The Priory Hospital Middleton St George

Quality Report

Middleton St George
Darlington
County Durham
DL2 1TS
Tel: 01325 333 192
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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
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.

Summary of findings

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

Overall summary

We rated The Priory Hospital, Middleton St George as requires improvement because:

- The hospital had experienced difficulties in the recruitment and retention of qualified nurses. It filled gaps in staffing with bank and agency nurses or staff working overtime. It could not always secure extra nurses which meant some shifts did not always have the correct number of nurses on duty.
- A patient had been secluded in his bedroom for a lengthy period.The records of this seclusion were missing at the time of our visit so we could not review these, but we were concerned whether this was the most appropriate or safe management of the situation.
- Patient risk assessments on Thoburn ward did not always fully document historical risk.
- Staff did not always explain patients' rights under the Mental Health Act to patients at appropriate times on Thoburn ward.
- Care plans on Thoburn ward did not all include the patients' views and did not identify strengths and goals.
- Staff did not always clearly record patients Section 17 pre-leave risk assessment in the care records.

However:

- Systems were in place to monitor and manage patient risk. Staff carried out comprehensive risk assessments in a timely manner and regularly reviewed these.
- Assessments of ligature risks (a ligature risk is a place where a patient intent on self-harm might tie something to strangle themselves) were in place, along with policies to support the management of these risks.
- The hospital had made safeguarding an integral part of its routine. Staff were aware of their responsibilities to report and raise any incidents and safeguarding issues.
- Staff had received mandatory training.
- Managers assessed and reviewed staffing levels to keep patients safe.
- Feedback from patients and carers was positive. We observed staff treating patients in a respectful manner, and with a caring and compassionate approach. Most patients were involved in their own care planning. Managers evaluated feedback from patients to improve patient care and treatment at the hospital.
- Senior managers were visible and actively involved staff in the vision and values of the organisation. Staff felt supported and consulted about their roles.
- There were good governance structures with individualised and group audits in place to support and deliver safe care and to monitor the performance of the hospital.

Summary of findings

Contents

Requires improvement

The Priory Hospital Middleton St George

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults; Acute wards for adults of working.

Summary of this inspection

Background to The Priory Hospital Middleton St George

The Priory Hospital Middleton St George is a 70-bed hospital that provides 24-hour support seven days a week for people aged 18 years upwards with mental health problems, personality disorders or both. It is registered with the Care Quality Commission to provide the following regulated activity:

- accommodation for people who require treatment for substance misuse
- assessment or medical treatment for people detained under the Mental Health Act 1983/2007
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

The hospital's registered manager, Victoria Colloby, has been in post since 2014.

Patient accommodation comprises:

- Dalton Ward – locked rehabilitation 13-bed ward for women
- Hazelwood Ward – locked rehabilitation 10-bed ward for women
- Lindon Ward – locked rehabilitation 15-bed ward for men
- Oak Ward – locked rehabilitation 10-bed ward for women
- Thoburn Ward – acute admission and alcohol / opiate detoxification 22 –bed ward for both women and men.

At the time of our visit, the hospital had 56 patients.

There have been seven inspections carried out at the Priory Hospital Middleton St George. The most recent inspection took place on 24 February 2014 and the hospital was found to be compliant.

We have reported on long stay rehabilitation wards and the acute ward for adults of working age together within this report.

Our inspection team

Team leader: Alma O'Rourke

The team that inspected the service comprised four CQC inspectors and a variety of specialists: a psychologist, an occupational therapist, two nurses, a pharmacist, a Mental Health Act reviewer and an expert by experience (someone with experience of similar services).

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.

During the inspection visit, the inspection team:

Summary of this inspection

- visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 19 patients who were using the service
- spoke with the registered manager and the managers for each of the wards
- spoke with 44 other staff members, including doctors, nurses, an occupational therapist, a psychologist and a social worker
- received feedback about the service from one commissioner
- received feedback from one local authority
- spoke with six carers
- spoke with an independent advocate
- attended and observed five ward rounds and multidisciplinary meetings
- attended and observed two patient community meetings
- looked at 33 care and treatment records of patients
- carried out a specific check of the medication management on two wards and
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

During this inspection, we spoke with 19 patients and six carers who were relatives or family friends. We observed two patient community meetings.

Patients we spoke with said staff were caring and treated them with dignity and respect. Carers were complimentary towards the staff, and considered them caring and supportive. Carers all felt, with the exception of one, that they were involved in their relatives care. Some carers said that they would like to see their relative's bedroom as visiting always takes place off the ward so they never see bedrooms.

Most patients said they felt safe on the ward. Not all patients had a key to their bedroom due to risk of self harm, but they reported that staff would open the door for them when they wanted to use it.

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?

Requires improvement 

We rated safe as requires improvement because:

- The hospital had undertaken a series of initiatives to improve recruitment of qualified nurses but it remained a significant challenge and sometimes wards weren't adequately staffed.
- The staffing tool used by the hospital to estimate the number and grades of nurses needed on Thoburn ward had not been adjusted following a merger with another unit. This led to a lack of clarity regarding how many staff there should be.
- On one ward a patient had been secluded in a room that did not meet the requirements of the code of practice. There was concern around the lack of paperwork for this and the delay of a medical review. This was not in line with the providers own policy or the code of practice guidance.
- There was a lack of clarity in recording pre-leave risk assessments for patients going on section 17 leave and it was not always clearly recorded in the care records.
- Discrepancies when auditing medicines were not always appropriately reported.
- Patient risk assessments on Thoburn ward did not always fully document historical risk.

