Annesley House

Quality Report

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

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

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

Summary of findings

Overall summary

This was a responsive inspection and we only looked at three of the five key questions, which were safe, effective and well led. At our previous inspection in August 2015, we rated the other two key questions of caring and responsive as good. We have received no further intelligence to suggest any issues that would change these ratings.

We issued a warning notice to the provider as we identified a breach of Regulation 12 in relation to patient observations.

We rated Annesley House as requires improvement because:

- Staff did not observe patients on Oxford Ward as often as needed to make sure patients were safe.
- Staff did not consistently store medicines at safe temperatures and emergency equipment was not always in date.
- There were eight vacancies for registered nurses and agency staff were used to cover. The provider did not make sure that the estimated number and grades of staff worked on each ward on every shift.
- The provider did not offer psychological therapies to each patient to meet their assessed need.
- The provider did not offer specialist training to all staff to help them support patients.
- There had been two changes of managers within the last nine months, which had unsettled the hospital. There was no registered manager in post at the time of our inspection. An acting manager was in post.
- Audits did not always identify the risks to the health, safety and welfare of patients.

However:

- The environment was clean and safe.
- Restraint and seclusion were used appropriately and in line with current guidance.
- Staff followed safeguarding, Mental Health Act and Mental Capacity Act procedures and policies.
- Staff assessed each patient's risks and needs and developed a care plan with the patient.
- The provider made sure that staff had mandatory training.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Location	Requires improvement 	Start here...

Summary of findings

Contents

Requires improvement

Annesley House

Summary of this inspection

Background to Annesley House

Annesley House is an independent hospital that aims to provide care, treatment and rehabilitation for up to 28 female patients on three wards. The hospital offers a nine bed low secure service on Durham ward, and a locked rehabilitation service on two wards: Cambridge with 11 beds and Oxford with eight beds. Cambridge Ward is the admission ward. The service aims to provide a range of clinical therapies and individual treatment programmes for women detained under the Mental Health Act (1983). We inspected all three wards. There were 26 women detained at the service across the three wards when we did our inspection.

Partnerships in Care Limited provided the service. The provider merged with the Priory Group in December 2016 and is now part of the Priory Group.

There was no registered manager at the time of our inspection. There was an acting manager in post.

Our inspection team

Team leader: Sarah Bennett

The team that inspected Annesley House consisted of one CQC mental health hospital inspection manager, five CQC mental health hospital inspectors, one CQC inspector from Primary Medical Services directorate shadowing, one specialist adviser who had experience as a forensic psychologist, another who had experience as a mental health nurse and one expert by experience (a person who has used mental health services).

Why we carried out this inspection

We inspected this service following a serious incident and information about the service from NHS England and the local clinical commissioning group (CCG). The inspection was unannounced.

When we inspected Annesley House in August 2015, we rated it as good overall. We rated Annesley House as good for safe, effective, caring, responsive and well-led. There were no breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identified at the previous inspection.

We told the provider it should consider the following:

- The hospital should continue to reduce the use of prone restraint.
- The hospital should ensure there are clear arrangements for returning unwanted medication to the pharmacy service.
- The hospital should ensure patients risk assessments are recorded prior to section 17 leave.
- The hospital should ensure staff are aware of their responsibilities under the Mental Capacity Act and adhere to the Code of Practice.
- The hospital should ensure patient's capacity to understand their rights is recorded.
- The hospital should ensure required staff complete food hygiene training.
- The hospital should ensure that calming rooms have the facility to reduce light into the room.
- The hospital should continue to ensure staff have good access to specialist training especially autism and eating disorders. Occupational therapists should have a greater understanding of sensory needs of people living with autism.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following three questions of the service and provider at this inspection:

- Is it safe?
- Is it effective?
- Is it well-led?

Before this unannounced inspection, we reviewed information that we held about the service, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited all three of the wards and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with 17 staff members; including ward manager, doctors, nurses, psychologist and occupational therapists
- spoke with the independent mental health advocate who was visiting and a visiting GP
- looked at 14 treatment records and 11 care records of patients.
- carried out a specific check of the medication management on all three wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Annesley House

Annesley House is an independent hospital that aims to provide care, treatment and rehabilitation for up to 28 female patients on three wards. The hospital offers a nine bed low secure service on Durham ward, and a locked rehabilitation service on two wards: Cambridge with 11 beds and Oxford with eight beds. Cambridge Ward is the admission ward. The service aims to provide a range of clinical therapies and individual treatment programmes for women detained under the Mental Health Act (1983). We inspected all three wards. There were 26 women detained at the service across the three wards when we did our inspection.

