. Group supervision dedicated to working with patient with obsessional disorders took place each week, although no data was available to the level of attendance at the sessions. Staff spoke positively about the support they received through supervision. Staff were also required to receive an appraisal once a year. Records showed that 19 out of 21 staff had received a full appraisal between January and March 2016. An appraisal system for consultants had been introduced by the Priory Group. Overall compliance with annual appraisals for the whole hospital was 98%. Team meetings had taken place once a month for the three months prior to the inspection. All the staff had attended the meeting on 1 April 2016, increasing from an attendance of eight staff in January and February. Discussions in the meetings covered changes to the ward, shift patterns, supervision arrangements, staff use of mobile phones on the ward and care planning.
- Training was provided to all provided to staff. Mandatory training involved a mixture of classroom sessions and online learning modules. The manager of the obsessional therapies team met with nurses and health care assistants each Monday to provide specialist training to help support nurses working with patient with obsessive compulsive disorders. A counsellor at the hospital had run training sessions on working with people self-harm. Staff also had access to a training and development programme run by the Priory Group.
- Poor performance was addressed through supervision. A disciplinary process was available to address poor performance through setting and monitoring specific



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

Good 

objectives. Staff subject to the disciplinary procedures were sent for further training. We reviewed the most recent use of the disciplinary procedure which had been at the end of 2015 concerning a member of staff who was frequently late for work. This problem was resolved. The human resources manager attended the senior management team meeting every two weeks to review performance management issues.

## Multi-disciplinary and inter-agency work

- Multidisciplinary ward rounds were held weekly and progress and review of care plans for each patient were discussed in these meetings. A 'white board' in the nurse's office clearly displayed key information about patients including the level of risk, level of observation, type of therapy they were receiving, the date of their next care programme approach (CPA) meeting and their Mental Health Act status. Nursing handovers took place twice a day at the start and end of each shift. There were also handovers each morning between the nursing and therapy teams. Notes were recorded in a handover book that included information on admissions, incidents and staffing issues. The outcomes of these meetings were passed to the ward manager. When staff worked half shifts, such as 1.00pm to 9.00pm, an interim handover took place. The senior management team, including the ward manager, hospital director and the medical director held a meeting on Monday and Friday mornings. There was a meeting for junior doctors, including the out-of-hours doctors, once a week. The consultants also had an informal lunch together once a week.
- The hospital had some relationships with local agencies. For example, they had made an arrangement for the hospital to inform the nearby London Underground station when patients absconded so that the station staff could identify the missing patient and be particularly vigilant in looking for anyone displaying signs of distress. The hospital worked in partnership with the London Borough of Enfield to manage safeguarding procedures. A safeguarding committee meeting was held three times a year with representatives from the police and the local authority. Support groups run by the charity OCD Action were held at the hospital once a month. An addictions group for people in the community was also held at the hospital.

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

- Training on the Mental Health Act 1983 (MHA) had been completed by 90% of staff nurses and 67% of health care assistants.
- This training was completed through an online course. The aims of the course were to ensure staff were able to define the difference between informal and formal patients, explain the general purpose and structure of the MHA, describe how the MHA is used in the care of people with mental disorders and understand the implications of the MHA for their work. The training module states that staff are required to work under the provisions of the MHA Code of Practice, but there were not specific references to these provision nor any mention of the guiding principles of the Code of Practice.
- On the first day of the inspection, there were four patients detained under the MHA on Lower Court. Three patients had been admitted for assessment and one had been admitted for treatment under the Mental Health Act. We reviewed the statutory documents relating to the detention of these patients and found them to be filled out correctly, up to date and stored appropriately. Statutory forms were initially checked by the administrator and formally scrutinised by a consultant psychiatrist.
- There was an assessment of the patient's capacity to consent to treatment on three of the four patient records we reviewed. One patient was receiving treatment that required either his consent or a second opinion in the form of a certificate from a registered medical practitioner stating that it is appropriate for the treatment to be given. A certificate confirming that this patient had consented to the treatment was attached to his medicines chart and a record of an assessment showing that the patient had capacity to consent was in the patient's file.
- There was a record on each file to show that the patient had been informed of their rights under the MHA when they were first detained, when there were changes to the section of the MHA under which they were detained and routinely thereafter. These records confirmed that the patient had capacity to understand the information that was being explained to them and they were signed by the patient. We spoke to one patient subject to

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

Good 

section two of the MHA. She said that a nurse had explained her rights to her, that she had received written information and she had been offered the support of an advocate.

- Administrative support was provided by the MHA administrator who was based at the hospital. The administrator was able to provide basic advice on the criteria for detention and assistance with completing forms. Formal advice on more complex matters was available from solicitors who specialise in this area of the law.
- The hospital managers carried out an audit of statutory forms relating to the MHA every three months. Other audits have included a review of compliance with the requirement to ensure that patients understand how the provisions of the MHA apply to them. This audit found that the requirements were being carried out correctly.
- An Independent Mental Health Advocacy service was provided by a local advocacy organisation. All detained patients were given information about this service. We were told that this service regularly visits the hospital.