However:

- Where gaps were identified in staffing numbers, staff were moved across wards to meet patient need and keep patients and staff safe. Agency and bank staff were used to support the numbers of staff needed to care for patients. The hospital had reviewed its recruitment and retention efforts and was making progress with recruiting qualified nurses.
- On the rehabilitation wards staff carried out thorough assessments of the risks to patients when they were admitted and at regular intervals during their care. All staff showed a good understanding of safeguarding patients from abuse and could explain how and when they would make a safeguarding alert.
- Patients said they felt safe on the wards.
- Annual ligature point assessments and comprehensive health and safety assessments had been completed.
- All wards were visibly clean and tidy.
- There was a robust monitoring system to review incidents involving aggression or violence or both.
- All staff carried personal alarms.

Summary of this inspection

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Patients on Thoburn ward did not always have their rights given or repeated following admission.
- Hospital managers had no systems in place to refer patients who lacked capacity to the independent mental health advocacy service. Ward based staff were unaware of their responsibilities in this area.
- Patients views regarding section 17 leave were rarely recorded. Patients did not always receive copies of section 17 leave forms or agree conditions.
- Thoburn ward did not have a full multi disciplinary team (MDT) membership. Patients requiring psychology and occupational therapy support were referred by the ward.
- Although patient admitted in the past 12 months all had physical health checks on admission we found some patients who had been admitted a number of years ago had no physical health check recorded.

However:

- Staff carried out comprehensive assessments of patients clinical needs. Care plans described how patients' physical and mental health needs should be met.
- The hospital provided full multi-disciplinary teams across the rehabilitation wards that included doctors, nurses, psychologists and occupational therapists.
- Staff received training in the Mental Health Act (MHA) and the Mental Capacity Act
- Staff had training to help them in improving their skills and knowledge to support patients.
- Consultant psychiatrists held ward rounds weekly.
- Staff received an annual appraisal of their work performance and most were receiving regular managerial supervision.
- Most patient records were complete and accurate.
- Staff received training in safeguarding.

Are services caring?

Good

We rated caring as good because:

- Patients felt staff treated them with dignity and respect and they described staff as caring.
- All patients had access to an independent advocate who visited the hospital weekly.
- Detained patients had access to an independent mental health advocate and could make direct contact with them.

Summary of this inspection

- Monthly patient meetings took place and we saw evidence of changes being made following patient feedback.
- Most patients were involved in their care planning.

Are services responsive?

Good

We rated responsive as good because:

- There was a good range of facilities to support treatment and care, including a sensory room on one of the wards, activities of daily living kitchen (where patients could prepare meals as part of their rehabilitation programme), meeting rooms, craft rooms, a faith room and lounge areas.
- Patients could access pleasant, well-kept outdoor space.
- There was evidence of good discharge planning in records.

However:

- Patients and staff felt they would like more variety in activities. Some patients felt there was a lack of activities at weekends.
- There was no fridge temperature recording in the daily living kitchen.

Are services well-led?

Good

We rated well-led as good because:

- The service was well led both at ward level and by the hospital director.
- There was a clear governance framework with close senior leadership team working and good engagement of medical staff. Daily meetings provided close contact between senior and middle managers enabling prompt awareness of and response to events taking place on the wards.
- There was a commitment towards continual improvement and innovation.
- The service was responsive to feedback from patients, staff and external agencies.
- Areas for improvement identified by staff had been recognised and the service was working actively with staff to respond to their concerns and make changes that would benefit them.
- There was clear learning from incidents.
- There were creative attempts to involve patients in all aspects of the service.

However:

- Documentation relating to an episode of seclusion on Linden ward was missing at the time of our visit.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983 (MHA). We use our findings to determine an overall judgement about the provider.

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients.

The provider had a MHA administrator who completed audits and scrutinised documents. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing and medical staff in meeting the responsibilities of the Act.

Completed consent to treatment forms were located with prescription charts. We saw referrals to second opinion appointed doctors (SOAD) were made appropriately.

Staff informed patients of their rights verbally and in writing. Staff told us, that if required, this could be provided in easy read format and other languages. However, some nursing staff were unclear how this would be done. We saw evidence of rights being explained at appropriate times on Hazelwood ward, Oak ward, Dalton ward and Linden ward.

We saw on Thoburn ward that rights were not always repeated or given to patients following admission. On two occasions, we saw a long gap after detention before rights were explained. On occasions, we saw a delay in repeating rights to those unable to understand on the first occasion.

The provider had an internal advocacy service and access to an independent mental health advocacy service. Hospital managers had no systems in place to refer patients who lacked capacity to this service. Ward based staff were unaware of their responsibilities in this area.

We saw on Thoburn ward situations where this should have happened to support the patient. When we brought this to the MHA administrator's attention a system was immediately put in place.

Section 17 leave forms were clearly written. However, patients own view of leave was rarely recorded. Patients did not always receive section 17 leave forms or agree conditions.

A further form was in use to authorise leave in the grounds and other parts of the hospital. The understanding of this was confused, and differed throughout the site. We saw that ground leave continued when the form review date had passed on Dalton ward. Staff told us this should not have happened. However we saw the same issue on Thoburn ward and were told that the fact the review date had passed did not mean the form was no longer valid. This was discussed with the Medical Director who immediately reviewed the form to avoid confusion.Throughout the hospital. we saw a lack of clarity on recording pre-leave risk assessments in patient records.