Partnerships in Care Limited provided the service. The provider merged with the Priory Group in December 2016 and is now part of the Priory Group.

There was no registered manager at the time of our inspection. There was an acting manager in post.

What people who use the service say

Three patients on Durham Ward told us they felt safe there. Three patients on Cambridge Ward told us they did not feel safe due to the risks of another patient. This patient was in seclusion at the time of our inspection, which reduced the risk to other patients.

One patient on Oxford Ward said they liked the responsibility of doing cleaning jobs on the ward. The provider had interviewed a patient on Cambridge Ward for a cleaning job in the hospital. They said this helped them to feel they were doing something useful during their stay there.

Four patients told us they did not feel safe when only agency staff who they did not know were on duty, as staff did not know the patients. One patient on Oxford Ward said that staff did not do the observations properly and this made them feel unsafe.

Summary of this inspection

Patients said they could access advocacy support and the advocate was very good.

Patients said nurses were supportive but there were not enough of them. Another patient said the staff were fantastic.

Three patients on Cambridge Ward told us they did not have the psychological therapies they thought they would get when they came to the hospital. One patient said they waited seven months before they started psychology and now only had one hour a week.

One patient said they had the opportunity to feedback on how the provider ran the service and had spoken at service user conferences.

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?

Inadequate

We rated safe as inadequate because:

- Staff on Oxford Ward did not do observations of patients as often as they should have done to keep the patients safe.
- Staff did not always make sure that medicines were stored at safe temperatures. Staff did not consistently check patients' physical health as required before giving them their prescribed medicines.
- Staff did not consistently check emergency equipment to make sure it was safe to use.
- The wards were clean. However, staff had not always recorded that they had done the cleaning needed.
- We observed that some staff wore long sleeves, nail polish and rings, which could have increased the risk of cross infection.
- The provider had not made sure that the estimated numbers and grades of staff were always present on the ward to make sure that patients were safe.
- Permanent staff reported incidents as needed. However, agency staff did not have access to the electronic incident reporting system. This meant that they were not able to record incidents on the system as they happened.

However:

- The provider had trained all staff in mandatory training and provided regular updates of this.
- Staff completed risk assessments that detailed how staff were to support each patient to manage the risks to their safety and welfare.
- Staff only restrained patients after de-escalation had failed and staff used the correct techniques. The provider had trained all staff in how to use restraint safely.
- Staff used seclusion appropriately and records showed that staff assessed, as needed, each patient when using the seclusion room.
- Staff received training in safeguarding adults and children from abuse and knew how to report to the local authority safeguarding team.
- The provider had safe procedures in place for children to visit the hospital.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of this inspection

- Agency staff did not have access to the computer system so they could not record the care and treatment they gave to patients in a timely way.
- The hospital did not employ enough psychological therapists to make sure that the provider offered all patients psychological therapies to meet their needs.
- The provider did not provide specialist training that staff needed to meet the needs of all patients they cared for.

However:

- Patients had a physical health examination on admission. Most patients had regular checks of their physical health.
- Staff had assessed the needs of patients and developed a care plan with each patient so that all staff knew how to support them.
- Staff completed an induction when they first started working at the service.
- The multidisciplinary team included doctors, psychologists, nurses, occupational therapists and social workers. They worked together to provide treatment for the patients and ensure patients' needs were met.
- The hospital worked well with the local authority safeguarding team.
- The provider trained staff in the Mental Health Act and the Code of Practice.
- Patients were aware of their Section 17 leave and where they could go, who with and for how long.
- The provider trained staff in the Mental Capacity Act and its guiding principles
- Where a patient lacked the capacity to make a decision about their physical healthcare, decisions were made in line with the Mental Capacity Act in their best interests.

Are services caring?

Good

Are services responsive?

Good

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- The changes of managers had unsettled and affected the stability of the hospital, its patients and staff.
- Staff vacancies and the use of agency staff had a negative impact on permanent staff and patients. Permanent staff told us that there was not enough consistent staff to provide a stable environment for patients.

