The Priory Hospital Dewsbury

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?	Requires improvement
Are services responsive?	Requires improvement
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

We rated The Priory Hospital Dewsbury as requires improvement because:

- We found poor practice in relation to the management of medicines. Staff had not recorded the medication stock correctly and some medicines that were in stock were out of date. Medication records were not always accurate; which meant that patients did not always have their medication as prescribed. Staff did not always risk assess patients who self- administered their medications nor did they monitor patients on anti-psychotics for side effects. There was no effective system for reporting medication errors.
- New systems and processes did not highlight concerns with regard to medication errors.
- Ligature cutters were not easily accessible to all members of staff. The provider had not accurately assessed the ligature risks. The provider had not mitigated all ligature risks.
- Inspectors identified safeguarding incidents during our inspection. Patients had not felt comfortable disclosing these to staff.
- Staff had not updated risk assessments after incidents occurred.
- Patients were not always involved with risk assessments.
- Staff did not always update patient care plans to reflect decisions made at multi-disciplinary team meetings.
- Physical health checks were not all carried out as described in patients care plans.
- Staff did not always treat patients with kindness. We saw two examples of staff treating patients disrespectfully.
- Seniors managers did not always identify areas for improvement.

However:

- Systems were in place for reporting and monitoring incidents. Staff debriefs usually occurred immediately after an incident. Incidents were scrutinised by the providers safeguarding lead.
- Staff had the qualifications and skills they needed to carry out their roles effectively.
- There were a range of professionals to care for patients.
- Staff informed patients of their rights at the time of initial detention, which continued throughout their detention.
- Community meetings took place daily.
- Patients knew how to complain and the provider dealt with complaints in line with their policy.
- Patients had regular leave from the hospital.
- Activities were meaningful and available to most people wishing to attend.
- Staff took part in a listening event to enable them to say how they would improve the service.
- Senior managers regularly visited the service.

Summary of findings

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Summary of this inspection

Background to The Priory Hospital Dewsbury

The Priory Hospital in Dewsbury is registered with the Care Quality Commission (CQC) to carry out the following regulated activities:

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

The hospital is made up of two long stay/rehabilitation mental health wards for working age adults wards:

- Hartley – 20 beds
- Jubilee – 12 beds

The Priory Hospital in Dewsbury provides care and support for men with long-term mental health problems; some patients have a learning disability. The hospital provides care to patients who are detained under the Mental Health Act, but also patients who are at the hospital on an informal basis.

The CQC inspected The Priory Hospital Dewsbury in November 2013. We found the hospital was not compliant with our previous regulations with regard to the management of medicines. At this inspection, we found there were different issues relating to medicines, which meant the hospital was not meeting this regulation.

The last Mental Health Act review was on 21 July 2015, the reviewer made recommendations and The Priory Hospital Dewsbury had made the required improvements.

The accountable officer for the service is Margaret Doyle. Margaret Doyle was not the accountable officer at the time of the inspection.

Our inspection team

The team that inspected the service comprised:

- Karen Bell CQC lead inspector; supported by two other CQC inspectors
- a specialist advisor who was a learning disability nurse
- a pharmacist
- a specialist advisor psychiatrist
- 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?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

Summary of this inspection

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service and two relatives
- spoke with the registered manager and managers or acting managers for each of the wards
- spoke with 10 other staff members; including a doctor, nurses, occupational therapist, and health care assistants
- spoke with an independent mental health advocate
- received feedback about the service from two care co-ordinators and service commissioners
- attended and observed one hand-over meeting and one multi-disciplinary meeting
- looked at nine care and treatment records of patients
- carried out a specific check of the medication management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

During our visit we spoke with 11 patients and two relatives. Most patients told us they felt safe. One person said they felt nervous as there were not always enough staff around.

Most patients said they were happy with the cleanliness. However, some patients and a relative said they thought the en suites were not always as clean as they should be.

Patients we spoke with told us they thought the food was good and mealtimes were flexible so they could eat when they wanted to. Some patients said they were able to make their own hot drinks.

Everyone said they had good access to a GP and dentist when required. One patient told us they had recently had blood tests at their GP and as a result of this their medication had been changed.