The provider had decommissioned seclusion rooms on site before our visit. Seclusion rooms protect disturbed patients or others from harm. We heard of two episodes of seclusion in a bedroom on Linden ward. We were unable to review all the records for these seclusions as one set was missing. In one record we saw there was no medical review until five hours after seclusion started. This was not in line with the providers own policy or the MHA code of practice guidance. We had concerns regarding the environment in which seclusion took place. It did not meet the requirements of the MHA code of practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Information provided by the hospital showed 91% of staff had completed training in the Mental Capacity Act and 90% in Deprivation of Liberty Safeguards (DoLS).

Most staff were able to tell us their understanding of the Mental Capacity Act (MCA) and told us all patients were assessed in relation to their capacity to consent to treatment, which we saw in care records. Psychologists told us they established consent before delivering specific psychological interventions and documented it in patients' care records.

Detailed findings from this inspection

During ward rounds, we saw staff reviewing patients' capacity to make decisions on specific issues. They assessed one patient, for example, on her ability to use her bankcard.

The care records we reviewed had documented reviews of patients' mental capacity during MDT reviews.

The hospital had a central Mental Health Act office that provided guidance and advice regarding mental capacity, consent, and DoLS.

At the time of our visit, there had been no DoLS applications in the previous six months.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

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

Long stay / rehabilitation wards and acute wards for working age adults safe?

Requires improvement

We have reported on long stay rehabilitation wards and the acute ward for adults of working age together within this report.

Safe and clean environment

All wards were visibly clean with good furnishings and well-maintained decoration. We saw cleaning schedules for the wards and domestic staff were on duty. Cleaning records were up to date.

Staff followed infection control principles. Handwashing facilities and alcohol gel was provided at the entrance to each ward and we saw staff using these throughout the inspection. Infection control audits were carried out monthly. There was evidence of re-audits being carried out when necessary to check compliance.

All clinic rooms were clean, tidy and well arranged. Equipment necessary for examinations and monitoring of basic medical observations was available. Locked medicine cupboards were well arranged with appropriate labelling and were secured safely to the wall.

Daily temperature checks on drug fridges and weekly cleaning of medical equipment took place. Resuscitation equipment and emergency drugs were accessible. Battery checks on defibrillation equipment had been completed and sealed emergency drugs boxes were in date and checked daily.

Wards had communal lounges, craft rooms and a room with a small kitchen area where patients could make drinks. The kitchen areas were clean and well maintained. The fridge and freezer temperatures in the food and drink and clinic areas were checked daily. Patients could use the laundry room on the ward to wash and dry their own clothing. There was an accessible garden that was well maintained.

The layout of the rehabilitation wards allowed staff to observe most parts of the wards. The nursing offices were positioned in a suitable area, allowing the main communal area to be easily seen. There was closed-circuit television (CCTV) covering all communal areas of these wards.

Each ward had quiet lounge areas where patients were less visible and there were no mirrors to mitigate this. However, staff explained that they would observe this area when in use and adjust patient observation levels according to risks.

The layout of the acute ward (Thoburn ward) did not allow easy observation of patients in all areas. This could result in unwitnessed incidents. The nursing office was positioned overlooking the main communal lounge. There was a separate quiet lounge where patients' were less easily observed. Staff told us they mitigated this by having staff present in this lounge and individual patient risk assessments. We saw staff in the lounge during our inspection.

All wards had designated rooms for activities such as crafts and listening to music. On Hazelwood ward, there were plans to use two decommissioned bedrooms for additional activity space. Patients told us they had been asked to contribute to suggestions for the redevelopment of these rooms. Thoburn ward had a female only lounge.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Patients' bedrooms on the rehabilitation wards were on ground level. The acute ward bedrooms were located on the first floor and were split to provide separate sleeping areas for male and female patients complying with same sex accommodation requirements. All bedrooms had en suite facilities including a shower. Nurse call alarms were present in all bedrooms.

There were numerous blind spots in the bedroom corridor on Thoburn ward. Staff told us that observations of patients mitigated this and having staff in communal areas at all times which we saw during our inspection.

Staff carried out environmental risk assessments, including ligature audits. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. There were ligature points on all wards that had been identified on the ligature audit. These included,

- doors within patient bedrooms
- door hinges in patient bedrooms
- nurse call alarm buttons in patient bedrooms
- patient beds in bedrooms
- patient toilets in bedrooms

Risks were mitigated by individual patient risk assessments and observations.

Seclusion rooms in all the wards were decommissioned in August 2015. These rooms had previously (2013) been judged to be non-compliant with regulatory standards. The hospital had taken the decision that, rather than upgrade the rooms, as part of a process of reducing restrictive practice, they would be decommissioned. Instead specialist de-escalation areas would be installed on each ward. The specialist room on Oak ward had been completed and plans were in place for each ward to have similar installed.

People visiting patients used a dedicated visitor room off the ward. Carers we spoke with confirmed they always saw their relative off the ward. One carer told us they would like to see their relative's bedroom.

All staff on duty had personal security alarms and radios were available to call for help in other parts of the hospital.

Safe staffing

The full establishment for the four rehabilitation wards was 29.2 (WTE) qualified nurses and 96.45 WTE nursing assistants. At the time of the inspection, 7.7 and 18.6 qualified nurses and nursing assistant posts respectively were vacant.