Summary of this inspection

- Staff did not always identify in audits where there were risks to the health, safety and welfare of patients.

However:

- Staff knew and agreed with the values of the organisation. They said that the recent merger had been positive and there were not many changes to their working practice.
- Teams worked together and offered mutual support.
- The provider had a recruitment plan in place to address the staffing issues.
- The hospital took part in national quality improvement programmes.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff knew who the Mental Health Act administrator was. The administrator had good knowledge of the Act and offered support to make sure staff followed the Act.
- The service kept clear records of leave granted to patients. Patients and staff were aware of the conditions of leave granted and the risks involved. Before the patient went on leave, staff assessed the risks and following the leave, assessed with the patient how their leave went.
- All staff had received training in the Mental Health Act, the Code of Practice and the guiding principles.
- Staff followed consent to treatment and capacity requirements.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely and regularly after, depending on the needs of the individual.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- There were regular audits to make sure that staff correctly applied the Mental Health Act.
- Patients had access to the Independent Mental Health Advocate who visited the hospital weekly.

Mental Capacity Act and Deprivation of Liberty Safeguards

- The provider told us that 95% of staff had received training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards.
- Staff spoken with had a good understanding of the Mental Capacity Act and its guiding principles.
- Staff understood, and where appropriate, worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice about the Mental Capacity Act within the organisation.

Requires improvement

Location

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

Is the location safe?

Inadequate

Safe and clean environment

- On all wards, we saw that the ward layout did not allow staff to observe all parts of the ward. Bedrooms were out of view from staff. The provider installed convex mirrors to reduce the risks. However, the mirrors were not visible from the nursing office on Oxford Ward. We observed during our inspection that staff carried out observations from the nursing office on Oxford Ward. This meant that they could only view the lounge area and not the bedroom corridors, which did not reduce the risks.
- Staff completed an annual ligature risk audit. A ligature risk audit is a document that identifies places/ objects to which patients intent on self-harm might tie something to strangle themselves. A manager had completed this on Cambridge Ward the day before our inspection. The provider had reduced the risks of ligature points by using anti-ligature fittings, for example, taps, curtain rails and shower fittings. Staff completed individual risk assessments for the risk of ligatures in each patient's bedroom. Staff said that since the change of provider, they had moved ligature cutters to the ward office from the clinic room. They said this made them easier to access so they could use them quickly in an emergency.
- We saw the clinic room on each of the wards. We found that staff were not consistent in checking the emergency equipment and drugs regularly. On Durham Ward, we saw that staff checked the emergency equipment as needed and recorded this. On Cambridge Ward, staff had checked the emergency equipment bag as needed and recorded that it was all there and in date. However, we saw that one medicine was out of date. The registered nurse on duty removed this and ordered more to replace this. On Oxford Ward, staff had not recorded that they had checked the emergency equipment bag daily as required.There was no record to say that staff had checked it on 6, 7 May and between 9 to13 May 2017. Staff on Oxford and Cambridge Wards had not completed the weekly check of the emergency equipment bags on 7 May 2017. However, other staff had completed weekly clinic room audits but had not identified where staff had not done checks so that the provider could take action to rectify this. This meant that the equipment and drugs staff needed to support a patient in an emergency might not be available.
- There was one seclusion room on Cambridge Ward. A patient was using the seclusion room at the time of our inspection so we were not able to do a full check. Staff told us that the seclusion room allowed clear observation, two–way communication, had toilet facilities and a clock.
- We saw that the wards were clean. Staff had completed records to say they had cleaned Durham and Cambridge Wards as required. However, on Oxford Ward there were gaps in the housekeeper weekly cleaning records for weeks commencing 20 March 2017, 17 April 2017 and 1 May 2017. This meant that the provider did not assure us that staff regularly cleaned the ward in order to reduce the risk of infection.

- We observed that some of the chair covers were torn in the lounge area of Cambridge Ward. Patients had also said this in their community meetings. The minutes of the clinical governance meeting dated 26 April 2017 showed that the provider had ordered chairs to replace these and on other wards.
- The provider told us that 97% of staff had received training in infection control. We observed that staff who worked on the wards with patients wore long sleeves, several rings and nail polish. These could increase the risk of cross infection. We asked the provider for their infection control and dress code policy after our inspection. These policies did not include wearing these items as a risk to infection control.
- Patients had access to call bells in their bedrooms but not in their shower rooms. Some patients said this made them feel unsafe as they might slip in the shower room and not be able to call for help. All staff carried alarms that they attached to their belt. Staff signed in and out for alarms at reception at the beginning and end of their shift. They tested their alarms before each use. The provider gave all members of the inspection team an alarm at the start of the inspection.