Most patients said they thought staff cared although some people said not. A patient told us staff were very respectful and that they had lots of fun and laughter.

A relative told us they got information about their loved ones care when they asked for it.

Two patients spoke very positively about their discharge and transition planning.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as **inadequate** because:

- The provider did not manage medication effectively. There were large amounts of medication held in stock, which staff had not recorded.
- Patients did not always have their medication as prescribed.
- Some medication was out of date.
- Patients going out on unplanned leave were not able to take their medication with them.
- Medication records were not always accurate.
- There were no risk assessments for medication to be self-administered.
- The provider had not accurately assessed the ligature risks.
- The provider had not mitigated all ligature risks.
- Ligature cutters were not easily accessible to all members of staff.
- Inspectors identified safeguarding incidents during our inspection. Patients had not felt comfortable disclosing these to staff.
- Staff had not updated risk assessments after incidents occurred.
- Patients were not always involved with risk assessments.
- Patients did not have access to all patient areas due to doors having slam locks installed.

However:

- Systems were in place for reporting and monitoring incidents.
- Staff debriefs usually occurred immediately after an incident.
- Incidents were scrutinised by the providers safeguarding lead.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not always update patient care plans to reflect decisions made at multi-disciplinary team meetings.
- Physical health checks were not all carried out as described in patients care plans.
- Monitoring of the side of effects of anti-psychotic medication was not carried out.
- The provider offered learning disability awareness training, which staff had not received.

However:

Summary of this inspection

- There were a range of professionals to care for patients.
- Staff informed patients of their rights at the time of initial detention, which continued throughout their detention.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- Patients were not always treated kindly we saw two examples of staff treating patients disrespectfully.
- A patient had not been advised that their room was to be emptied due to a new carpet being fitted.

However:

- Advocacy services were available to patients.
- Community meetings took place daily.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- Patients knew how to complain and the provider dealt with complaints in line with their policy.
- Facilities for people with a disability were available.
- Patients had regular leave from the hospital.
- Activities were meaningful and available to most people wishing to attend.
- On admittance to the hospital patients were given a service user guide.

However:

- During our inspection we found the office door on one of the wards was left open which compromised patient information.
- Patients had to ask to have access to the quiet room, television lounge and kitchen.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- Systems and processes in place to monitor the service did not highlight all areas requiring improvement.
- Systems had been introduced to ensure medication errors did not continue to occur these were not robust.
- There was a lack on monitoring of medication.
- Seniors managers monitoring of the service did not always highlight areas for improvement.
- Staff said the morale was low due to recent high turnover of staff, particularly leadership positions.

However:

Summary of this inspection

- Staff took part in a listening event to enable them to say how they would improve the service.
- Staff were positive about the input from the clinical services manager.
- Senior managers regularly visited the service.

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.

Systems were in place to ensure the adherence to the MHA. The provider monitored compliance with the Mental Health Act at the regional business review meetings.

Files we reviewed contained all original MHA statutory papers and all documentation appeared to be completed in accordance with the requirements of the MHA.

Information was available to detained patients on their rights under the MHA. The provider had produced leaflets for informal patients. These were available in a pictorial format to aid understanding.

The provider told us that staff Mental Health Act training was recorded and monitored by the hospital support services manager. Staff accessed online training and followed 'Foundations For Growth' training system. The hospital director told us that MHA and Code of Practice training was all online.

All three detained patients we spoke with informed us staff regularly reminded them of their rights under the MHA. A review of electronic computerised care records confirmed that detained patients were informed of their rights at the time of initial detention and regularly throughout their period of detention.

Mental Capacity Act and Deprivation of Liberty Safeguards

The hospital displayed information in easy read format on the Mental Capacity Act and deprivation of liberty safeguards. These were displayed on both wards. Two patients were subject to deprivation of liberty safeguards authorisations at the time of our visit with no applications pending.

Where appropriate mental capacity assessments were carried out which in some cases led to best interest decisions being made. Staff we spoke with understood their responsibilities in assisting patients to make decisions in relation to their care.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Inadequate

Safe and clean environment

The Priory Dewsbury had two locked wards. These were accessed through a main entrance and then via a courtyard and garden area. Entry to the wards was controlled by a key fob entry system. On the first day of our inspection we were concerned that a member of staff did not know the code to allow us to leave the building. This meant if an emergency had occurred people would have been put at risk of not being able to evacuate.