## Good practice in applying the Mental Capacity Act

- Training on the Mental Capacity Act 2005 (MCA) had been completed by 80% of staff nurses and 100% of HCAs.
- There had been no applications for the authorisation to deprive patients of their liberty in the six months before the inspection.
- Some staff that we spoke to appeared unfamiliar with the principles of the MCA.
- An audit of the use of Mental Capacity Act was carried out in June 2015. This involved an in-depth review of capacity assessments on admission, how the capacity assessments were carried out, evidence used in capacity assessments and a review of any best interest decisions. The audit found three areas for improvement. These were to improve the quality of capacity assessments by increasing the frequency of audits, to improve assessments through involving families, interpreters and speech and language therapists, and to ensure that capacity is reassessed whenever there is a change in the patient's presentation.

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

Good 

### Kindness, dignity, respect and support

- Our observations of staff attitudes were positive. Staff told us the medical director visited the ward at least three times each week to meet with staff and patients.
- Four of the patients we spoke with had been subject to restrictions under the MHA or been on enhanced observations. Overall, patients were very positive about the care and treatment they received and told us they felt safe. One patient said that staff were good, kind and always listened to them, although they felt there was not much communication with staff on night shifts. One patient said it would be better if there was an occupational therapist and more access to art therapy.
- Patients told us that staff engaged with them very well and developed an understanding of their needs very quickly. All the patients felt that observations were generally unobtrusive. One patient commented that staff always listen to her. One patient said that he valued the way that staff in the obsessional disorders department had a very good understand of his obsessive compulsive disorder.
- A satisfaction survey was completed by patients at the end of their admission. There had been 15 surveys completed in March 2016 in which 13 patients stated they had 'definitely' been treated with dignity and two said they had 'somewhat' been treated with dignity.

### The involvement of people in the care they receive

- Information for patients with obsessional disorders provided comprehensive details of how care and treatment is delivered. It included biographies of all the staff in the department, details of the therapies provided and an explanation of how a treatment package is developed and monitored.
- Patients met with the named nurse each week to discuss their care and treatment. Ward rounds took place each week. Patients with obsessional disorders usually attended these meetings, but if their disorder prevented them from attending they would receive a

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

Good 

feedback sheet with an update of an evaluation of their progress and behavioural action plan. Patients on the addictions treatment programme usually wrote a list of the things they would like staff to discuss in the meeting and their named nurse would provide them with feedback. Responses to the patient satisfaction survey showed that 13 out of 15 patients discharged in March 2016 felt they had definitely been involved in decisions about their care. One patient told us they met with their consultant most days, as he was changing their medicines.

- An advocacy service visited the hospital once a week. This service was provided by the National Youth Advocacy Service. A leaflet for the service was available on the ward giving full contact details and stating that an advocate visited the ward each week. An Independent Mental Health Advocate was provided by a local service commissioned by the local authority.
- A support group for families took place on a weekly basis to support people to reintegrate into family life when they were discharged.
- Separate community meetings took place each week for general psychiatry patients, OCD patients and patients on the addictions treatment programme. Attendance at the meetings was quite low with often only a couple of patients attending. Discussions at recent meetings included a concern by one patient that they had not seen their primary nurse for four days and another patient was concerned about the manner of a nurse working on the night shift.
- The ward manager said that patients had been involved in recruitment panels for new staff. This was welcomed by the consultant for obsessional disorders. Feedback from patients was a standing item on the minutes of clinical governance meetings.
- We did not see any evidence of patients making advance decisions.

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

Good 

Access and discharge

- Bed occupancy for Lower Court between 1 July 2015 and 31 December 2015 was 88%. This meant that, on average, there were 25 patients on the ward at any time.
- Since 1 April 2016, all patients on the addictions treatment programme and general psychiatry patients were privately funded. Patients receiving care and treatment for obsessional disorders were either privately funded or funded by NHS England. A typical length of stay for general psychiatry patients was between two and four weeks. Admissions for patients with OCD tended to be much longer, ranging from six months to two years. Patients admitted for the treatment of addictions followed a 28 day treatment programme.
- Patients were not admitted to the ward to beds allocated to patients who were on leave.
- Most admissions to the ward were planned. There were some emergency admissions from accident and emergency departments.
- If a patient's mental state deteriorated during their admission, staff would increase their level of observation. Two bedrooms were equipped with anti-ligature facilities to accommodate patients presenting a heightened level of risk. Patients requiring treatment in a psychiatric intensive care unit would be transferred to the Priory Hospital at Potters Bar. There were no recorded delayed discharges from this ward.

The facilities promote recovery, comfort and dignity and confidentiality

- Lower Court was a large and well equipped ward. All patients had their own bedroom with ensuite facilities. The clinic room was clean, well maintained and well equipped. There was a therapy room and a large activity room
- Whilst it was an open plan ward, the furniture had been arranged to ensure that there were quiet areas. There were also facilities for patients to meet with visitors in private.
- Patients were able to make telephone calls in private.
- Lower court was an open ward. Patients had unrestricted access to extensive, well-kept grounds surrounding the hospital.
- Patients had unrestricted access to a small kitchen to make snacks and hot drinks. There was a checklist showing that the kitchen had been cleaned each day. All the food in the fridge was in date.