Safe staffing

- The provider told us that the staff sickness from August to December 2016 ranged from 1.08% to 2.80%.
- The provider said that four registered nurses left in February and the hospital director left in March 2017. One of the registered nurses transferred to the bank staff list.
- The provider told us that, as at 6 April 2017, there were eight whole time equivalent vacancies for registered nurses: three each on Cambridge and Durham Wards and two on Oxford Ward. There was one whole time equivalent health care worker vacancy in the hospital. Staff told us and rotas showed the number of registered nurses did not match the estimated number and grade on all shifts. For example, on each shift day and night on Cambridge Ward there should be five staff – two registered nurses and three health care workers. Staff gave us a copy of the rotas and allocation of staff on each ward day and night. This showed on Cambridge Ward from 1st to 12th May 2017, that in 14 of the 24 shifts, the rotas did not match the estimated number and grade of staff.
- Staff and patients on Oxford Ward told us that managers often moved registered nurses to Cambridge Ward. This meant that agency registered nurses who were unfamiliar with Oxford ward often worked there. On the day of our inspection, managers moved a registered nurse from Oxford to Cambridge Ward to fill the gap there.
- The provider used agency and bank nurses to fill the vacancies. The provider told us that they used regular agency staff and some had a block booking so had worked there for several months. Three patients told us that on the night of 5 May 2017, unfamiliar agency staff had worked on the ward. They said that they did not feel safe, as the staff did not know their name. We saw on the 'weekly authorisation form for agency staff usage' that 10 agency staff worked that night and most had worked at the hospital before. It was not clear if they were familiar with each ward and the patients there.
- All ward managers and the nurse in charge attended the morning managers meeting from 9 am to 10 am off the ward. This meant that if the nurse in charge was the only registered nurse on the ward, a registered nurse was not present in communal areas of the ward at all times.
- We saw and staff told us that managers increased staffing levels where the levels of patient observations had to be increased to reduce the risks to their safety and welfare.
- Two of ten patients told us there was not enough staff for their named nurse to have regular one to one time with them.
- Staff rarely cancelled escorted leave or ward activities because there was too few staff.
- There were enough staff to safely carry out physical interventions.
- Two psychiatrists worked at the hospital. One doctor told us that there was enough medical cover day and

night so that a doctor could attend the ward quickly in an emergency. There was an on-call system with doctors from the other four hospitals in the area. Each doctor did on – call for one week in every seven.

- The provider made sure that staff received and were up to date with appropriate mandatory training. Mandatory training figures ranged from 86% to 100%.