The full establishment for Thoburn acute ward was 11.6 (WTE) qualified nurses and 20.32 WTE nursing assistants. At the time of the inspection, 2.8 and 3.6 qualified nurses and nursing assistant posts respectively were vacant.

Nursing shifts usually consisted of 13 .5 hours with a one hour break during a day shift. A night shift was 10.75 hours with a 45 minute break. Shift patterns were 7am until 8.30pm (days) and 8pm until 7.30am (nights).

Staffing levels had been estimated using a staffing ladder tool based on estimations of clinical need. Ward managers told us they took into account individual patient needs and adjusted staffing levels as necessary. For example, additional 'special duty nurses' would be made available in addition to the ward staffing establishment. This was to support patients who needed constant observation or during periods of leave. Staff shortages were covered by bank and agency use and ward managers told us they tried to always use bank or agency staff who were familiar with the wards.

Thoburn ward had recently merged with a smaller unit (Aspen) which was adjacent to Thoburn ward. The staffing ladder had not been adjusted following this merger and so the required number of staff according to the system did not match the number deemed appropriate for clinical need by senior management. We found this was causing confusion amongst staff regarding what the correct staffing numbers should be. This also meant that the number of nurses on shift did not match the number of nurses listed on the staffing ladder. Some staff told us there was generally enough staff on duty, but not always the right number of qualified nurses.

The number of qualified nurses on shift on the rehabilitation wards did not always match the number of nurses listed on the staffing ladder also. We examined the staffing data for the month of September and found that out of 150 day shifts across the four rehabilitation wards, 70 did not have the required number of qualified nurses on duty as prescribed by the staffing ladder. We looked at the night shifts on the acute ward, Thoburn, and found that 12

out of 30 night shifts did not have the required number of qualified nurses on duty. Set against the staffing ladder estimations for Thoburn ward none of the shifts had the correct staffing establishment.

We reviewed actions taken by the hospital to limit the impact on quality and safety of patient care when this happened. Additional twilight shifts, extra nursing assistant shifts, ward manager clinical support and senior nurse on call support were all ways in which the hospital managed gaps in staffing.

The hospital director informed us that the recruitment of qualified nursing staff had been difficult and was on their risk register. A number of initiatives and schemes to help retain staff had been developed. These included:

- developing a new four year plan to increase salary
- paying half registration fees for qualified staff
- making open university courses available for HCA to undertake their nurse training
- introducing a higher rate of pay for overtime worked
- writing to staff who had previously worked at the hospital and inviting them to return.

At the time of our inspection, the hospital had five qualified nurse vacancies advertised. An additional three qualified nurses had been successfully recruited and were due to start work shortly.

We observed qualified nurses present in communal ward areas during our inspection visit. However, due to the staffing issues, there was a risk that qualified nurses may not always be in communal ward areas at all times. Most patients' said they felt safe on the ward. However, one patient said they did not feel safe "when there were agency staff on, when you don't know who they are". Patients told us they felt there were enough staff on the ward. One patient said there was always someone there if you need to talk.

Staff told us escorted leave or ward activities were rarely cancelled due to the use of bank or agency staff to cover gaps in nursing shifts. Occasionally however, leave was cancelled or re-scheduled due to last-minute staff sickness. The senior management team monitored all cases of cancelled leave or activities.

Full medical staffing with permanent consultant posts had recently been achieved. This meant that medical cover for both day and night was appropriate to meet the needs of patients. Wards had one full time consultant psychiatrist and one 0.5 WTE staff grade doctor or advanced practitioner to provide cover during the day. Outside of normal working hours, a medical on-call rota system was in place. The on call speciality doctor or advanced practitioner were resident on site or could attend the hospital within 20 minutes of being called. In addition to this a consultant psychiatrist on call rota was also in place. This meant that patients' physical and mental health needs could be quickly assessed and treated urgently when necessary. A new GP contract to support patients physical healthcare needs was scheduled to be in place by the end of 2015.

The hospital did not supply ward level sickness data, but the sickness rate across the hospital for the period May 2014 to June 2015 was 5%.

Overall compliance with mandatory training for the hospital was 95%. This was above the hospitals target of 90%.

Assessing and managing risk to patients and staff

We examined 15 care records from across the four rehabilitation wards and found risk assessments were individualised and up to date in all records. Risk assessments considered risk of suicide and self-harm and included control measures to mitigate against these. The hospital had recently introduced the short-term assessment of risk and treatability (START) risk assessment tool and this was present in 11 records. We reviewed seven care records on Thoburn ward and found risk assessments had been completed upon admission to the ward and regularly reviewed in all records. However, risk assessments did not fully document historical risks and this section was not always updated.

Throughout the wards we saw a lack of clarity on recording pre-leave risk assessments and pre-leave risk assessments were not always recorded in patients' records. Prior to leave consideration should be given to patients current risk assessment and this should be clearly recorded.

Thoughtful discussions took place focusing on minimising restrictive practice whilst ensuring the safety of the patient. During a ward round, we observed staff discussing with a patient the appropriateness of having a light with a flex in her bedroom, which would assist with her visible impairment.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Staff were aware of and able to describe the hospital policy for conducting patient observations. Qualified nurses were able to increase observations based on need. Decisions to reduce the level of patient observations could only be taken by the consultant psychiatrist. We observed a ward round where discussions with a patient included recent risk behaviours. We saw discussions taking place between MDT and the patient regarding approaches to prevent escalation of negative behaviour and observation levels were agreed with the patient.