We looked at the facilities on both wards at the hospital. The main lounge area was the central point of each ward. There was one wing where the patient bedrooms were situated and another wing was for patients who were moving to more independent living which had two bedrooms and a lounge. All the bedrooms were en-suite. There was an additional bathroom with a bathtub available for patients located off the lounge area.

Staff said the alarm system could not always be heard in the senior management team office, which was in a separate building. This meant staff were at risk should an incident occur that required urgent assistance.

There were blind spot risks in some areas of the main ward but these were mitigated due to the number of staff. The activity rooms and telephone room had large windows that staff could look into. Patients could only access the clinic room with a member of staff. Staff told us patients did not use the lounge area in the independent living area of the ward but all patients were able to use it if they should choose to do so. If patients chose to use this lounge staff would be unable to see into the lounge unless they were in it.

The Priory had identified the ligature risks. This was done by way of a matrix which rated ligature risks from one to three, three being the highest risk. However, staff had not completed the matrix in accordance with The Priory policy. The risk rating for bedrooms was three according to the policy, but on 10 matrix sheets all the risk ratings were one. Because risks had not been rated correctly, the provider was unable to assure itself that patients were safe. We raised this with the registered manager during our inspection and were told that the risk assessment would be completed again.

The door handles were identified as anti-ligature. However, it would be possible to tie ligatures on the door handles by way of attaching a ligature on one side of the door handle and directing the item over the door onto the other side. There was nothing identified to mitigate these risks. The door frame had an apparatus to stop the door slamming, this was exposed when it opened and closed therefore presenting as a ligature risk. Staff had identified this as identified as a level two ligature risk. There was no evidence of fully completed documents to show how these risks would be reduced.

A member of staff we spoke with was unclear about processes with regard to ligature risks. They said people at high risk of suicide would be on observations. However, they were unable to describe how risk would be mitigated for those patients not on regular observations. The member of staff told us that only qualified ward staff had access to ligature cutters which were kept locked in the

clinic room. As not all staff members had access to the clinic room this would mean a delay in accessing the scissors should they be required to prevent a suicide attempt.

Wards appeared clean. The main lounge area was not homely. It was a large space with little furnishing. The dining area was furnished well. Patients were congregated in this area. There were more furnishings and colourful displays which gave it a warmer feel.

During our inspection, a patient told us about an incident which was patronising and demeaning. We considered this to be a safeguarding concern. As the person had not felt comfortable telling staff about the incident we shared the person's concerns with the registered manager who agreed to investigate and make a referral to the local safeguarding unit.

Staff told us they understood their safeguarding responsibilities. They were able to confidently talk about what they would do should they suspect abuse was occurring. Staff said they thought their managers would take any concerns raised seriously.

Safe staffing

On the first day of our inspection the registered manager told us they were staffed to establishment level. However, due to staff resignations they had been operating on a high level of agency staff. A recruitment drive had resolved the situation. At the time of our inspection there were 6 patients on Jubilee ward and 15 patients on Hartley Ward.

Establishment levels were reported as:

Clinical services manager 1 WTE

Consultant Psychiatrist .8 WTE

Consultant Clinical Psychologist .4 WTE

Psychology Assistant 1 WTE

Occupational therapist 1 WTE

Occupational therapy assistant 4 WTE

Hartley Ward

Ward manager 1 WTE

Qualified 6 WTE

Preceptor Nurse 1WTE

HCA 14 WTE

Jubilee Ward

Ward Manager 1 WTE

Qualified 6 WTE

Preceptor Nurse1 WTE

HCA 14.5 WTE

Some members of staff were concerned about staffing levels. Because of this, we reviewed staff rotas, which did appear to indicate a shortage of staff particularly during the weekend. We spoke with the management team who told us there had not been any issues with staffing numbers recently and confirmed they had been fully staffed. As information from the management team conflicted with what staff were saying and the information on rotas we asked to see the clocking in records for the weekend prior to our inspection. This confirmed there had been a full complement of staff on duty. The manager told us they could not account for the inaccuracies in the rota.

