

The Priory Hospital Woking







Quality Report

Chobham Road
Knaphill
Woking
Surrey
GU21 2QF
Tel: 01483 489211
Website: www.priorygroup.com

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated the Priory Hospital Woking as good because:

- There were sufficient, appropriately trained, staff working at the hospital to meet the needs of the patients.
- Staff were confident in recognising and responding to safeguarding concerns.
- Medicines were securely stored and staff safely managed the administration of patients' medicines.
- Incidents were reported appropriately by staff using the hospital's electronic system and the lessons learned from investigating incidents were shared to all staff.
- Patients received a comprehensive assessment from a doctor and ongoing monitoring of their mental and physical health by the hospital's clinical staff.
- Patients had access to a structured treatment programme that matched their needs.
- The hospital's multi-disciplinary team was cohesive and met regularly to review patient needs.
- Staff used relevant tools to monitor patient progress and risks.
- Patients' concerns and complaints were recorded and investigated within the hospital policy target times.
- The governance structure and processes were effective. There was a yearly schedule for clinical audit and plans in place for continuous improvement in the treatment programmes available to patients.

However

- The amount of staff who had completed the training for the prevention and management of violence and aggression was below the hospital target.
- The quality of patient care plans and risk assessments was variable and not all plans contained complete information.
- Staff individual supervision rates had fallen below the hospital target due to a vacancy at ward manager level.
- The administrative resource allocated to the Mental Health Act was insufficient for the amount of detained patients.

Summary of findings

Contents

Summary of this inspection

	Page
Background to The Priory Hospital Woking	5
Our inspection team	5
Why we carried out this inspection	5
How we carried out this inspection	5
What people who use the service say	6
The five questions we ask about services and what we found	7

Detailed findings from this inspection

Mental Health Act responsibilities	10
Mental Capacity Act and Deprivation of Liberty Safeguards	10
Overview of ratings	10
Outstanding practice	19
Areas for improvement	19

Good



The Priory Hospital Woking

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Substance misuse/detoxification;

We inspected this service as a location and not as a core service. The service provides services to male and female adults with a range of mental health needs and issues with addictions.

Summary of this inspection

Background to The Priory Hospital Woking

The Priory Hospital Woking provides an acute inpatient service and an inpatient substance misuse treatment programme for men and women of working age. It has 35 rooms for patients across two gender specific wards. Cedar ward has 19 beds for men and Maple ward has 16 beds for women. There was one corridor of four beds which could become part of the male or female ward dependent on the gender mix required at the hospital at any time. At the time of our inspection there were 27 patients receiving treatment.

The hospital has an acute treatment programme for a range of conditions which include depression, stress and anxiety, and an eating disorders treatment programme for female patients.

The hospital provides a treatment programme for patients with addiction issues with substances and behaviour and provides medically assisted detox to patients who require this.

Patients who have used the inpatient services at the hospital can access up to 12 months of follow-up care. The day programme also provides an individual or group therapy programme to people who have not been inpatients but have been referred to the programme by a consultant psychiatrist.

We last inspected the Priory Hospital Woking in April 2016. The hospital received a Good overall rating. It had received one requirement notice from the last inspection which required that the hospital improved the timetable of structured activities available to patients that met their needs. During this inspection we saw that the hospital had a range of timetabled programmes available to all patients and were compliant with this requirement.

Our inspection team

The inspection team comprised: a CQC inspector, an assistant inspector, a CQC Mental Health Act reviewer, a psychiatrist specialist advisor, a mental health nurse specialist advisor, and an expert by experience.

Why we carried out this inspection

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

How we carried out this inspection

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

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

- Is it well-led?

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service

Summary of this inspection

- spoke with the registered manager and managers or deputy managers for each of the wards
- spoke with 16 other staff members; including doctors, nurses, therapists, and a peer support worker
- attended and observed two morning flash meetings, a nurses meeting and one multidisciplinary meeting
- collected feedback from patients using comment cards
- looked at 14 care and treatment records of patients
- carried out a specific check of the medication management on two wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with seven patients and collected one comment card completed by a patient.