Patients and patients' bedrooms were only searched if staff had reason to suspect there was an increased risk to patient safety. Patients needed to consent to this and if they did not then agreement from the consultant psychiatrist needed to be sought for a search to take place against the patient's wishes. Security cupboards were located on all wards where particular belongings were locked away. Patients could access these at any time of the day by asking a member of staff. Items that were locked away included toiletries, sharp objects and valuable items. Patients were individually risk assessed and those who were considered low risk of self-harm kept their possessions in their own rooms.

There were 348 episodes of restraint relating to 35 patients in the hospital over a 12-month period. Oak ward had the highest amount of restraint. There were three incidents of prone restraint. This is when the patient is restrained in a face down position. The hospital informed us that these related to two patients who put themselves in the prone position by turning themselves over. This was confirmed by the patients records.

Number of incidents of restraint in the last six months

Hazelwood ward 76, Dalton ward 66, Oak ward 192, Linden ward two, Thoburn ward 12

Number of incidents of restraint that were in the prone position

Hazelwood ward one, Dalton ward two, Oak ward 0, Linden ward 0, Thoburn ward 0

Staff told us that restraint was only used as a last resort after de-escalation and other techniques had failed. Prevention and management of violence and aggression (PMVA) techniques were used and patients commented that often only arm holds were used. No prone restraint was used, apart from those patients who put themselves in that position.

The wards did not have a seclusion room due to them recently being decommissioned. On Linden ward, we heard that a patient had been secluded in his bedroom for eight days. We were unable to check all the circumstances of this intervention, or that records were being kept appropriately, as the complete set of records were missing at the time of the inspection. We were concerned as to whether such a lengthy use of seclusion in a patient's bedroom would have been safe or appropriate, or that adequate reviews were undertaken to identify alternative management strategies, such as transfer to another facility. It was not clear that the departure from the guidance in the Mental Health Act code of practice (for example that seclusion should only take place in a designated room with specific facilities) was based upon any cogent rationale based upon the patient's best interests, rather than simply due to the limitations of the facilities immediately available.

When we watched people being given their medicines and looked at prescription charts, we found that medicines were administered safely. We looked in detail at the hospital's system for accounting for medicines. On Hazelwood ward we found a discrepancy in the records and the system was not fit for purpose. Nurses auditing medicine stock had not reported a discrepancy that involved the miscounting of the stock of an antidepressant. When we brought this to managers' attention checks were immediately carried out that confirmed patients had received their medicines in the right way. We were assured the processes for recording and checking medicine stocks on the wards would be reviewed.

The hospital was visited once a week by a specialist mental health pharmacist who clinically checked patients' prescriptions and gave advice on the management of medicines. The pharmacist audited the use of medicines and reported to the 'Healthcare Clinical Governance committee' and 'Quality Monitoring and Assurance Group'.

The hospital had an accountable officer (a senior person within the organisation with the responsibility of monitoring the management of controlled drugs to prevent mishandling or misuse) as required by law. The

accountable officer's representative was in regular e-mail contact with the local controlled drugs intelligence network but they did not attend or always submit reports to meetings.

The hospital had a Home Office licence to keep stocks of controlled drugs. We checked the stock levels of three controlled drugs and found that quantities matched the records in the controlled drugs register.

Staff, were trained in safeguarding and had a clear understanding of safeguarding procedures. They demonstrated a good understanding of safeguarding issues and gave recent examples. A safeguarding group met twice a week to review safeguarding alerts and incidents. We saw a flowchart in the ward offices that clearly showed how safeguarding issues should be escalated. Ward managers told us they had strong links with the local authority safeguarding team in Darlington.

We spoke with the local authority safeguarding team who informed us they have monthly meetings with the hospital and communication is very open and transparent. They were confident that safeguarding was dealt with in accordance with policy and procedure.

On Linden ward, one patient was at risk of developing pressure ulcers. A care plan was in place for this and it was managed by regular dressings and referrals to specialists such as tissue viability nurses.

Track record on safety

The hospital had reported 33 serious incidents in the past 12 months. Of these, 23 related to Linden ward and were categorised as patient-on-patient assaults. There were five incidents on Oak ward, which included patient self-harm, patient on patient assault, allegations of historical rape, patient violence, aggression and verbal abuse. Four incidents related to Thoburn ward that included a patient's indecent exposure to another patient, a patient engaging in sexual intercourse with another patient and an allegation of historical sexual abuse. We reviewed safeguarding records for these incidents and saw staff had provided support to patients, involved police and the local safeguarding team where appropriate. There were no incidents recorded on Dalton Ward.

All incidents were discussed at the daily morning meeting, which took place each weekday morning. The senior management team, ward managers and others attended this. The daily incident log from the electronic incident reporting system was checked following the meetings to ensure nothing was missed. Information and learning from this was disseminated the same day via email to staff and printed for staff notice boards.

A weekly safeguarding meeting was attended by the safeguarding lead and deputy safeguarding lead. We reviewed minutes from this meeting and saw they were comprehensive covering actions from previous meetings, reviews of current cases, incident's since the last meeting, complaints, lessons learnt and good practice. A summary of this meeting was fed through the monthly 'governance meeting'.

Reporting incidents and learning from when things go wrong

All staff could tell us about the processes to follow for incident reporting. Health care assistants were able to report incidents using the electronic reporting system however not all health care assistants had access to the system which required log on details. Without access, they would inform the qualified nurses of the incident and they would input into the system. This could potentially lead to a delay in reporting incidents.