The psychiatrist for The Priory Hospital Dewsbury was not at the hospital full time. However, we were told they were less than 30 minutes away should they be required urgently at Dewsbury.

Staff told us there was no problem with section 17 leave off the ward and staffing levels were satisfactory to provide any required escorted leave.

Most staff had completed the mandatory training. This included fire safety, deprivation of liberty safeguards, infection control, introduction to health and safety, Mental Capacity Act, safeguarding vulnerable adults and safe handling of medicines. Staff had the qualifications and skills they needed to carry out their roles effectively. There was compliance with mandatory training of 91% for Jubilee ward and 81% for Hartley.

Assessing and managing risk to patients and staff

Managers said due to the high use of agency staff there had been a number of errors relating to the management of medicines. The provider had taken steps to address this and all members of agency staff had completed competency training in the safe management of medicines.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

A manager from another Priory Group hospital had investigated a number of the incidents. However, where the investigator had made recommendations there was not a plan in place to ensure these were actioned.

During the inspection, we identified a medication error, which staff had not identified at ward level. On further discussion with the clinical services manager, we were told that there were no audits relating to medicines taking place at ward level.

On Jubilee ward, we looked at all the care plans relating to medicines that were to be taken as needed (PRN). The provider's policy stated patients and nurses should sign PRN care plans. Patients and staff had not done this. We found care plans did not always match patients' prescription charts. One patient's care plan stated they were prescribed salbutamol, however, after reviewing the patient's prescription chart we discovered this was not the case. We spoke with a member of staff about this who was unclear as to whether the patient was on this medicine. Three other patients had been prescribed various medications with no care plan in place to have the medication PRN. Prior to our leaving one of the care plans was located but this was very brief and did not state if the medication was to be given orally or inter-muscular.

A patient had been prescribed medication, which had been documented on the drug card as out of stock on 27 October 2015 but on the drug chart for the afternoon dose on the following dates 28, 29 and 30 October 2015 it had been signed that a nurse had administered the medication.

A patient's drug chart had a date to stop a prescribed medication for further review. We found staff had not done this. Staff had continued to give the patient the medication for a further three days. We showed this to the clinical services manager who cancelled the medication on the drug chart.

The provider did not have a system in place, which would allow patients to take essential medication with them when going on unplanned leave. We saw evidence in patients records where they had gone out for the day without their medication; this could have a detrimental effect on their health. The provider told us they would speak with the pharmacy about this. If the leave was planned the pharmacy administered 'to take out' medication which ensured patients did not miss their medication whilst away from the hospital.

On Hartley ward, we reviewed information about four patients and checked the validity of the T3 with prescribed medication. Three patients were self-administering their own medications. However, although they had a care plan in place for this, there was no evidence that it had been risk assessed. The nurse produced a risk assessment document, which they stated they did not fill in.

We checked the medicine management system at the hospital and saw that an independent pharmacist supplied the medicines. They also carried out a quarterly audit of medication practices although this did not relate to items held in stock at the hospital. We checked the stock of medication held on both wards and saw there was no system in place to check for and evidence the number of items held. We checked a document which one staff nurse told us was used for recording medicines on the ward mid-week and on a Sunday but this held only one entry for 27 October. None of the staff including ward managers knew which medicines were currently being stored on the wards. We found staff had not correctly disposed of a number of items, which had expired. We also found wards held a large number of medicines which staff told us were no longer prescribed to anyone on the ward, this included ampoules of injectable medicine such as rapid tranquillisation medication.

We looked at the medicines policy dated 30 March 2014. This gave clear guidelines on how staff should manage medicines at ward level. It stated stock levels should be counted on a weekly basis and entered onto the hospital's electronic system. We saw that not all staff had access to the system and this included agency staff who had been working on the ward. The policy also stated that expiry dates should be checked.

We looked at six patients' risk assessments and found most staff had effectively assessed and managed risks to individuals on admission. These included physical health, and risk to self and others, which staff reviewed regularly. In four care records, we saw staff had not updated risk assessments when incidents had occurred. For example, one person had been involved in 14 incidents in August 2015. Staff had written their risk care plan in October 2014 and it showed no updates relating to the ongoing concerns. We also saw that following discussions at multi-disciplinary meetings relating to risk, staff had not always updated risk

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

assessments. For example, when an increase in number of staff was required to support the patient when accessing the community staff had not included it on the patients most up to date risk assessment.