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

Good 

- Patients were able to lock their bedrooms. Items that patients had restricted access to could be kept in secure lockers.
- Activities for patients were facilitated by the therapy department. There were some nurse led activities in the evenings or at weekends. Most patients had visitors in the evenings, although patients on the addictions treatment programme only had visitors at weekends.
- The addictions treatment programme involved structured therapy sessions covering six and a half days each week. The obsessional disorders department provided a support group therapy session and a music imagery session on Saturday mornings.

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

- The ward was situated on the ground floor and was accessible for people with disabilities.
- All leaflets and other information was written in English. Staff said that this information could be translated into other languages if required.
- Information was display about treatment, patients' rights, how to make a complaint to the hospital and how to contact the Care Quality Commission.
- The hospital was able to arrange interpreters and signers if they were required.
- An extensive menu of healthy food was available for each meal. The menu included dishes that were clearly labelled as being dairy free, gluten free, vegan and free from genetically modified ingredients. Kosher and Halal food was available on request.
- The hospital helped patients to access spiritual support according to the specific requirements of the patient. Staff explained that this was usually done with the assistance of the patient's family.

## Listening to and learning from complaints

- There were eight complaints on Lower Court during 2015. Many of these complaints covered a number of separate issues, amounting to 67 in total. Of these issues 12 were upheld, 13 were partly upheld, 36 were not upheld and the outcome of six complaints was inconclusive. Both staff and patients understood how complaints could be made.

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

Good 

### Vision and Values

- We interviewed six staff on Lower Court including the ward manager, registered nurses, health care assistants and a junior doctor. They all had a positive attitude that was caring and supportive to patients. Staff spoke positively about working with their team and the ongoing opportunities for learning and development.
- Staff spoke positively about the hospital director and the ward manager. All staff knew who the hospital director was and said that she was visible and frequently visited the ward. Staff also said that the ward manager was always available and approachable. The medical director said that he visited each ward at least three times each week and discussed patients' care with nursing staff.

### Good governance

- A governance process was in place and information was being shared and discussed in regular meetings. A weekly clinical team meeting had been set up to review and discuss recent incidents, clinical issues, ward issues and staffing. This was attended by the hospital director, ward managers and medical director. The minutes and outcomes of this meeting were recorded in paper format in a book, but this not formal shared with all the staff. The hospital acknowledged that the mechanism or learning from discussions in the clinical meetings could be improved.
- The overall compliance rate for mandatory training was 86%. Nineteen of the 23 permanent staff had received an appraisal in the three months prior to the inspection, with many appraisal summaries including very positive comments. Shifts were covered by sufficient numbers of staff who were suitably qualified and staff spoke positively about spending time engaging with patients. Incidents were reported and there was an impetus to learn from these incidents. However, we were

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

Good 

concerned about the sporadic nature of one-to-one supervision. We did not consider the regular group supervision to be of equivalence to one-to-one supervision provided by the employee's line manager.

- Governance of the hospital was provided through the monthly Clinical Governance meeting. The minutes of these meetings were distributed across the staff team. A regular safeguarding meeting also took place and the medical advisory committee met twice a year.
- The ward manager told us that he had sufficient authority to manage the ward and make decisions about the appropriate number of staff required for each shift. The ward manager was supported by a ward clerk.
- Staff could submit items to the risk register through the ward manager.

## Leadership, morale and staff engagement






- A staff survey was carried out in October 2015. Sixty-four percent of respondents said that they were proud to work for the Priory Group and 67% said that working at the hospital made them want to do the best work they could. However, only 43% said that they would recommend the Priory Group to their friends and family as a good place to work.
- The sickness rate for permanent staff across the hospital in 2015 was 5%. There were two members of staff on long-term sick leave.

- There were no concerns about bullying or harassment raised during this inspection.
- Staff told us that they either knew, or knew how to find out about, the whistle blowing process and they all felt able to raise concerns without fear of victimisation.
- Staff spoke positively about team work and mutual support. Staff told us that they valued the opportunities for working and learning together with colleagues at training days and group supervision sessions. One health care assistant said that she really enjoyed working at the hospital and found her colleagues to be very supportive.
- Staff said that they found the ward manager and senior managers very approachable. Staff told us that the hospital director was visible and visited the wards frequently. They said that they felt able to give input into service development through team meetings on the ward and at senior management team meetings through their ward manager.

## Commitment to quality improvement and innovation

- The obsessional therapies department was one of very few services in the country that provide inpatient treatment for obsessional disorders. The lead consultant held a research post with a local university and was involved in research involving evaluations of compassionate focussed therapy treatment of obsessive compulsive disorders.

# Child and adolescent mental health wards

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

## Are child and adolescent mental health wards safe?

Good 

### Safe and clean environment

- Oak and Birch wards were located in a converted building which had not been purposely built as a hospital. Staff could not easily observe patients at all times due to the layout of the environment. The hospital had steps in place to mitigate the risks to patients and staff. For example, staff observed patients assessed to be at risk of self-harm, in accordance with the provider’s policy for close observation. The doors to the ward were locked at all times so patients could not leave without supervision. Additionally, staff made regular hourly checks on the location of all patients within the building. Staff could observe ‘blind spots’, in the corridors through the use of CCTV monitors in the staff office.
- The provider had taken steps to improve the safety of the building through modifications to door frames and fitted anti-barricade doors. However, there were ligature points throughout the wards. The provider had made a detailed risk assessment of all parts of the building, for example of the risks in patient bedrooms. Staff regularly reviewed and managed risks to individual patients through increased observation.
- Birch ward was designated as a mixed ward, although at the time of visit all the patients were female. There were

two male patients on Oak ward. All patients had single bedrooms. The two male patients were placed in adjacent bedrooms. Toilets and washing facilities were designated as being for either male or female patients.