Assessing and managing risk to patients and staff

- Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others. There were 20 incidents of seclusion at the hospital in the last six months up until 30 April 2017. Nine of these were over 24 hours and the other 11 were for less than 24 hours. There were no incidents of seclusion in February 2017.
- Long- term segregation is where, in order to reduce a sustained risk of harm posed by the patient to others, a multi-disciplinary review and a representative from the responsible commissioning authority decides that a patient should not be allowed to mix freely with other patients on the ward or unit on a long-term basis. However, patients should not be isolated from contact with staff or deprived of access to therapeutic interventions. There were no incidents of long - term segregation in the last six months up to 30 April 2017.
- We looked at 11 care records of patients. These showed that staff completed a risk assessment of each patient on admission and updated this regularly and after every incident.
- On Cambridge Ward, we found that staff gave patients toilet paper as needed due to the risk of one patient who swallowed it as a means of self–harm. Patients told us how this restricted them and they felt that staff did not treat them with dignity. Records we looked at did not include risk assessments for each patient on the ward as to why staff needed to use this blanket restriction. A blanket restriction is something that the hospital or staff on the ward imposes on all patients and is not based on each patient's individual risk.
- Staff did not always follow the observation policies. On Oxford Ward, we saw that staff had not completed patient 15-minute observation sheets on 14 May 2017 from 18:30 to 19:45. The sheets were pre–printed with the times. This meant that the observation was not based on each patient's individual need and the times they needed staff to observe them. On Oxford Ward, we observed that staff completed the observations from the nursing office on the ward. They did not go and check on the patients.A member of staff on Oxford Ward told us that the provider had installed convex mirrors for staff to view the corridor and bedroom areas of the ward. There was no view of these areas from the nursing office so staff used observations to reduce these risks. The provider observation policy dated April 2016 stated, "When conducting both general and enhanced observations of patients, staff must make visual contact of the patient ensure and check that the patient is well and responsive." Therefore, staff did not comply with the provider's observation policy.
- We saw that staff did not complete the observations on 16 May 2017 (the day of our inspection) at 11:15, 11:30 and 11:45. Staff filled in the observation sheets for these periods at 12:10. Staff did not complete the observation for 13:45 until the inspection team highlighted this to the nurse in charge at 15:10. The provider's policy, dated April 2016 stated, "Checks are to be conducted within the timeframes required as per observation level." Staff had not followed this policy. The policy also stated, "Random spot checks must be conducted out of those timeframes." We saw that that staff did not do these during our inspection. The provider policy stated that the nurse in charge would delegate staff to the observations. The nurse in charge did not do this on Oxford Ward.
- At the hospital reception, there was a button, which staff, patients and visitors pressed on entering, and this signalled if a random search was needed. Records we looked at showed that staff did additional searches on patients based on the patients individual risk assessment.
- Three patients on Cambridge Ward told us they did not feel safe on the ward because of another patient. This patient had assaulted staff and one of the patients. Commissioners had assessed the patient, as needing to be moved to a more secure placement but this placement had not been identified. The patient was in seclusion at the time of our inspection, which reduced the risk to other patients.

- One patient had injured two nurses on Cambridge Ward in the last three months. Both staff attended hospital because of their injuries.
- Staff only used restraint as a last resort after de-escalation had failed. The provider said and records showed that 98% of staff had received training in the management of violence and aggression.
- Records showed and staff said that rapid tranquilisation (an injection given to calm a patient down) was not often used. The records we looked at showed that staff followed the National Institute for Health and Care Excellence (NICE) guidance when they used rapid tranquilisation.
- Staff showed they had a good understanding of why they would use seclusion and that it should be for the shortest time possible.
- We reviewed the records for the patient who was in seclusion at the time of our inspection. These showed that staff had followed the seclusion policy and registered nurses, the doctor and the multidisciplinary team had completed the required reviews.
- The provider trained staff in safeguarding. The provider told us and records showed that 96% of staff had received training in safeguarding adults level 1 and 98% had received training in safeguarding children level 1. Staff knew how to make a safeguarding alert and did this when appropriate. For example, one patient gave their partner their bankcard and staff were concerned the patient could be at risk of financial abuse so they reported this to the local authority safeguarding team.
- Medicines were not always stored or disposed of safely. On Oxford Ward, we found staff had not tested the temperature of the medicine fridge since 5 May 2017, as the thermometer was not working. Staff had not taken action to address this. Staff had only recorded the temperature of the clinic room once since 5 May 2017 to make sure it was safe to store medicines. On Durham Ward, we found that medicines that staff had put in a sealed bag and recorded as out of date on 2 March 2017 were still waiting to be disposed of. There were tablets for a patient who left in January 2017 still in the clinic room. On Cambridge Ward, we saw that staff had stored two boxes of medicines for destruction in the clinic room. Staff told us they were not sure of the process for returning medicines not used to the pharmacy.
- Doctors had not always reviewed medicines they had prescribed to be given when needed to make sure they were still effective in treating the patient. On Cambridge Ward, the doctor had prescribed medicines for a patient to be taken as required. The doctor had not reviewed one of these medicines since July 2016 and another since November 2016. Staff had given another patient a medicine to help the patient sleep, which was prescribed to be given only as required almost every night from the 1st to 16th May 2017.
- Staff did not always give patients their medicines safely. One patient was prescribed a medicine that the doctor had instructed staff to check the patient's pulse before giving. The patient's medicine chart showed that staff had only recorded this on six days out of 15 in May. For another patient, staff had not recorded they had taken the patient's pulse twice in May before giving the prescribed medicine. The doctor had prescribed another patient medicine for their diabetes, which needed staff to test their blood sugar before giving. Staff had recorded they had done this on only 11 of 22 days in April 2017.
- All medicine cards included a photograph of the patient and recorded any allergies.
- There was a visitor's room on the ground floor of the hospital that was safe for children to use. Staff told us that the hospital social worker completed a risk assessment before a child visited the hospital to make sure they were safe.