There was an open and transparent attitude towards patients if things went wrong. Ward managers and nursing staff were able to give detailed examples of reportable incidents and how patients were kept informed and explanations given if necessary. The senior management team were directly involved when an apology to a patient was needed.

Not all staff could explain how learning from incidents was shared. All incidents were discussed at the weekday daily morning meeting attended by the senior management team which we observed. Following each meeting, an e-mail bulletin was sent to all staff with key messages. Ward managers told us incidents were also discussed in MDT within 24 hours to allow any changes to be made in terms of care and interventions provided to patients following an incident. Managers told us they shared lessons learnt and any changes to practice through 'lessons learnt' bulletins, in team meetings and at staff handovers. Copies of email bulletins were displayed in the nursing office.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Post incident reviews were undertaken to review any good practice or learning. Staff could be referred to occupational health and offered direct support from ward managers when a serious incident had occurred.

Are long stay/rehabilitation wards and acute wards for working age adults effective?
(for example, treatment is effective)

Requires improvement

We have reported on long stay rehabilitation wards and the acute ward for adults of working age together within this report.

Assessment of needs and planning of care

We reviewed 15 care records across the rehabilitation wards. Records contained comprehensive and timely patient assessments following admission to the hospital. Physical examinations were completed on admission and regularly reviewed for eight patients. Two patients had a recent physical health check but there was no evidence this had been completed on admission to hospital. These patients had been admitted quite some time ago. Two patient records on Dalton ward had no physical health examinations. These patients had also been admitted quite some time ago. We saw in one care record that discussions had taken place with a patient in a ward round as a physical health assessment had not taken place during admission. Staff sought consent from the patient to complete this assessment but this was declined at that time and was to be revisited.

We could see that ongoing physical health care checks were being carried out in most cases following admission. However one patient had a physical examination on admission but this had not been reviewed in more than 16 months. The hospital informed us there was no current provision for a GP service, however this was currently being negotiated and a new contract was due to commence by the end of 2015.

Nursing staff said that if they had concerns relating to a patients physical health, they would support patients to attend the local general hospital. When we talked with carers most felt their relatives physical health needs were well cared for. They were aware of regular trips to the dentist and hospital appointments. Two carers said their relative had diabetes and they were being well supported.

We examined seven care records on Thoburn ward and found they all contained timely, holistic assessments of patient needs. We looked at six care plans of patients who had been in hospital between one and three weeks. All care plans were up to date and five patients had received a copy of their care plan. Care plans included a recovery plan but strengths and goals of the patient were not clearly recorded. Three care plans did not include the patients views. We did, however, observe patients discussing their care and treatment plans with staff in MDT meetings. The patients' views were fully taken into account during these meetings and discussions with the patient took place regarding their current treatment plan, risk assessment and observation levels.

Physical examinations were completed on admission for all except one of the records we reviewed on Thoburn ward. This was due to the patient refusing to have a physical examination.

On the rehabilitation wards, all care plans were up-to-date, personalised, holistic and recovery orientated, detailing strengths and goals of patients. In one care plan, we saw evidence that a patient was being supported to prepare meals in preparation for independent living. During a ward round on Hazelwood ward, we observed two patients involved in developing care plans to achieve reduction in medication in line with NICE guidance for borderline personality disorder. We also saw evidence of the use of psychological formulation in understanding one patient's behaviour and the use of Dialectical Behaviour Therapy (DBT) model in care planning.

All information was stored securely on the electronic records system, which ensured that confidentiality of patient information was maintained. Patient information was accessible to staff when needed. Records of day-to-day information were stored on paper in the nursing office for fast access by all staff. These contained; care plan, risk assessment, health information, patient profile and daily nursing notes. Healthcare assistants had read access to the electronic system and qualified nurses entered information on their behalf. During ward rounds, we saw members of the MDT updating the electronic records of patients as it occurred.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Some carers we talked to described the hospital as the best place their relative had been and they had made the most improvement at the hospital than anywhere else.

Best practice in treatment and care

NICE guidance was followed by staff when prescribing medication. This included 'management of depression CG90', 'management of schizophrenia CG178' and 'common mental health disorders: Identification and pathways to care CG123'.

Records were regularly audited against compliance with NICE guidance and staff were involved in this process. These were management of borderline personality disorder CG78, management of schizophrenia CG178 and management of post-traumatic stress disorder CG26. Due to the complexity of some patients, the medical director told us that there were occasional instances when NICE guidance was not followed but this would be recorded.

Psychological therapies as recommended by NICE were being offered on all rehabilitation wards. These included Dialectical Behaviour Therapy (DBT), schema therapy and eye movement desensitisation and reprogramming. Hazelwood ward was providing a comprehensive DBT program and Oak ward was progressing towards a full comprehensive programme.

Staff monitored the progress of patients with diary cards and progress was also discussed between MDT and patients during ward rounds. Health of the Nation Outcomes Scale was also used to monitor health outcome of patients on the ward.

Access to psychology was not routinely available for patients on Thoburn ward although referrals for assessment or brief interventions could be made subject to assurance from commissioners that service users would be in hospital long enough to complete assessments and interventions.

Patients' nutrition and hydration needs were being assessed and met. One patient had developed a healthy eating plan with support from staff and this had been reviewed monthly. In dining rooms, there was a hot and cold water dispenser, a fridge containing milk, cordial and other items. Fruit was available and patients also had their own snacks locked away in the kitchen area which nursing staff could access for them.