- Both Oak and Birch wards had a suitably equipped clinic room. On each ward staff dispensed patient medicines from a half folding door to the clinic room/. Equipment, such as blood pressure monitors and scales was serviced regularly. Emergency equipment included a ‘grab bag’, defibrillator, oxygen cylinder, suction machine, first aid box and ligature cutters. Records showed staff checked the equipment daily and the contents of the grab bag once each week. Emergency medicines were in date.
- There were no seclusion facilities at the hospital. Situations involving heightened risks to patients were managed by increasing the levels of observation.
- Staff told us they were aware of safe hand washing practice and had training on this. The ward manager and deputy said no audits were carried out on this.
- All parts of the wards were clean, well maintained and appropriately furnished. Domestic staff kept records on the cleaning tasks they had carried out. Each day, a member of staff was assigned the responsibility of checking the ward for any cleaning or maintenance issues. Staff logged and reported any maintenance issues and signed any issues off once completed. Staff tested alarms weekly to make sure they were working correctly.

### Safe staffing

- There were two nurses on duty on each ward at all times. The number of health care assistants varied according to the number of patients to ensure that there was one member of staff for three patients during the day, and one member of staff for every four patients at

# Child and adolescent mental health wards

night. Additional HCAs were allocated to the wards for every patient on enhanced observations. This level of staffing was determined by a 'staffing ladder' that was used across the Priory Group.

- In the three months from 1 October 2015 to 31 December, bank and agency staff had been used to cover 231 shifts on Birch Ward and 125 shifts on Oak Ward as a result of staff sickness, absence or vacancies. A full complement of staff had not been provided on the ward on eight occasions on Birch ward and six occasions on Oak ward during this period.
- The overall staff turnover rate for the hospital was 48%. Overall sickness for the hospital was 5%.
- The full complement of staff for the child and adolescent mental health services unit was 21 HCAs and 13 nurses. There were six vacancies for nursing posts. Although there were no vacancies for HCAs at the time of the inspection, the high turnover of HCAs was recognised as a challenge for the ward, with new staff taking time to get to know patients and become familiar with the ward.
- Bank and agency staff were used on a regular basis to cover for the current vacancies as well as covering for staff sickness and other absence. Bank staff were familiar with the ward. Some permanent staff worked additional shifts as part of the hospital's bank of staff. Some agency staff were placed on three month contracts to cover for staff vacancies to promote consistency in staffing.
- The ward had recently begun to include bank and agency staff in team meetings and provide supervision.
- The ward manager was able to adjust the level of staffing on the ward according to needs and the number of patients who were admitted to the ward.
- A qualified member of staff was allocated to the communal areas of the ward at all times during each shift.
- 
- Medical cover was provided by the ward doctor during the day between 0900hrs and 1700hrs. An on-call doctor was on site at all times to cover all three wards. Ward doctors carried out physical assessments and treated patients for minor injuries and illnesses. If a patient had health problem which required further medical assessment they were taken to the general hospital nearby.

- In February 2016, 74% of staff nurses and 71% of HCAs were fully compliant with the requirements for mandatory training. Compliance rates across the hospital had risen to over 90% for the hospital for all courses by May 2016.

## Assessing and managing risk to patients and staff

- There were no facilities for seclusion of patients at the hospital.
- There were 20 incidents that required the use of restraint between 16 August 2015 and 15 February 2016. Nine patients were involved in these incidents.
- There was no record of patients being restrained in a prone position.
- We reviewed the records of three patients and found that risk assessments had been carried out on admission by a registered nurse or the ward doctor. These assessments were frequently updated. All three patients were assessed as presenting a risk of deliberate self-harm. Other risks included suicidal thoughts, absconding, self-neglect and inappropriate sexual behaviour. Risk management plans or care plans included details of how these risks were to be managed in a way that was specific to the individual needs and preferences of the patient.
- There were some rules on the wards that formed of the therapeutic routines. Patients were required to be in bed by 10.30pm on weekdays and 11.00pm at weekends, and patients were required to get up at 7.45am each morning. There was some flexibility in this rule for older patients. Patients had full access to their bedrooms during the day. Use of telephones was restricted to between 5.00pm and 9.00pm. Unrestricted access to smart phones was considered to present risks to patients' progress and were not permitted on the ward. The ward provided a mobile phone to each patient that they could use for calls and text messages.
- Decisions to grant leave to informal patients were based on risk and competency. Patients were usually escorted when they left the hospital grounds, unless they were 17 or older.
- Searches were carried out by two members of staff when patients returned from leave. Patients were given a list of items that were banned from the ward. Searches involved looking through patients' bags, checks with a metal detector and removal of patient's shoes. The hospital had a policy for searching patients who returned from leave. We found that searches were being

# Child and adolescent mental health wards

conducted in manner which upheld the privacy and dignity of patients. All patients were searched to the same level as there were fears that lower risk patients may be bringing banned items onto the ward for higher risk patients. There was a thorough search of three or four bedrooms each week. Searches were carried out with the patients' consent. If the patient did not give their consent to a search, the matter would be discussed with the multi-disciplinary team and the patient would be placed on one-to-one observations to reduce any risk to their safety.