Track record on safety

We received a notification of a serious incident on Oxford Ward in March 2017. This is under investigation by the coroner and the hospital has a process in place to investigate so that any lessons can be learnt.

The provider notified CQC and the local authority of safeguarding incidents. They carried out investigations where appropriate and made changes to practice.

Reporting incidents and learning from when things go wrong

Requires improvement

Location

- Staff reported incidents on the provider's electronic incident reporting system. However, as agency staff did not have access to the computers, it was not clear how incidents would be reported if there were only agency staff members on duty.
- Staff told us that they learnt from incidents in reflective practice sessions, supervisions and staff meetings.
- We found on Oxford Ward staff had not completed observations as needed.
- Staff told us they had a debrief following incidents. Staff on Oxford Ward told us that they and patients were well supported following the death of a patient there and were given opportunities to debrief.

Is the location effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- We looked at 11 care records of patients. These showed that before a patient was admitted, staff from the hospital completed an assessment of the patient's needs. Staff completed a care plan with the patient following their admission. Patients told us they were not involved in their care plans; however, we saw evidence of patients' involvement in their care planning in the records we looked at. Staff reviewed patient's care plans regularly or when their needs changed.
- Care records showed that staff checked the patient's physical health needs within six days of admission. There were plans in place for patients' physical health conditions where appropriate. Ten records showed that staff monitored patients physical health needs. However, one record showed that staff completed the patient's routine physical observations in April 2017. The next review was due on 11 May 2017 but staff had not recorded that they had done this at the time of inspection.
- Care plans we looked at were up to date, personalised and holistic.
- Information that staff needed to deliver care was stored securely. However, electronic records were not available to agency staff.

Best practice in treatment and care

- In the records we looked at, we saw staff had followed the National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. Staff followed the provider's high dose prescriptions protocols.
- The provider did not offer psychological therapies as recommended by NICE to patients when they needed them. A forensic psychologist worked at the hospital for three days of their week. The provider employed one trainee psychologist who worked for less than half a week at the hospital. Following health and safety risk assessments, they could not have any contact with patients at this time. The forensic psychologist told us that they saw 10 of the patients at the hospital.
- Three of six patients' records on Oxford Ward showed they attended a weekly "mindfulness" group. One patient's records showed their last recorded psychology session was on 15 March 2017. However, their last review stated they needed cognitive behavioural therapy. There was no record that this had been offered. Another patient was admitted in February 2015 and had only two recorded psychology sessions since admission. Their last review minutes said they needed psychological therapy. Another patient's records showed they last had contact with a psychologist in October 2016, but their care plan review stated they needed psychological therapies. One patient told us they had been at the hospital for 10 months and it had taken seven months to get psychology. This was only for one hour a week and no group therapies were offered.
- A psychologist specialist advisor was part of the inspection team. They looked at the dialectal behaviour therapy (DBT) offered to patients at the hospital. They said that staff could not offer patients a full DBT programme , as there was only three staff trained in this approach, so a DBT-informed therapy was offered instead.

- Patients had access to physical healthcare. A GP visited the hospital each week to see patients. Patients went to the GP surgery for cervical screening and other physical health checks. A foot health practitioner visited weekly.
- A dietician visited the hospital to offer advice when needed. Staff ran walking groups and a gym instructor visited weekly.Patients and staff said that menus offered healthy options, less desserts and fruit was always available.
- Staff used recognised rating scales to assess and record severity and outcomes. This included health of the nation outcome scales (HONOS).
- Clinical staff took part in clinical audits. These included environmental checks, clinic room, medicine checks and high dose prescriptions.