All the patients were positive about the treatment they were receiving at the hospital. Patients told us that they found the support provided by the nursing and therapy staff had made a significant improvement to their wellbeing and recovery. They told us that staff were caring and respectful.

Patients told us that they felt confident raising issues with staff and that their concerns and complaints were responded to in a timely way.

Patients said that they found the standards of housekeeping and cleanliness were good.

All patients appreciated the quality and choice of the food available and said that the standards of catering were particularly good and that the chef was accommodating and flexible to all patient meal requests.

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 good because:

- All areas of the hospital were clean and well maintained. The cleaning schedules were thorough and carried out effectively.
- The hospital was fully staffed in the role of health care assistant. Vacancies for qualified nurses were covered by regular agency nurses who knew the patients, had received an induction to the wards and received mandatory training.
- Patients told us that there were sufficient staff to meet their needs.
- There was a strong culture of safeguarding adults and children. Staff were confident in recognising and reporting safeguarding concerns.
- Medicines were safely managed and stored and this was audited regularly.
- Staff reported incidents effectively and these were investigated by managers. Learning outcomes were shared to all staff via the learning from experience process.

However:

- Due to the absence of suitably experienced trainers, staff training in the prevention and management of aggression and violence was low at 52%. We saw that a trainer had been identified and staff were booked to complete this training in May 2018, therefore reaching 85% compliance.
- Patient risks were assessed and discussed at regular intervals but there was a variation in the completeness of risk records in patient files.

Good



Are services effective?

We rated effective as good because:

- All patients received a comprehensive assessment on admission by the resident medical officer. Patients' physical and mental health was monitored throughout their admission.
- Patients had access to a structured treatment programme that was tailored to their needs and delivered by appropriately qualified staff.
- Staff used relevant tools to monitor patient progress and risk levels during their treatment.
- There were good multi-disciplinary processes in place such as the daily meeting, weekly ward rounds and twice daily handover between therapy and nursing staff.

Good



Summary of this inspection

However:

- There was a significant variation in the quality and completeness of patient care plans.
- Due to a ward manager vacancy nursing staff supervision rates had fallen to 53%
- The resources allocated to the administration support of the Mental Health Act were insufficient for the number of detained patients.

Are services caring?

We rated caring as good because:

- We saw positive and caring interactions between staff and patients during our inspection.
- Patients told us that staff were supportive and kind. They said that they found the staff attitude and behaviour therapeutic and helpful to their recovery.
- Patients had weekly meetings with their doctor and keyworker.
- Staff gave new patients a clear and informative introduction pack.
- There was a well-recorded weekly community meeting on each ward.

Good



Are services responsive?

We rated responsive as good because:

- The hospital responded quickly to newly referred patients. Self-funded patients were seen within one to two weeks of referral and NHS patients could be referred and assessed at any time.
- Patients told us that the facilities at the hospital were good. They liked their bedrooms, the common areas on the ward, the food and the hospital grounds.
- After discussion with staff, patients were able to come and go freely during the day through the open front door.
- There was an effective system for managing complaints. These were clearly recorded and responded to within the hospital target times.
- Patients had access to advocacy services.

Good



Are services well-led?

We rated well-led as good because:

- The senior team were visible on the wards and staff said that they were approachable and supportive.

Good



Summary of this inspection

- There were clear governance processes in place that demonstrated monitoring of serious incidents and patient safety, clinical and medical input, risks and health and safety.
- Staff experience was collected via regular surveys. Managers had devised an action plan and listening events to respond to feedback and deliver improvements.
- Audits were scheduled across the year and plans for continuous improvement for each of the treatment programmes were in place.

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.