- Observations of patients by nurses and HCAs were used to manage the risks that patients presented. The level of observation was determined by the risk assessment and reviewed on an on-going basis. Observation levels could only be reduced with the agreement of the ward doctor or the consultant psychiatrist. Constant observation of some patients was used on the ward. Records of observations were completed and stored.
- Staff told us that they had received training on safeguarding and were familiar with the procedures. The records for one patient showed that a safeguarding referral had been made by nursing staff to the local authority and this was being investigated.
- There was good medicines management practice on both wards. We checked eight patient medicines administration record (MAR) charts on Birch and nine MAR charts on Oak. All were well completed and showed that staff had ensured that patients had been supported to take their medicines as prescribed. In some instances, patients had declined to take their prescribed medicines and this was clear from the charts.
- Records of the storage and administration of controlled drugs were kept on each ward.. The records showed that the service met legal requirements in relation to the monitoring and storage of controlled drugs. A pharmacist had made a check on the accuracy of these records in March 2016.
- A fridge was available to store medicines and staff carried out daily checks to ensure that medicines were stored at the correct temperature.
- Parents were allowed to visit patients in their bedrooms. Visits from friends and siblings took place in a room away from the ward. These visits needed to be booked in advance.

Track record on safety

- There were three incidents within the CAMHS service between 25 January 2015 and 12 November 2015 that were classified as serious incidents requiring investigation.

Reporting incidents and learning from when things go wrong

- We interviewed five members of staff who all knew which incidents needed to be reported and how to report them. Staff told us that when incidents occur the first priority is to ensure the safety of patients. The ward manager or senior nurse would be informed and an entry made on the electronic patient record. Between 1 April 2015 and 31 March 2016, there were 192 records of other incidents. One hundred of these incidents involved self-harm including attempted suicide and self-inflicted injury. There were eight incidents of patients absconding, 17 incidents of aggression and 13 incidents of violence.
- We reviewed the reports of six incidents. We found the descriptions of the incidents were thorough. Each incident was classified according to the risk presented. On the records of more serious incidents there was clear evidence of the staff discussing the incident with the patient and a record of lessons learned from the incident. A document was produced for staff every two weeks highlighting the action points from investigations of incidents. However, this document was brief. It did not include any details of the incidents so it was difficult to understand the context of these action points.
- Staff said that they met every two weeks for group supervision and group DBT sessions. They said that incidents were discussed in these meetings. Debriefing sessions for all staff were recorded after incidents took place.

## Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

- We reviewed the records of three patients. Overall these records demonstrated good practice, including holistic care planning assessments.



# Child and adolescent mental health wards

- Comprehensive assessments of patients' physical and mental health were completed shortly after admission and were updated regularly during and admission. Initial assessments were completed by either a doctor or a registered nurse. Blood pressure, height and weight were monitored each week and physical health checks were being conducted regularly.
- All these records included care plans that were updated by the multidisciplinary team each week. They were personalised and recovery orientated, including statements of the patient's strengths and their personal goals. There was evidence on each file that the patient had been involved in developing the plan.
- Progress notes, care plans, and assessments were stored on an electronic patient record, secured by using passwords. All staff had access to these records. Observation records were paper based and stored in the nursing office.

## Best practice in care and treatment

- Young people were admitted to the ward for the treatment of depression, trauma and attention deficit hyperactivity disorder (ADHD). Patients were sometimes admitted for the treatment of psychosis. The first choice of treatment was therapy. The ward manager said that the multidisciplinary team was reluctant to rush into prescribing medicines, and this reflected guidance for working with children and adolescents.
- On admission each patient was allocated a therapist. Therapies included cognitive behavioural therapy and dialectical behavioural therapy mindfulness and family therapy. Therapies took place in one-to-one sessions and within groups.
- All patients had weekly physical health checks including blood pressure, height and weight.
- Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) were used to measure improvements in the health and social functioning of patients during their admission. A summary of HoNOSCA scores showed that all patients were assessed against the HoNOSCA scale on admission and on discharge. The children's global assessment scale (CGAS) was also used as a clinical outcome measure.
- Clinical audits were led by the clinical services manager. We reviewed audit reports on the Mental Capacity Act, the care programme approach (CPA), risk assessments and safeguarding. These reports showed that staff and patients had been involved in the audit. For example,

the CPA audit showed that staff supported patients in completing a questionnaire about what room they would like the meeting to be held in, whether they wanted to chair the meeting and whether they would like to meet with visitors before the meeting took place.