Skilled staff to deliver care

- The full range of mental health disciplines and workers provided input to the hospital. However, there were not enough psychological therapists to provide the support that patients needed.
- Permanent staff were experienced and qualified. However, it was not always clear whether agency staff who did not work there regularly had the skills and qualifications needed for their role.
- Staff received an appropriate induction, which included the care certificate for healthcare support workers.
- The provider told us that staff had regular supervision. At the time of our inspection, the provider's records showed that 100% of staff on Durham Ward, 93% on Cambridge Ward and 89% on Oxford Ward had supervision at least every two months.
- Medical staff said they had an annual appraisal. Two nursing staff said they had not had an appraisal. The provider's records showed that 89% of staff on Durham Ward, 80% on Cambridge Ward and 100% on Oxford Ward had an annual appraisal.
- Staff told us they received mandatory training but did not receive specialist training for their role. At our previous inspection in August 2015, we recommended that the provider offer staff specialist training in autism and eating disorders. Staff said the provider had not offered this training, although the provider told us Autism training was included in the staff induction.
- The provider took prompt action to address poor staff performance when an allegation was made in December 2016.

Multi-disciplinary and inter-agency team work

- There were regular and effective multidisciplinary meetings. The multidisciplinary team consisted of a psychiatrist, a psychologist, nurses, health care workers, occupational therapist and assistants. A pharmacist visited weekly.
- At the beginning of each shift, there was a handover, which lasted about 20 to 30 minutes. These included all staff on the shift and agency staff.
- Agency staff did not have access to the hospital computer systems. It was not clear how agency staff would input information about patients' needs if there were no regular staff on duty.
- The provider had good working relationships with the local authority safeguarding team.
- Following our inspection, we spoke with representatives from two of the clinical commissioning groups who placed patients at the hospital. They expressed concerns about how the provider made sure individual patients needs were met and had met with the managers to inform them of this.

Adherence to the MHA and the MHA Code of Practice

- A competent staff member examined Mental Health Act papers at the time of the patient's admission and we saw that these included all the information required.
- Staff knew who the Mental Health Act administrator was. The Mental Health Act administrator had good knowledge of the Act and offered support to make sure staff followed the Act.
- The service kept clear records of leave granted to patients. Patients and staff were aware of the

Requires improvement

Location

conditions of leave granted and the risks involved. Before the patient went on leave, staff assessed the risks and following the leave assessed with the patient how their leave went.

- All staff had received training in the Mental Health Act, the Code of Practice and the guiding principles.
- Staff followed consent to treatment and capacity requirements. Copies of consent to treatment forms were attached to medication charts where applicable.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely and regularly after, depending on the needs of the individual.
- Administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice was available from a central team.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- There were regular audits to make sure that staff applied the Mental Health Act correctly.
- Patients had access to the Independent Mental Health Advocate (IMHA) who visited the hospital weekly. They told us they delivered a presentation on their role to staff during induction. The IMHA produced quarterly reports on themes that patients had spoken with them about. They discussed this in their meetings with the hospital director.

Good practice in applying the MCA

- The provider's records showed that 95% of staff had received training in the Mental Capacity Act and Deprivation of Liberty Safeguards.
- There were no Deprivation of Liberty Safeguards applications made in the last six months. All patients were detained at the hospital under the Mental Health Act.
- Staff spoken with had a good understanding of the Mental Capacity 2005 and its guiding principles.
- Where a patient lacked the capacity to make a decision about their physical healthcare, this decision was made in line with the Mental Capacity Act in their best interests.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding the Mental Capacity Act with the organisation.

Is the location caring?

Good

Is the location responsive to people's needs?

(for example, to feedback?)

Good

Is the location well-led?

Requires improvement

Vision and values

- The values of Partnerships in Care were "We believe that our patients and their families deserve the highest quality care possible with the values of: valuing people, caring safely, integrity, working together and quality." Staff were aware of and agreed with these values. They said that these had not changed following the merger of the organisation with the Priory Group.
- Staff knew who the most senior managers in the organisation were and these managers had visited the hospital. Senior managers did a weekly walkabout of the hospital and spoke with staff and patients.

Good governance

- On the computer system there was a summary of the risks, needs and staff performance for each ward (known as a dashboard) that provided key performance indicators for staff to achieve. For example, this included the status of each patient under the Mental Health Act, when staff needed to tell them their rights, risk assessments, details of seclusion, observation levels for each patient and their

physical health checks. This gave the ward manager a quick overview of how the ward was running and what staff needed to do to make improvements for the patients. Managers at the daily morning meeting reviewed the dashboard for each ward weekly. These meetings included the nurse in charge from each ward, hospital director, ward managers and occupational therapists, psychologist and psychiatrists when they were available.