- At the time of inspection 93% of hospital staff had completed training in the Mental Health Act.
- Most patients were at the hospital on a private basis and either self-funding or funded by medical insurance. On the day of the visit, there were three patients detained under the Mental Health Act.
- There was evidence in the files scrutinised that patients were provided with an explanation of their rights under section 132 on admission and subsequently in line with hospital policy.
- At the time of inspection the administrative support for the Mental Health Act was limited. The administrator worked three days or nights per week as a health care assistant. They had been undertaking the role for one year but received no formal training, nor supernumerary time to complete the compliance requirements under the MHA.
- Staff we spoke with had a good understanding of the Mental Health Act and Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

- At the time of inspection 87% of hospital staff had completed training in the Mental Capacity Act.
- There was a dedicated lead for the Mental Capacity Act and one of the hospital staff acted as a trainer for other staff.
- There was evidence in the records that we reviewed that the admitting clinician had recorded the patient's capacity to consent to treatment on admission.






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	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

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

Good 

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

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

Good 

Safe and clean environment

- The two wards were spread across a purpose built two-storey wing and partially situated in the older part of the hospital building. All patient bedrooms had en-suite bathrooms.
- All areas of the hospital were clean and well maintained. There was a comprehensive housekeeping schedule in place and we saw routine cleaning happening during our inspection. Patients we spoke with told us that the hospital was clean and if they raised any issue regarding housekeeping this was quickly addressed by staff.
- The bedroom areas were zoned to assist with staff observations of patients. On each ward the six rooms closest to the office had the best line of sight visibility. Other rooms were located on a second floor of the ward. The rooms closest to the offices were furnished with anti-ligature fixtures and fittings. Patients who were assessed as having higher self-harm risks were placed in these rooms.
- Each ward had a single sex lounge for male and female patients and this was equipped with board games and a television. Patients could also use a communal lounge area for either male or female patients.
- All patient areas had been assessed by staff for ligature risks and staff were aware of the location of high risk areas. Staff had ranked individual patient risks regarding

ligatures and these were recorded in the patient clinical records. Known risks were mitigated by staff presence, closed circuit television (CCTV) and regular environmental checks.

- Each ward had a clinic room which was clean and well organised. We observed nurses effectively conducting a medicines round with the patients from the ward. The medicines were safely stored and disposed of and a pharmacist completed a monthly audit of the clinic room and fed-back any learning to the hospital managers.
- During our inspection a room on Maple ward was being adapted to become a new clinic room. The existing room was cramped and the move to another room was to give staff more space to store medicines and equipment, and carry out the administration of medicines to patients.
- The training records we viewed showed that 90% of staff had completed infection control training and 95% had completed basic life support training including the use of a defibrillator. This meant that staff were able to respond to emergencies.

Safe staffing

- There were qualified nurse vacancies at the hospital with 6.5 registered mental health nurse (RMN) positions vacant. At the time of inspection the vacant hours were covered by eight bank RMNs.
- The senior management team told us that recruiting to the vacant posts was a key priority. They had implemented a series of initiatives in to attract more applications from qualified staff. These included local and national recruitment events, reviewing pay to offer a location allowance and salary bandings, and paying the cost of staff registering with their professional bodies.