On both wards, there was a lack of engagement in risk assessments by patients. We received mixed responses from staff on reasons for this. Some staff said that patients did not want to engage however, care records we reviewed did not reflect this. Other staff said they had not had time to go through the documentation with patients. Records we looked at confirmed there were no plans in place to ensure staff reviewed this. This meant patients did not have the opportunity to say how they would like to be supported during times of distress or periods of being unwell.

There had been 102 incidents of restraint from 1 April to 30 September 2015. Data we received from the provider confirmed these incidents involved 11 patients. Two of the restraints were prone restraints and data showed there was no use of rapid tranquillisation in that time period.

Patients did not have access to the quiet room, television lounge and the kitchen without asking staff. This practice is restrictive. Restrictive practices are any type of support or practice that limits the rights or freedom of movement of a person.

Track record on safety

The provider told us prior to the inspection that there were 31 serious incidents in the last 12 months. Twenty-nine of these incidents were on the Jubilee ward. Thirty of these incidents were allegations, or incidents, of physical abuse and sexual assault or abuse. The main themes were; patient on patient assaults and patients assaults on staff. The regional quality improvement lead monitored the incident reports. Incidents were also scrutinised by the providers safeguarding lead.

Reporting incidents and learning from when things go wrong

There was a clear system in place for reporting incidents. Staff entered the information onto the electronic system and any prompts for safeguarding alerts to be made were picked up by ward managers, the registered manager or the clinical services manager. Members of the psychology team reviewed all incidents and a corporate report was created. The psychology team reviewed the report for themes and trends. The registered manager fed back the information to staff at ward level via team meetings. Minutes from these meetings confirmed this. Most staff we spoke with told us that after each incident there was a de-brief which they said they found very useful. They said the de-brief took the form of a discussion with the team about what went well and what had not gone so well.

The provider looked at themes and trends of incidents which showed the number of incidents and a breakdown by type of incident. This resulted in an analysis of the key risks to the service. Where themes were identified the provider considered this and where possible made changes to the service.

The provider understood and complied with the duty of candour. The duty of candour sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at nine care records and found staff completed comprehensive and timely assessments after admission. The care records held individualised information to enable staff to provide patients with personalised care. The doctors confirmed they completed physical health assessments, including blood tests on admission.

We found inconsistencies in the monitoring of patients' physical health. Care records of three patients showed there should have been blood glucose monitoring, electro cardiograms and monitoring of cholesterol levels. There was no evidence these checks had taken place. Ward managers confirmed there were no audits in place for checking compliance with physical health care monitoring. This meant patients were at risk that symptoms of ill health were missed.

Best practice in treatment and care

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Monitoring of the side effects of anti-psychotic medication was not carried out which is stated as best practice with regard to anti-psychotic medication. This meant symptoms of side effects may be missed.

The hospital had an agreement with a local medical centre where patients could attend with any physical health needs. Patients were registered and staff made appointments when necessary. In addition, if patients required urgent physical health, care staff would accompany them to the local accident and emergency department or out of hour's GP service.

Two ward managers and two deputy ward managers stated they were not following any best practice guidance in relation to providing rehabilitation for patients. They said they were not aware of anything in place at the hospital. However, care plans we reviewed contained outcome star care notes. The star recovery model is a recommended in NICE guidance for rehabilitation services. Outcomes for patients were assessed through use of the nationally recognised assessment tool Health of the Nation Outcome Scale (HONOS). Occupational therapy staff provided and coordinated activities. These plans were formulated following assessments based on skills and recovery. We were told by the occupational therapist that not all patients were engaging in these programmes. Psychology staff also carried out assessments with patients during the initial stages of their admission. However, it was reported to us that not all of the patients assessed were continuing with any interventions delivered by the psychology team.

Skilled staff to deliver care

The team included a range of disciplines required to care for the patients. This included a consultant psychiatrist, psychologist, occupational therapist and assistants, nurses and healthcare support workers. We were told the psychologist in post was not trained in learning disabilities.