- The provider ensured staff received mandatory training and were regularly appraised and supervised. Staff reported incidents and followed safeguarding, Mental Health Act and Mental Capacity Act procedures. There were monthly ward managers, charge nurse meetings, and local clinical governance meetings.
- We found that a sufficient number of staff of the right grades and experience did not always cover shifts.
- We found that staff did not always complete observations on Oxford Ward. Managers and senior nurses had not identified this as a risk to patients' safety.
- Staff had completed weekly clinic room checks. On Oxford Ward, staff completing the checks had not identified where other staff had not recorded the room and fridge temperatures. The checks had not identified that there was out of date medicine in the emergency equipment bag on Cambridge Ward. They also had not picked up that medicines that needed to be disposed of were stored in the clinic rooms on all wards.

Leadership, morale and staff engagement

- There had not been a registered manager in post since March 2017. The provider had recruited a manager who had left withdrawing their registration application. An interim manager from another hospital within the organisation was in post at the time of our inspection. They had not yet applied to be registered. Staff told us that the change of managers had been unsettling as each manager had their own way of working.
- Staff knew how to use the whistle blowing process. We saw that staff used this in within the previous 12 months and as a result, the provider dismissed a staff member.
- Staff spoken with told us they were able to raise concerns without fear of victimisation.
- Staff told us that assaults by patients on staff affected morale; although they said that reflective practice sessions had helped this. Staff also said that when staff were moved around wards this affected their morale as they knew that agency staff were on duty to cover their ward who did not know the patients well.
- Staff said that the recent merger of the organisation had helped morale as they had an opportunity to learn from others and the provider had used the better parts of each organisation to improve the service.
- Staff told us that the provider offered senior staff nurses a one-day course called 'Moving into Management'. They also offered ward managers a six-day leadership course.

Commitment to quality improvement and innovation

- Patients took part in the service user forum. Some patients had recently been awarded a national service users award and had attended the award ceremony.
- The hospital took part in national quality improvement programmes. There was a peer review visit from the Royal College of Psychiatrists in April 2017 and the provider was awaiting feedback from this.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must make sure that observations are done as needed for each patient to keep them safe.

The provider must make sure that staff check the emergency equipment bag as needed and identify and replace any equipment that is out of date.

The provider must make sure that medicines are safely stored, disposed of and reviewed.

The provider must make sure that staff complete physical health observations of patients where the doctor has prescribed medicines that need this.

The provider must make sure that the estimated number and grades of staff are employed on each shift to safely meet patients' needs.

The provider must make sure that they offer all patients assessed as needing psychological therapies to progress their recovery.

The provider must make sure that staff identify in audits where there are risks to the health, safety and welfare of patients.

Action the provider SHOULD take to improve

The provider should consider reviewing their infection control and dress code policies and that all risks of cross infection are reduced. This should meet the Department of Health Code of Practice on the prevention and control of infections and related guidance 2015.

The provider should consider the need for agency and bank staff to have access to the records needed so they can safely carry out their role.

The provider should consider the need for all restrictions to be risk assessed for each patient.

The provider should risk assess the staffing levels and complement of staff on each ward daily so there are always enough staff of the right grade to safely meet patients' needs.

The provider should consider the need that audits completed identify all the risks to the health, safety and welfare of patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The rooms where medicines were stored were above the recommended safe temperatures and staff had not taken action to reduce these. • Medicines were not disposed of as required. • Medicine prescribed for patients to betaken as required had not been reviewed. • Staff had not always recorded the physical observations of the patient before giving their medicines as requested by the prescribing doctor. • Staff had not checked the emergency equipment as often as needed. • The provider did not always make sure that the estimated number and grades of staff worked on each ward on each shift to safely meet patients' needs. • Staff did not always identify in audits where there were risks to the health, safety and welfare of patients. This was a breach of Regulation 12 (1) (2) (b)(f)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care • Psychological therapies were not offered to each patient to meet their assessed needs. This was a breach of Regulation 9 (1) (2) (3) (b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Staff on Oxford Ward had not completed observations on patients as often as needed to keep the patients safe. This was a breach of Regulation 12 (1) (2) (a) (b)