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

Good 

- The hospital had no health care assistant (HCA) vacancies.
- The shift vacancies for qualified nurses were filled predominantly by locum nurses some of whom had been working at the hospital for many months. This meant that they had a good knowledge of the patient needs on each ward. All staff in bank or agency roles received a full hospital induction and completed the mandatory training relevant to their role.
- The hospital used a staffing ladder to establish the staffing mix dependent on the number of patients on the wards. In the daytime there was a minimum of two qualified nurses and up to three health care assistants on each ward. At night there were generally three staff on each ward. This increased to four staff when there were 14 or more patients. The patients we spoke with told us that there were staff available to assist them whenever they needed them.
- The medical cover was provided by a medical director, a consultant psychiatrist and a ward doctor. Overnight cover was provided by a resident medical officer. There were ten further visiting consultants who had referral rights to the hospital's inpatient beds and therapy programmes.
- Emergency and out-of-hours cover was provided by a consultant and a member of the senior management team. Staff we spoke with told us that they considered the level of cover was reliable and available when they needed to use it.
- Staff maintained a centralised record of staff training which included alerts for when training was due for renewal. The completion rates for mandatory training were generally good and courses covered infection control, safeguarding, basic life support, safe handling of medicines and fire safety. At the time of inspection the completion rate for the prevention and management of violence and aggression (PMVA) was low at 52%. This was caused by a delay in sourcing and training suitable staff to deliver the training. This had been recorded as one of the top risks by the hospital senior team in the risk register. Hospital managers showed us that a further 32% of staff requiring this training were booked to attend this training in May 2018. This meant that by the end of May the hospital would reach its minimum training target of 85% in PMVA.
- We reviewed 14 sets of care records for patients from both wards. There was evidence in all records that risk screening had taken place. Patient risks were recorded for all patients at the point of admission. All patients had a risk assessment in place and we saw that this was being reviewed by staff at regular intervals.
- We saw completed and detailed examples of patients' risks recorded and updated during the course of the patients' admission. However the quality of the risk assessments was variable. In some assessments the information recorded in sections of the risk assessment was brief and the crisis and contingency elements of the care plan and risk assessment had not been completed.
- We observed in a ward round that patients discussed and reviewed their risk assessments with their consultant as part of a structured conversation about their progress and recovery.
- We saw that all qualified nurses had recently completed a competency checklist with their manager to demonstrate their understanding and ability to implement the hospitals standards in relation to medically assisted detox. This covered understanding the risks that patients were exposed to during detox, that staff were able to recognise withdrawal symptoms, make specific physical health assessments for opiate and alcohol withdrawal and use a range of monitoring tools to ensure that a patient was kept safe during the detox period.
- The staff we spoke with were confident about how to recognise and report safeguarding concerns. The hospital had a lead for safeguarding who also acted as a regional safeguarding lead for the Priory group. We saw evidence of safeguarding activity recorded in patient care records and current issues were discussed at the weekly nurses meeting. A log of safeguarding concerns raised with the local authority safeguarding team was maintained by the hospital to monitor the progress and outcome of investigations.
- There were good arrangements in place with the pharmacy provider to support the medicines management process. The pharmacist described an open culture for learning and improving practice in the safe management of medicines with changes in practice shared at governance meetings and via a lessons learned bulletin.

Assessing and managing risk to patients and staff

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

Good 

- We reviewed the medicines charts for all patients which were in good order. However the rationale for the prescribing of some PRN medicine and the frequency of reviewing this had not been recorded on all charts.

Track record on safety

- The hospital had recorded 12 serious incidents in the 12 months prior to this inspection. There had been 21 incidents of restraint involving eight patients in the six months prior to inspection. The majority of restraints involved times when staff were restraining a patient to prevent absconson from the hospital. There had been one incident of prone restraint in this period and it was reported that the patient had placed themselves in the prone position. The hospital did not use prone restraint or train staff in its use.
- The most frequent reported type of serious incident in the six months prior to inspection was the absconson of detained patients or informal patients leaving the hospital site without informing nursing staff. These incidents triggered the hospital's missing person policy and the Police became involved in locating the missing person. There had been seven absconsions from January 2018 to the date of inspection.
- The hospital had recently completed a review of the main entrance area to establish how the risk of patients absconding could be better mitigated. The main entrance was open from 8am to 7pm and this was staffed by a hospital receptionist during these hours. The review led to a reconfiguration of the reception area with a new walled area to more clearly demark the beginning of the patient area, and the introduction of CCTV in the reception area. Other doors out of the hospital had been fitted with alarms. Staff reported that the frequency of patients leaving the hospital without nurses' knowledge had reduced because of these improvements.

Reporting incidents and learning from when things go wrong

- Staff recorded all incidents on the hospital's electronic e-compliance report. These were reviewed and signed off by the director of clinical services and the hospital director.
- The staff we spoke with were knowledgeable about the process for recording incidents and felt confident in using the electronic reporting tool.