## Skilled staff to deliver care

- The multidisciplinary team included two child and adolescent mental health consultants, two ward doctors, nurses, a ward manager, deputy ward manager, a head of child and adolescent therapy, staff from the education department and an activities co-ordinator. Assessment and treatment was also provided by family therapist, a dialectical behavioural therapist and a psychodynamic therapist.
- All new staff, including bank and agency staff, took part in an induction programme covering orientation to the ward environment, safety, risk and observation policy and professional conduct. All permanent staff had an initial induction period of six months.
- The Priory Group policy states that every member of staff working in direct contact with patients will have access to regular supervisions which will focus on reflecting on practice, supporting, guiding, and coaching. Staff said were due to receive supervision every month. We looked at a sample of 18 staff and found that only six had received supervision in April, five in March, 11 in February and 14 in January. Some additional supervision had taken place in groups. However, between February and April 2016 an average of seven staff attended fortnightly group supervision sessions and an average of five staff attended the dialectical behaviour therapy supervision session that took place every two or three weeks. Staff spoke positively about the dialectical behaviour therapy supervision. Appraisals had been carried out with 15 staff between January and March 2016. Overall compliance with annual appraisals for the whole hospital was 98%. We read the summaries of these appraisals. Comments from the appraiser were often very positive with staff frequently being described as excellent, diligent and hard working. Staff being appraised commented that they felt they had made progress, they valued being part of a team and they had valued opportunities for training. One member of staff said that there was a lack of structure to the ward and inadequate supervision. Team meetings had taken place on 20 April 2016 and 18 February 2016, both

# Child and adolescent mental health wards

attended by 18 members of staff. These meetings included discussions about observations, searches, security, and bed times. In 2015, there were only three team meetings. These were held in February, April and September. The meetings in April and September were held as part of training days for the full staff team. These training days also included group supervision sessions.

- Staff had had a full training day on 4 March 2016. Staff also had access to a training and development programme run by the Priory Group. Staff told us about training they had received on National Institute for Health and Care Excellence (NICE) Guidance and safeguarding.
- Poor performance was escalated to the ward manager and addressed through the disciplinary procedure.

## Multi-disciplinary and inter-agency work

- Ward rounds were held weekly and were led by the consultant psychiatrist. Patients were always invited to attend the ward round. A social worker would also attend if they were available.
- Handovers took place twice a day, at the start and end of each shift. We attended one handover meeting. At the meeting staff discussed each patient on the ward, covering the level of observation, mental state, attendance at therapy sessions, involvement in education, activities, contact with their family, interaction with other patients and specific incidents.
- There was also a handover between therapists and nurses each morning. There was a senior management team handover on Mondays and Friday when the ward managers would meet with the hospital director.
- The CAMHS service maintained relationships with the patients' local authorities ensuring follow up care was planned for after patients were discharged. CPA meetings took place every four to six weeks.

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

- Training on the Mental Health Act 1983 (MHA) had been completed by 72% of staff nurses and 73% of HCAs.
- This training was completed through an online course. The aims of the course were to ensure staff were able to define the difference between informal and formal patients, explain the general purpose and structure of the MHA, describe how the MHA is used in the care of people with mental disorders and understand the implications of the MHA for their work. The training

module states that staff are required to work under the provisions of the MHA Code of Practice, but there were not specific references to these provision nor any mention of the guiding principles of the Code of Practice.

- On the first day of the inspection, there were three patients detained under the MHA on the CAMHS wards. Two patients had been admitted for assessment and one had been admitted for treatment. We reviewed the statutory documents relating to the detention of these patients and found them to be filled out correctly, up to date and stored appropriately. Statutory forms were initially checked by the administrator and formally scrutinised by a consultant psychiatrist.
- There was a record of the patient's capacity to consent to treatment on all three records. One patient was receiving treatment that required either their consent or a second opinion in the form of a certificate from a second opinion approved doctor (SOAD) stating that it is appropriate for the treatment to be given. A certificate confirming that this patient did not have capacity to consent to the documented treatment plan was attached to their medicines chart. The medicines chart for this patient included a form of medication to be taken as required that was not included on the SOAD certificate. This medication had not been given to the patient. The ward doctor and the ward manager assured us that they would address this.
- Patients were informed of the right to appeal under the MHA and this was recorded on patient files. These records confirmed that the patient had capacity to understand the information that was being explained to them and they were signed by the patient.
- Administrative support was provided by the MHA administrator who was based at the hospital. The administrator was able to provide basic advice on the criteria for detention and assistance with completing forms. Formal advice on more complex matters was available from solicitors who specialise in this area of the law.
- The hospital managers carried out an audit of statutory forms relating to the MHA every three months. Other audits have included a review of compliance with the requirement to ensure that patients understand how the provisions of the MHA apply to them. This audit found that the requirements were being carried out correctly.

# Child and adolescent mental health wards

- An Independent Mental Health Advocacy (IMHA) service was provided by a local advocacy organisation. All detained patients were given information about this service. We were told that this service regularly visits the hospital.

## Good practice in applying the Mental Capacity Act

- Training on the Mental Capacity Act 2005 (MCA) had been completed by 71% of staff nurses and 100% of HCAs.
- An audit of the use of Mental Capacity Act was carried out in June 2015. This involved an in-depth review of capacity assessments on admission, how capacity assessments were carried out, evidence used in capacity assessments and a review of any best interest decisions. The audit found three areas for improvement. These were to improve the quality of capacity assessments by increasing the frequency of audits, to improve assessments through involving families, interpreters and speech and language therapists, and to ensure that capacity is reassessed whenever there is a change in the patient's presentation.