Information provided demonstrated that 97% of staff had completed their annual appraisals for 2015. Annual appraisal enables the managers to review staff competency and ensure their development.

Additional training was available to staff including, introduction to learning disabilities and awareness and introduction to autism. Information from the provider showed that none of the staff working at the hospital had completed this training despite the hospital having a number of patients with autism and other types of learning disabilities.

Multi-disciplinary and inter-agency team work

A multidisciplinary team (MDT) is a group of health care and social care professionals who provide different services for patients in a coordinated way. The ward followed a multidisciplinary collaborative approach to care and treatment. A consultant psychiatrist, psychologist, occupational therapist, assistants, and nursing staff attended the meetings. There was no attendance from an independent pharmacist.

MDT meetings were held on the wards on a monthly basis and patients had the opportunity to attend the meetings. Following the meeting, staff entered a summary of the meeting into the care records electronically by an administrator. We found in three of the nine patients records we looked at, the discharge planning section of the meeting record contained the same word for word entry for consecutive meetings. This meant care records were not person centred. We observed an MDT; there was a clear agenda with secretarial support. The process was inclusive, respectful and appeared purposeful.

The wards held care programme approach meetings (CPA) that involved multi-professionals, for example social workers and care co-ordinators. A CPA is a way that all inpatient and community services are assessed, planned, coordinated, and reviewed at least annually, for someone with mental health problems or a range of related complex needs.

Adherence to the MHA and the MHA Code of Practice

Systems were in place to ensure the adherence to the Mental Health Act (MHA). The provider monitored compliance with the Mental Health Act at the Regional Business Review meetings.

Information was available to detained patients on their rights under the MHA. The provider had produced leaflets for informal patients. These were available in a pictorial format to aid understanding.

During our inspection we were accompanied by a mental health act reviewer who provided us with the following information:

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

There were 16 patients who were detained under the mental health act and five informal patients.

Staff told us that where required, patients were provided with the service of an independent mental health advocate (IMHA) and/or independent mental capacity advocate (IMCA). We observed that a patient's information board was displayed on the ward corridor wall. This had a variety of information notices including IMHA details. However, no Care Quality Commission (CQC) detained patient's poster or information leaflets were displayed or available on the ward.

All three detained patients spoken to informed us that they were regularly reminded of their rights under the MHA; a review of the electronic computerised care records confirmed this.

Good practice in applying the MCA

The hospital displayed information in easy read format on the mental capacity act and deprivation of liberty safeguards. These were displayed on both wards. Two patients were subject to deprivation of liberty safeguards authorisations at the time of our visit with no applications pending.

Where appropriate mental capacity assessments were carried out which in some cases led to best interest decisions being made. Staff we spoke with understood their responsibilities in assisting patients to make decisions in relation to their care.

At the time of our inspection, there were two patients subject to a deprivation of liberty safeguard authorisation.

The provider's training records showed that only 52% staff had received mental capacity act training.

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

Requires improvement

Kindness, dignity, respect and support

Some patients told us staff did not always treat them with respect. One patient thought some members of staff could be sarcastic with them.

Whilst we saw some good interactions between staff and patients, we witnessed two incidents of disrespectful interactions with patients. One member of staff put a finger over their mouth indicating to the patient to be quiet. We also saw a patient trying to speak with a member of staff who continued the conversation as they walked into the office and then spoke with the patient through the window. From our conversations with staff it was clear they wanted the best for patients. Staff knew patients well and understood the best way to communicate with them.

During our inspection, we witnessed staff assisting a patient who was wearing only his underwear to use the bathroom just off the lounge area. This impacted on the patient's dignity and privacy.

On the first day of our inspection a patient returned from leave to find all their belongings out in the corridor. This was due to a new carpet being fitted. Staff had not advised the patient that this would be happening. We spoke with a member of the management team about this who told us they had forgotten to tell the patient.

The involvement of people in the care they receive

The care records contained detailed personalised care plans written in a person centred way however, they did not show these had been written with input from patients.