- All incidents were discussed in a monthly learning from experience meeting which was chaired by the director of clinical services. We reviewed the minutes of the last four meetings. The meeting was attended by senior clinical staff and ward managers. Incidents and complaints were reviewed by severity and type and emerging themes were identified. Actions and progress to complete them were detailed and reviewed at each meeting.
- The outcome of the learning from experience meeting was shared with all staff and it was a standing item on the agenda for the hospital's clinical governance meeting. This ensured that all staff were informed of incidents that had happened in the hospital and what lessons had been learned to prevent re-occurrences.
- The majority of staff we spoke with said that they felt well supported by the senior team in dealing with serious incidents and the impact that they had on staff and other patients.

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

- We looked at 14 care records for patients from both wards. The patients' clinical records were stored on electronic care notes and each patient also had a paper file which contained assessments and care plans. At times this meant staff needed to refer to two systems to locate and record patient information.
- All patients received an admission assessment carried out by the admitting doctor and subsequently a nursing assessment was completed by the mental health nurses. We saw that these were being completed for new patients. The assessment included risk, physical health and mental health history, the context or purpose for the admission and medicines.
- There was evidence in patient records that physical health was being monitored at regular intervals and this included the recording of blood pressure and pulse,

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

Good 

weight and body mass index. There were records of alcohol and drug testing via breathalyser and urine sampling for patients on the addictions treatment programme.

- Patients who were admitted on to the addictions treatment programme completed additional assessments and screening for alcohol and substances during their admission. Patient urine and breathalyser results were recorded by staff at the point of admission and regularly reviewed during their stay on the programme.
- All patients we reviewed had an initial care plan created upon admission and these were stored in an individual patient file. The ward manager audited the patient care plans each month. Some patient care plans were complete, holistic, and personalised to the patient needs. These also recorded the patient involvement and views on the plans. However we also saw care plans that were not at the same standard.
- Staff told us that they had recently introduced a care plan audit to improve the quality of care plans and we saw that this was being completed.

Best practice in treatment and care

- We observed two daily, morning 'flash' meetings which were attended by the senior hospital team, ward staff, therapy staff and hospital doctors. All patients were briefly reviewed and any significant events from the previous 24 hours, and plans for the current day, were discussed. The meetings were focussed and effectively led.
- The hospital offered structured therapy and activity programmes for addictions treatment, a general programme for acute mental health patients, and a programme tailored for patients with eating disorders. The hospital offered a new mental health stabilisation programme with individual support for acute mental health patients who were not ready for group interventions. This programme was useful for NHS patients whose admission may be of limited duration due to recall to an NHS hospital with short notice.
- The addiction treatment programme provided a structured day for patients six days per week. The programme was delivered by the hospital's clinical psychologists and therapy assistants. All patients attending the programme agreed to a contract of behaviour and attendance for their duration of treatment.

- The addiction treatment programme included art and drama therapy, relapse prevention, yoga and meditation. All patients met with their keyworker and consultant each week and where appropriate attended community alcohol and narcotics anonymous groups.
- The eating disorder programme was delivered by therapists and clinical psychologists with specialist knowledge in working with patients with an eating disorder. The hospital offered both day patient and inpatient treatment for adults with an eating disorder. The treatment timetable was a structured six-day week which offered meal-time supervision by nursing and therapy staff, group and individual therapy including mindfulness and psychotherapy, cognitive behavioural therapy (CBT), art therapy and relapse prevention.
- The addiction and eating disorder programmes were supported by nursing staff who monitored the patients' physical health including BMI.
- Staff used appropriate tools to support patients during detoxification. We saw that staff completed the objective opiate withdrawal scale (OOWS) for rating and measuring the signs of opiate withdrawal for patients. Patients receiving opiate detox completed a self-assessment subjective opiate withdrawal scale (SOWS). Patients undergoing alcohol detoxification completed the clinical institute withdrawal of alcohol scale (CIWA-Ar).
- Patients who were experiencing a serious mental illness had access to the hospital general programme provided by the hospital therapists. This was divided in to two modules. Module 1 was delivered in the main hospital building and patients normally completed this within a week and transferred to module 2 which was delivered in the Lodge building at the entrance to the hospital grounds. The treatments included CBT, understanding therapy, self-awareness, group psychotherapy, art therapy and managing stress.
- The nursing staff completed Health of the Nation Outcome Scales (HoNOS) on admission and at six month periods. These assessments monitored the severity of patient symptoms and their responses to treatment.