## Are child and adolescent mental health wards caring?

Good 

## Kindness, dignity, respect and support

- Throughout our interviews, staff consistently demonstrated positive attitudes towards the young people they worked with. All staff said they found it rewarding to see patients getting better. For example, a senior health care assistant told us about how a patient she key works was showing improvement through engaging in therapy and how pleased she was to see them smiling. One member of staff told us about how talented the patients were at art and other creative activities.
- Patients we spoke with said that most staff were kind, respectful and supportive. They said that the nurses and therapists were interested in working with them and patients felt involved in care planning. We visited on a hot day when patients complained that the ward was too hot with little ventilation. Some patients had mixed views of staff, describing some as amazing and others as

being insensitive and unhelpful. Some young people had a strong sense of being treated unjustly by some members of staff. For example, young people told us that a patient on Oak Ward had been targeting other patients, making allegations against them and deliberately provoking them into negative behaviours. They thought it was very unfair that they were blamed for bullying that person when they complained about their behaviour. This matter was raised with the hospital managers. They said that a meeting was facilitated each week by the clinical psychologist and lead therapist at which patients could talk about any concerns they had, any incidents of them feeling unfairly treated and any problems with interactions between patients. They also said that staff were sensitive to difficulties that arise between patients and that interactions between patients were discussed at meetings twice a week. They said that staff supported patients to address any disputes in a positive way. If it was not possible to address alleged bullying or other disputes, one of the patients could be moved to another ward.

- Between January and March 2016, eight patient feedback forms had been completed. Overall the responses were very positive. There were many comments about the staff being friendly and understanding of patients' problems. One respondent said that they had made lots of friends on the ward.
- The hospital was part of the Quality Network for In-patient CAMHS (QNIC). Their QNIC certificate for 2014/15 showed quality ratings of over 90% for environment and facilities, staffing and training, access, admission and discharge and care and treatment. Rights and safeguarding and clinical governance scored 100%. Information, consent and confidentiality was rated at 85%.

## The involvement of people in the care they receive

- The ward used a feedback questionnaire to gather the views and feedback of patients. Eight respondents said they were either happy or very happy with the way staff listened and understood them
- An advocacy service visited the hospital once a week. This service was provided by the National Youth Advocacy Service (NYAS). A leaflet for the service was available on the ward giving full contact details and stating that an advocate visited the ward each week.
- When patients were admitted to the ward, their families were always invited to a welcome meeting. This

# Child and adolescent mental health wards

provided an opportunity for parents to meet with therapists and nursing staff. A meeting was also arranged for the young person's parents to meet with the consultant psychiatrist in the first week of admission. Parents are encouraged to visit the ward frequently and nurses were able to update them on their child's progress by telephone. A carers' support group took place once a month. Family therapy was carried out with most patients.

- Community meetings were held once a week. Minutes of these meetings were written up and displayed on a notice board. At a recent meeting, patients discussed the ward rules and plans for activities. A satisfaction survey was completed by patients when they were discharged. Eight surveys had been returned between January and March 2016. These surveys were overwhelmingly positive. In response to a question about whether patients felt listened to and understood by professionals, four patients said they were very happy and four said they were happy. Patients commented that staff were friendly, they had made lots of friends and that staff helped with their problems. Feedback from patients was a standing item on the minutes of clinical governance meetings. The minutes of the clinical governance meeting on the 15 January 2016 showed that two CAMHS patients attended the meeting and asked whether one of the rooms could be converted into a multipurpose room with punch bags, whether patients could go running each day and reported that the fridge had been turned off causing the food to spoil. Patients were also asked to submit questions to be asked at selection interviews for new staff.
- We did not see any evidence of patients making advance decisions.

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

Good 

Access and discharge

- Bed occupancy between July and December 2015 was 95% on Birch ward and 88% on Oak ward. This means that, on average, 19 out of the 21 bedrooms were occupied during this period.
- Patients were not admitted to the ward to beds allocated to patients who were on leave. When patients go on leave their rooms are locked and are not reopened until the patient returns.
- Patients were occasionally moved between wards in response to bullying or serious disagreements between patients. These moves always take place with the consent of the patient.
- Discharge was always planned and took place at an appropriate time of day. When patients were discharged a party takes place to wish them well in the future.
- If patients become increasingly unwell, the level of observation is increased. Staff try to avoid transfers to psychiatric intensive care units as it can be difficult to find places and it can be very disruptive for the patient. A patient was recently transferred to a low secure unit but returned to the hospital after two weeks. This meant that consistency and continuity was being maintained.
- There were two delayed discharges on Birch Ward between 1 July and 31 December 2016. Delays to discharge were usually caused by a lack of accommodation for patients to move to. All delayed discharges are reviewed by NHS England, the commissioning authority. The ward manager said that the commissioner at NHS England often attended ward rounds for patients whose discharge had been delayed and helped speed up the process by liaising with local authority housing departments.