Advocacy services were available to patients at the hospital with weekly sessions held by two independent mental health advocates. We spoke with one of them who told us they supported patients with a range of issues from attendance at MDT and CPA meetings, and support with making complaints.

Community meetings took place daily on both wards and minutes showed that the agenda involved planning the day.

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

Requires improvement

Access and discharge

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The provider reported an average bed occupancy of 99% over the last six months for Jubilee ward. The average bed occupancy of Hartley ward was 82% for the same period.

Staff told us that prior to or on admission to the hospital all patients were provided with information on the hospital and the services provided. This was contained in an information booklet titled 'The Priory Hospital Dewsbury, Service User Guide. We saw this contained a variety of information on general information about the hospital and ward, contraband, care plans, observation and much more.

Data from the provider showed there had been no delayed discharges between 1 April and 30 September 2015. Staff told us there had not been any discharges in the last year, however we were aware that some patients had recently been discharged from Jubilee ward.

Discharge planning was not adequate in one person's care plan. Staff had copied and pasted the same notes for three months. This meant we could not be sure if these details were correct and if the person's discharge planning had been carried out effectively.

The facilities promote recovery, comfort, dignity and confidentiality

Occupational therapists led activities during weekdays. At weekends, activities were led by nurses or self-directed. On both wards, patients and staff planned activities during the morning community meetings. We saw both wards displayed a plan of the activities on noticeboards in the main lounge area. Information provided showed that in August 2015, on average, each patient on Jubilee ward attended 57 hours of meaningful activities and on Hartley ward 42 hours were attended weekly. Activities included shopping trips, cooking, woodwork, art and crafts and attending to the hospital rabbits. One patient was able to work as a volunteer at a local shop.

Patients had their own en-suite bedrooms and were able to have their own things around them including furniture.

There was no privacy film on interior windows and some patient bedrooms overlooked the gardens. There was a slight tint to the windows but in some lighting it was possible to see in. This compromised patients' privacy and dignity.

Locks on all the doors in patient areas were slam locks. However, the ward manager's office door did not have an automatic closer on it and during the inspection we saw the office door on Jubilee ward was left open with patient information left on the desk. This meant anyone could access patients' personal data and patient safety was compromised. We highlighted this to the ward manager during our inspection.

Meeting the needs of all people who use the service

Bathrooms and ward facilities were accessible for disabled people.

Patients told us food was good and there was a good choice. Patients in some cases were involved in menu planning and shopped for food with the assistance of staff.

We saw some examples of pictorial notices, however, on Jubilee ward there was lack of appropriate signage for people with a learning disability. One patient told us there used to be more signs with pictures.

Listening to and learning from concerns and complaints

The hospital displayed information in easy read format on how to make a complaint. These were displayed on both wards. Data provided showed there had been 15 complaints received in the last 12 months; seven of which were upheld and a further two were partially upheld. One complaint remained open at the time of our visit as the investigation was still taking place. Complaints were dealt with according to the provider's policy. The registered manager had responded to the complainant within timescales agreed and where appropriate an apology was given. Whilst we were unable to see any examples of where the service had been changed because of complaints, we were told this would be done where necessary.

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

Requires improvement

Vision and values

Staff told us the visions and values of the organisation were, to be open, honest, caring and acting with integrity and honesty. Another member of staff said patient centred care, dignity and good communication was at the forefront of the care they gave. The provider told us the behaviours

they aspire to were, putting people first, being a family, acting with integrity, being positive and striving for excellence. Staff told us they saw some senior managers of the service. There were regular visits from the quality director and

Staff told us the input from the clinical services manager was making a positive impact on the team. Other members of staff said they felt with the recruitment of a new ward manager the culture of the hospital was changing for the better.

Good governance

The hospital had clinical audit and governance systems and processes in place. Clinical governance meetings took place every month. They included hospital, clinical and ward managers and doctors. Minutes form a Clinical Governance meeting held in September 2015 showed that patients attended the meetings. Agenda items included advocacy, medicines, equipment, safeguarding, complaints, incidents and serious incidents, infection control, health and safety, staffing, nutrition, reducing restrictive practice and patient involvement topics. We saw actions identified were followed up and closed when finalised.