Skilled staff to deliver care

- Each ward had access to a multidisciplinary team including doctors, nurses, clinical psychologists and therapy assistants, healthcare assistants, and a wellness advisor who provided massage, relaxation and sporting

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

Good 

activities. The hospital had commenced recruitment for an occupational therapist at the time of inspection and had recently appointed to a new role of peer worker within the addiction therapy programme.

- The hospital had implemented new Priory guidelines on medically-assisted withdrawal which included guidance for alcohol and opiate detox. This policy had been introduced in January 2018. To improve staff skills and knowledge of procedure and process all hospital staff had recently completed a Priory Group training session on best practice in addiction treatments and managing withdrawal symptoms.
- All new staff received an induction programme and orientation to the wards and to the hospital and hospital procedures. This was also the case for bank and agency staff.
- Staff told us that they were receiving regular support from their managers which included group supervisions. However individual supervision rates had fallen to 53% for nurses and health care assistants. Senior staff told us that this was due to a ward manager vacancy which had been advertised at the time of inspection.

Multi-disciplinary and inter-agency team work

- At the beginning of each treatment day the therapy staff received a handover from nursing staff before the patients attended their groups or individual sessions. At the end of the therapy treatment the therapy team prepared a handover for the nursing staff for all patients who were returning to the wards for the evening. This handover helped keep patients safe as all staff had the most up to date information about the patients' health.
- The director of clinical services had good links with the local authority safeguarding lead and a hospital manager was a regional safeguarding lead. Staff had a good understanding of safeguarding procedures and the role of the local authority safeguarding team and how to contact them.
- Staff explained that they maintained links to the community NHS teams where they could do this. However the nature of the admissions of some NHS patients was often short term as the patients could be recalled to an NHS hospital within a few days of their placement at Priory Hospital Woking.
- All patients who had completed a treatment programme were able to access a follow up day provision. Therapy

staff also had developed links with service providers in patients' home areas so they could link patients to on-going support or top up support when they needed it.

Adherence to the MHA and the MHA Code of Practice

- At the time of inspection 93% of hospital staff had completed training in the Mental Health Act.
- Most patients were at the hospital on a private basis and either self-funding or funded by medical insurance. On the day of the visit, there were three patients detained under the Mental Health Act. The hospital traditionally has had few detained patients but the number of detained patients had increased in the last 12 months. There had been an increasing number of NHS patients from trusts in the south of the country because of a shortage of beds.
- Surrey Advocacy Service provided an independent mental health advocate (IMHA). The advocate attended the hospital when required. Patients who lacked capacity to consent were referred to the service when required.
- There was evidence in the files scrutinised that patients were provided with an explanation of their rights under section 132 on admission and subsequently in line with hospital policy.
- At the time of inspection the administrative support for the Mental Health Act was limited. The administrator worked three days or nights per week as a health care assistant. They had been undertaking the role for one year but received no formal training, nor supernumerary time to complete the compliance requirements under the Mental Health Act. The senior team had recorded the lack of a dedicated Mental Health Act administrator on the hospital risk register and were seeking to improve this.
- Staff we spoke with had a good understanding of the Mental Health Act and Code of Practice.

Good practice in applying the MCA

- At the time of inspection 87% of hospital staff had completed training in the Mental Capacity Act.
- There was a dedicated lead for the Mental Capacity Act and one of the hospital staff acted as a trainer for other staff.
- There was evidence in the records that we reviewed that the admitting clinician had recorded the patients' capacity to consent to treatment on admission.

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

Good 

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

Good 

Kindness, dignity, respect and support

- We saw respectful and caring interactions between the staff and the patients during the inspection. Staff we saw were kind and attentive when attending to the patients. It was clear that both nursing and therapy staff had strong relationships and knowledge of the patient needs.
- We overheard patients giving very positive feedback to staff about how much they valued the support from staff and how effective the treatment programme had been in their recovery.
- The patients we spoke with said that there was normally sufficient staff available to meet their needs. They said that felt safe and enjoyed the good standards of housekeeping and catering at the hospital.