The facilities promote recovery, comfort and dignity and confidentiality

- CAMHS patients had a separate enclosed part of the garden with picnic tables. This could be used for playing games such as football. There was a separate annexe downstairs from the wards with rooms that could be used by CAMHS visitors and patients. The art room was very well equipped. Patients spoke highly of the art teacher and the support she gave them with Art A levels and GCSEs. Patients were also able to produce art work on the ward, both individually and in groups.
- Patients had personalised their bedrooms with posters and their own possessions.
- There was an education room on Birch which was used by patients from both CAMHS wards.

# Child and adolescent mental health wards

- Patients could make phone calls from the office in private if they wished.
- Patients we spoke to said food was good, and they could make a drink or snack when they wished
- There were lockers that patients could use to secure their possessions.
- There were activities during the evenings and at weekends. An activity coordinator was employed to work on some evenings and on Saturday afternoons.

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

- Both wards were situated on the first floor. There was no lift available so access for disabled people was very limited.
- All leaflets and other information was written in English. Staff said that this information could be translated into other languages if required.
- Information was displayed about treatment, patients' rights, how to make a complaint to the hospital and how to contact the Care Quality Commission.
- The hospital was able to arrange interpreters and signers if they were required.
- An extensive menu of healthy food was available for each meal. The menu included dishes that were clearly labelled as being dairy free, gluten free, vegan and free from genetically modified ingredients. Kosher and Halal food was available on request.
- The hospital helped patients to access spiritual support according to the specific requirements of the patient. Staff explained that this was usually done with the assistance of the patient's family.

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

Good 

### Vision and Values

- We interviewed seven staff on Birch and Oak including the ward manager, deputy ward manager, registered nurses, health care assistants and a therapist. They all demonstrated a positive attitude that was caring and supportive to patients. Staff spoke positively about working with their team and the ongoing opportunities for learning and development.

- Staff spoke positively about the hospital director and the ward manager. All staff knew who the hospital director was and said that she was always visible and frequently visited the ward. Staff also said that the ward manager and deputy ward manager were always available and approachable. One nurse said that the deputy ward manager was an excellent role model and mentor. The medical director said that he visited each ward at least three times each week and discussed patients' care with nursing staff.

### Good governance

- A governance system was in place. The overall compliance rate for mandatory training was 86%. Shifts were covered by sufficient numbers of staff who were suitably qualified and staff spoke positively about spending time engaging with patients. Incidents were reported and learning from incidents was taking place. Fourteen staff had received an appraisal in the three months prior to the inspection, with many appraisal summaries including very positive comments. Staff were supported through regular group supervision sessions. One-to-one managerial supervision sessions to provide support and make sure competency is maintained took place less frequently. Governance of the hospital was provided through the monthly clinical governance meeting. The minutes of these meetings were distributed across the staff team. A regular safeguarding meeting also took place and the medical advisory committee met twice a year.
- The ward manager said he felt supported by the hospital director and that he had sufficient authority to manage the ward. He was supported by a ward clerk and valued the support he received from his colleagues.
- Staff could submit items to the hospital's risk register through the ward manager or they could speak directly to senior managers.

### Leadership, morale and staff engagement

- A staff survey was carried out in October 2015. Sixty-four per cent of respondents said that they were proud to work for the Priory Group and 67% said that working at the hospital made them want to do the best work they could. However, only 43% said that they would recommend the Priory Group to their friends and family as a good place to work.

# Child and adolescent mental health wards

- The sickness rate for permanent staff across the hospital in 2015 was 5%. There were two members of staff on long-term sick leave.
- There were no concerns about bullying or harassment raised during this inspection.
- Staff told us that they either knew, or knew how to find out about, the whistle blowing process and they all felt able to raise concerns without fear of victimisation.
- Staff spoke positively about team work and mutual support. Staff told us that they valued the opportunities for working and learning together with colleagues at training days and group supervision sessions. One health care assistant said that she really enjoyed working at the hospital and found her colleagues to be very supportive.
- The ward manager had been in post for about one year. During this time he had had training in leadership and resilience to staff working on the ward.
- Staff said that they found the ward manager and senior managers very approachable. They said that they felt able to give input into service development through team meetings on the ward and at senior management team meetings through their ward manager.

## Commitment to quality improvement and innovation

- The hospital was part of the Quality Network for In-patient CAMHS (QNIC).

# Outstanding practice and areas for improvement

## Areas for improvement

### Action the provider **MUST** take to improve

- The provider must ensure that ligature points across the wards are minimised. Audits of ligature points should be completed for all areas of the hospital, including the laundry room on Lower Court.

### Action the provider **SHOULD** take to improve

- The provider should ensure that it has a full complement of permanent nursing staff.

- The provider should ensure that staff are familiar with the principles of the Mental Health Act Code of Practice and the Mental Capacity Act.
- The provider should ensure that the issuing and routine testing of personal alarms is recorded.
- The provider should ensure that regular, individual supervision is available to all staff.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
Assessment or medical treatment for persons detained under the Mental Health Act 1983	<b>We found that the premises used by the service provider were not safe to use for their intended purpose.</b>
Diagnostic and screening procedures	
Treatment of disease, disorder or injury	There were high risk ligature points in rooms designated as safer rooms. There were high risk ligature points in the laundry room that had not been identified.
	This is a breach of regulation 12(2)(a)