There was a lack of monitoring of medication. The provider had recently put systems in place to audit the daily administration of medication. However, during our inspection we found errors in recording which the provider had not identified during the daily audit. We could not be sure that all audits of the service were effective.

Leadership, morale and staff engagement

A listening event took place at the hospital in September 2015. All staff were invited to attend to give their responses to questions on whether they thought the service was safe, effective, caring, responsive and well-led. Staff were also asked how they would improve the service. Once responses were collected, group sessions were held and key themes identified. These included; improving communication, improving how the multi-disciplinary team worked and ensuring colleagues felt their safety and well-being was taken seriously. Following this, the provider developed an employee engagement action plan for 2015/2016 and the hospital director had planned a number of workshops with senior staff identified to lead on pieces of work through 2016.

The employee engagement report showed satisfaction levels were on average 71% favourable. This was in areas which covered, health and wellbeing, if The Priory was a good place to work, if the employee would recommend the hospital to friends and family, if staffs learning and development needs were regularly reviewed and how satisfied staff were with the training and development they received.

Some staff members were concerned about the recent high turnover of staff, particularly leadership positions. Staff thought this was having a negative impact on staff morale. The provider confirmed that all positions had been filled which they hoped would lead to a more stable team.

Commitment to quality improvement and innovation

The provider had a healthcare audit calendar for 2015, this gave the hospital guidance on what audits to complete and when they should be completed by. The senior management team carried out some audits and others were carried out by ward managers. These audits included:

Reducing restrictive practice

Schizophrenia

Mental health act

Restraints

Mental capacity act

Infection control

Safeguarding

Risk assessments, care plans, CPA and observations

Preventing suicide

Clinical supervision

Ligature audit - environmental

Audits were detailed and actions identified were followed up. However, some of the issues we found during our inspection had not been identified. This meant that audits were not robust.

Information we received from the provider stated the hospital did not participate in clinical audits or national service accreditation and peer-review schemes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure medication administration systems are robust
- The provider must ensure they have an accurate and up to date record of medication stored on each ward
- The provider must ensure patients are able to have their medication when on unplanned leave
- The provider must ensure medication is administered as prescribed
- The provider must check medication is not out of date
- The provider must ensure there are risk assessments completed for medication to be self-administered
- The provider must ensure the monitoring of the side effects of anti-psychotic medication is carried out
- The provider must update patient records to reflect decisions made during multi-disciplinary team meetings
- The provider must ensure physical health checks are carried out including blood sugar monitoring, electro cardiograms and monitoring of cholesterol levels
- The provider must ensure patients are informed of all changes, for example refurbishment which impacts on their care, privacy and dignity
- The provider must ensure patients are treated with dignity and respect at all times

Action the provider SHOULD take to improve

- The provider should ensure ligature risks are assessed accurately
- The provider should ensure where possible all ligature risks are mitigated
- The provider should ensure ligature cutters are accessible to all staff at all times
- The provider should ensure that rooms containing patient data are locked at all times
- The provider should ensure risk assessments are updated after incidents occur
- The provider should ensure patients are involved with risk assessments
- The provider should ensure rotas reflect the actual staff on duty
- The provider should ensure office doors are locked to ensure patient information is secure

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 How the regulation was not being met: Patients were not protected against the unsafe and in-proper management of medicines. Medication administration systems were not robust. There was not an accurate and up to date record of medication stored on each ward. Patients were not always able to have their medication when on leave. Medication was not always administered as prescribed. Some medication was out of date. This was a breach of regulation 12(2) (g)

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 How the regulation was not being met: The risks to the health and safety of patients receiving care or treatment was not adequately assessed. The provider did not monitor the side of effects of anti-psychotic medication. The provider did not complete risk assessments for medication to be self-administered. The provider did not always update patient records to reflect decisions made during MDT meetings.

This section is primarily information for the provider

Requirement notices

The provider did not ensure physical health checks were carried out including blood sugar monitoring, electro cardiograms and monitoring of cholesterol levels.

This was a breach of regulation 12 (2) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect How the regulation was not being met: People using the service were not treated with respect and dignity at all times while they were receiving care and treatment. The provider did not inform a patient that their bedroom was going to be refurbished and found their belongings outside their bedroom in the corridor which caused them distress.