There was no dedicated occupational therapist aligned to the Thoburn ward, however an occupational therapy assistant worked on the ward Monday to Friday and provided a range of activities for patients.

Skilled staff to deliver care

All rehabilitation wards had a range of mental health disciplines including psychology, occupational therapy and social work. Thoburn acute ward did not have a dedicated social worker attached to the ward, however, referrals for social work support could be made. There was no occupational therapist or psychologist input to Thoburn ward, however referrals for assessment could be made and response would be the same day or the next.

All new members of staff received a three-day initial induction, which included the Mental Health Act, food and hygiene and the observation policy. Staff then received three day training in PMVA, first aid, basic life support, and worked on the wards for two days as a supernumerary member of staff.

One new member of staff told us they had to wait three weeks to attend PMVA training. They had not been allowed to be involved in dealing with any incidents until the training was completed.

We were informed that for health care assistants, a 'care certificate' course would be available soon. Some wards had health care assistants who were new in post and not experienced in mental health work. Ward managers explained how extra supervision and support was being offered to these staff members.

Staff of various disciplines explained that additional specialist training was available for their specific role and the senior management team would fund outside learning if this were appropriate. Thoburn ward had two drug and alcohol detoxification beds and staff had received training in substance misuse, which helped them care for patients undergoing detoxification. Ward managers told us leadership training was available. Psychology staff told us that whilst they had a good range of relevant expertise they had difficulty in accessing funding for continuing professional development.

The hospital's supervision policy required ward staff to receive supervision every month. Managers told us this had been very challenging to achieve due to staffing issues. However, staff we spoke with reported they received

monthly supervision. For clinical supervision a reflective practice group for nurses and health care assistants, facilitated by a psychologist, took place every two weeks on the rehabilitation wards. Qualified staff on Thoburn ward told us they had to schedule their own clinical supervision, with no protected time to undertake this.

Supervision arrangements for psychology were robust, with clinical supervision taking place every fortnight. All psychology staff attended a weekly DBT consultation meeting to review practice and discuss individual patients. The psychology team met for peer supervision three times per month and attend a monthly psychology business meeting.

Records indicated that 100% of non-medical staff had an annual appraisal apart from Oak ward, which was 93%.

The process for managing poor performance using performance development plans linked with supervision and was monitored by ward managers. We looked at the hospitals step-by-step guide to the disciplinary process. We selected one record and saw the process had been followed.

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings occurred on a weekly basis on all rehabilitation wards. Each ward had adopted a pattern of review to ensure that all care needs had been assessed and discussed with the MDT as much as possible. The monthly schedule consisted of:-

- Week one, a general business ward round, discussing progress of each patient
- Week two, discussion and formulation of risk assessments
- Week three, general business ward round
- Week four, consideration of care plans and review

Each MDT meeting would usually consist of,

- Patient
- Ward manager
- Consultant psychiatrist
- Psychologist
- Social worker
- Occupational therapist
- Nursing assistant
- Named nurse or nurse in charge
- Advanced nursing practitioner

A pharmacist, not employed by the provider, visited the wards weekly.

On Thoburn ward multidisciplinary team meetings took place twice weekly and would usually consist of the consultant psychiatrist, advanced practitioner and nurse in charge or manager. We were told that nurses were not always available to attend and contribute to MDT meetings due to staffing issues. Many of the patients on Thoburn ward were from outside of the area, and external agencies would usually be asked to 'dial in' to MDT meetings to allow contribution from community teams.

We observed MDT meetings on all wards and found them to be effective, patient centred, collaborative and recovery focussed. We found that patients were treated with kindness, dignity and respect during the meetings. One patient became distressed and agitated during a meeting. Staff supported the patient in a professional and caring way. We observed staff seeking patients consent to make medication changes.

There were effective working relationships with teams outside the organisation such as the local safeguarding team and commissioners. Local area care coordinators and commissioners were regularly invited to meetings and kept up to date with patient's progress.

Adherence to the MHA and the MHA Code of Practice

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients.

The hospital had not completed adjusting its policies and procedures to reflect the changes following the recent update to the code of practice. Following inspection the provider sent us information detailing changes which should have been made to the policies following the updated code. During inspection we did not see evidence that policies and procedures had all been updated and non adherence to the code highlighted below reinforced that these changes had not taken place. However, we heard that key staff had attended events regarding this and that work was on going to ensure staff were aware of the impact of changes to practice. This had included a review of restrictive practice.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

The provider had a MHA administrator who completed audits and scrutinised documents. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing and medical staff in meeting the responsibilities of the Act.

Completed consent to treatment forms were located with prescription charts. We saw referrals to second opinion appointed doctors (SOAD) were made appropriately.

Staff informed patients of their rights verbally and in writing. Staff told us, that if required, this could be provided in easy read and other languages. However, some nursing staff were unclear how this would be done. We saw evidence of rights being explained at appropriate times on Hazelwood ward, Oak ward, Dalton ward and Linden ward.

We saw on Thoburn ward that rights were not always repeated or given to patients following admission. On two occasions, we saw a long gap after detention before rights were explained. On occasions, we saw a delay in repeating rights to those unable to understand on the first occasion.

The provider had an internal advocacy service and access to an independent mental health advocacy service. Hospital managers had no systems in place to refer patients who lacked capacity to this service. Ward based staff were unaware of their responsibilities in this area. We saw on Thoburn ward situations where this should have happened to support the patient. When we brought this to the MHA administrator's attention a system was immediately put in place.