The involvement of people in the care they receive

- Patients had regular weekly meetings with their consultant psychiatrist and their programme keyworker or lead nurse. We observed a ward round where patients were encouraged to raise issues and feedback on their progress.
- On admission all patients were given an introduction pack to the hospital which gave information about the ward, the treatments available and staffing at the service. Additional information was shared with patients who were attending the addiction treatment programme regarding expectations and agreements which formed a contract between the patient and the therapy programme.
- The hospital held a weekly community meeting where patients could share their views about what was happening on the ward and raise any concerns directly with staff. The minutes of the meetings were displayed on the ward notice boards and were formatted in a 'you said, we did' to make them easy to read. The standing items on the agenda for these meetings included

maintenance and housekeeping issues, issues with nursing or therapy support and introductions to new patients and saying farewell to those leaving the hospital.

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

- The average bed occupancy for the six months prior to inspection was 75%. There were 27 occupied beds at the time of inspection. Eleven patients were referred by the NHS and the remaining patients were funded via their private health insurance cover. There was one patient completing a detox programme at the time of inspection.
- The hospital's response time to private referrals was one to two weeks from the patient's referral to their initial assessment.
- The hospital received referrals for NHS placements from a wide geographical area. Most of these patients received treatment for a short period of several days until an NHS bed was available in their local area. Other NHS patients could remain at the Priory Woking for several weeks. All NHS patients had access to a stabilisation programme and the acute mental health group work programmes.
- NHS referrals were for patients where no NHS acute mental health bed was available to them locally at the time they needed it. These requests for beds at the Priory Hospital could be received at any time of day or night. There was always a doctor available on site, and a consultant psychiatrist on call, to assess the referral and admit the patient if needed. Patients referred with higher risks such that they required regular restraint or seclusion to manage their mental health condition, were declined at the point of initial referral.
- On admission all patients received a mental health and physical health assessment by the admitting doctor. We saw that admission check lists were followed and completed for recently admitted patients.

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

Good 

- The admissions manager helped new patients familiarise themselves with the ward and hospital environment.
- The hospital reported one patient who had a delayed discharge. This patient had been significantly affected by a complex funding situation between different health and local authority areas. The hospital managers had taken appropriate legal advice to advance the problems affecting the patient's discharge.

The facilities promote recovery, comfort, dignity and confidentiality

- Patients had access to a good range of individual clinic rooms and group meeting rooms. These were well appointed and comfortable. Staff commented that finding meeting spaces was becoming increasingly pressurised as they were often all being used.
- The patient bedrooms were comfortable, equipped with an en-suite bathroom and television. Housekeeping staff replaced towels every other day. Each room had a lockable space for patient possessions. Patients could have a key to their rooms if they requested this and were free to return to their rooms at any point during the day.
- Patients ate their meals in a pleasant dining room in the older hospital building. Patients had an extensive menu choice and told us that the food was good quality and that dietary or cultural food requests were always met by the chef.
- There were well equipped kitchen areas with coffee and tea making facilities, and fridges for cold drinks which patients could use all day.
- The front door was open and patients were free to come and go after discussion with staff. The hospital had an extensive garden to the front of the main building which was being enjoyed by patients during our inspection. There was a large comfortable seating area which some patients used as a smoking area. Other seats were spread across the grounds. Patients had the use of a tennis court within the hospital grounds.
- The Lodge was a separate building at the entrance to the hospital drive. This was the base for the therapy staff and also a venue for individual and group therapy sessions, family meetings and meetings with key workers.

Meeting the needs of all people who use the service

- Information for patients was available at the reception area and on notice boards on the ward. This included how to make a complaint and responses to issues raised by patients. Advocacy and safeguarding contacts were also displayed on the notice boards.
- Each patient was given a patient information booklet on admission to the hospital. The booklet gave information about their allocated care team, the hospital facilities and arrangements for medicines, therapy and leaving the hospital. It also contained useful contact numbers for advocacy and safeguarding services.
- Patients had access to a hospital Wi-Fi service but staff told us that this was unreliable as the Wi-Fi coverage was poor. Patients undergoing detox agreed not to have access to their mobile phones during the first seven days of treatment.
- Staff we spoke with told us that information in other languages was available if needed and that interpretation and translation services could be provided for patients needing these services.
- Information was given to patients about their condition and the treatments available to them. This included specific information about the impact of addictions including alcohol and opiates and what to expect during their treatment. The opiate guidance did not include information of heightened risks of overdose after detox which could improve patient safety especially for patients who may leave the treatment programme early.
- The hospital wellbeing co-ordinator provided group and individual activities for patients and this included massage and relaxation.

Listening to and learning from concerns and complaints

- Patients were given information about how to make complaints by staff and the process was also described on the ward noticeboards.
- The hospital held a weekly community meeting with patients. The patients were encouraged to raise any issues, compliments and complaints during these meetings. We saw that these were responded to with the outcomes shared at the next meeting and displayed on the ward noticeboards.
- The hospital reported 13 formal complaints in the previous 12 months. Eleven of these had been upheld

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

Good 

after investigation. The main themes were theft of patient property, sharing information with other agencies and billing and issues with access to, and cost of, treatments.

- The director of clinical services and the hospital director were able to describe the hospital policy in managing complaints and were able to show inspectors completed investigations and complaint responses.
- The hospital had received 17 compliments from patients in the four month period to the end of December 2017.

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

Good 

Vision and values

- The staff we spoke with were familiar with the local senior management structure. They told us that the director of clinical services and the hospital director were frequently on the wards and that they were approachable.
- Staff spoke warmly about their efforts and those of colleagues in doing everything they could to improve patients' health and experience. They described the hospital ethos was to make a positive difference in the outcomes for patients. We saw that this was a shared vision from the reception staff, the catering and facilities staff, the therapies and nursing staff and management.

Good governance

- There was a clear governance structure in place led by the hospital director. This included a monthly clinical governance meeting chaired by the hospital director. There were three sub groups reporting in to the monthly governance committee which were health and safety, medical advisory committee and learning by experience/patient safety.

- The hospital maintained a risk register which was dated and reviewed regularly. The current actions taken to mitigate each risk were recorded.
- The previous medical director had recently left the position. However the role was being filled one day per week by a Priory consultant whilst awaiting the completion of the recruitment process. The interviews were scheduled for 30th April 2018.

Leadership, morale and staff engagement

- The staff we spoke with were very positive about their jobs and working at Priory Hospital Woking. They said that all members of the team were supportive and colleagues and managers were encouraging and helpful.
- The most recent staff survey results were from November 2017. There were areas of low staff morale indicated in some responses. These included staff recommending the hospital to others as a good place to work and confidence that positive actions would be taken by managers as a result of the feedback.
- The issues raised by the survey had been responded to by the hospital managers and an action plan for staff engagement with these issues was in place. At the time of inspection two listening groups with staff had taken place to discuss and understand the feedback results.
- Staff we spoke with were confident that could raise concerns with their managers and were aware and confident in the local whistleblowing policy.

Commitment to quality improvement and innovation

- There were action plans for continuous improvement in place for the hospital's key therapy programmes: eating disorder services, therapy services and addiction services.
- An audit calendar detailing ten audits to be completed in 2018 included ligatures twice yearly, risk assessments, Mental Health Act, preventing suicide and clinical supervision.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **SHOULD** take to improve

- The provider should ensure that targets for staff training in the prevention and management of aggression and violence are achieved according to their training plan by the end of May 2018.
- The provider should ensure that all patients' care plans and patients' risk assessments are completed to a consistently good standard to ensure holistic and specific goals and risk plans.
- The provider should ensure that staff receive individual supervision meetings at the frequency stated in their staff supervision policy.
- The provider should ensure that sufficient support and resources are allocated to the administration of the Mental Health Act.