Section 17 leave forms were clearly written. However, patients own view of leave was rarely recorded. Patients did not always receive copies of section 17 leave forms or agree conditions.

A further form was in use to authorise leave in the grounds and other parts of the hospital. The understanding of this was confused, and differed throughout the site. We saw that ground leave continued when the form review date had passed on Dalton ward. Staff told us this should not have happened. However we saw the same issue on Thoburn ward and were told that the fact the review date had passed did not mean the form was no longer valid. This was discussed with the Medical Director who immediately reviewed the form to avoid confusion. Throughout the hospital. we saw a lack of clarity on recording pre-leave risk assessments in patient records.

The provider had decommissioned seclusion rooms on site before our visit. Seclusion rooms protect disturbed patients or others from harm. We heard of two episodes of seclusion of two different patients on Linden ward. We were unable to review all records of these seclusions as one set was missing. In one record we saw there was no medical review until five hours after seclusion started. This was not in line with the providers own policy or the MHA code of practice guidance. We had concerns regarding the environment in which seclusion took place. It did not meet the requirements of the MHA code of practice.

Good practice in applying the MCA

Information provided by the hospital showed 91% of staff had completed training in the Mental Capacity Act and 87% in Deprivation of Liberty Safeguards.

Most staff were able to tell us their understanding of the Mental Capacity Act (MCA) and told us all patients were assessed in relation to their capacity to consent to treatment, which we saw evidenced in care records. Psychologists told us they established consent before delivering specific psychological interventions and documented it in patients' care records.

During ward rounds, we saw staff reviewing patients' capacity to make decisions on specific issues. They assessed one patient, for example, on her ability to use her bank card.

The care records we reviewed had documented reviews of patients' capacity during MDT reviews.

The hospital had a central Mental Health Act office that provided guidance and advice regarding mental capacity, consent, and Deprivation of Liberty Safeguards (DoLS).

At the time of our visit, there had been no DoLS applications in the previous six months.

Are long stay/rehabilitation wards and acute wards for working age adults caring?

Good

We have reported on long stay rehabilitation wards and the acute ward for adults of working age together within this report.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Kindness, dignity, respect and support

Staff attitudes and behaviour when interacting with patients was observed to be responsive, respectful and supportive. We saw staff speak to patients with compassion and professionalism throughout our visit.

Patients told us staff were caring and supportive. One patient commented that staff stayed with them if they were distressed, even if their shift had finished which they appreciated. One patient told us "they are very good at what they do". Another patient said, "staff are always there if you need them". A patient on Oak ward described the consultant psychiatrist as excellent due to his ability to listen to patients and give them time. One patient told us staff could be abrupt when they have a lot to do, telling patients what they can or cannot do. Some patients told us staff did not always knock before entering bedrooms.

Carers described staff as "very tolerant", "a good team", and "lovely". Carers said staff were always available to talk with them. Some said this was mainly healthcare assistants rather than the qualified nurses.

We saw that patient bedrooms on the rehabilitation wards had been personalised and a number of patients had their own mobile telephone.

Two patients mentioned the lack of a chaplain at the hospital. One patient had recently been granted leave to attend church, the other patient told us she only managed to get to church about twice a month. Senior management confirmed that attempts to secure a hospital chaplaincy service had been difficult however, they had recently been successful and a contract with a local NHS Trust was due to start this year.

During ward rounds, we saw service users being treated with kindness, dignity, respect and compassion by all MDT members. This was the case both when patients were present and in team discussions. Staff understood the individual needs of patients and had a clear vision of the patient's pathway. This was reflected in the MDT meetings and in staff interviews.

We were told the hospital site for rehabilitation wards would become smoke free in January 2016. The hospital had set up a smoke-free steering group which had both staff and patient representatives. Smoking cessation support was offered to all service users in preparation for the site becoming smoke free.

The involvement of people in the care they receive

Prior to admission to the hospital, each patient was individually assessed and detailed information was given to the patient. On the rehabilitation wards, patients were encouraged to visit the hospital and meet staff before moving to the service. This was in order to engage patients and build therapeutic relationships in order to make transition to the hospital easier. When formally admitted, patients were offered extra support from staff depending on need to assist with orientation to the individual ward.

Patients were actively encouraged to participate in care planning and risk assessments. This was demonstrated during MDT meetings and in care records. During a ward round, we observed members of the MDT invite a patient to write their own care plan related to managing access to their bank card so that it was not used to abscond or self-harm. We saw staff asking patients which issues they wanted to discuss during ward rounds.

There was an expectation that all patients participate in DBT on Hazelwood and Oak ward and this was discussed in pre-admission assessments. Other treatments (e.g. schema therapy) were delivered if appropriate and in line with patients' needs. Patients on these wards had been trained in risk assessments and had participated in care planning alongside staff.

Carers and relatives we talked to said they were invited to reviews. If they could not attend, they were sent the minutes from the meetings. Some said they were involved in care planning if their relative wanted them to be involved. One carer we spoke with did not feel fully involved in their relatives care. However, they had been able to communicate this to the consultant. A carer's newsletter had been produced and carer's information leaflets about each ward were being developed. Some carers expressed their concern that they had never been allowed access to any of the ward areas. The lead social worker explained this decision was originally made on grounds of confidentiality but that this was currently under review. The hospital provided a family visiting room that was based within an office block in the hospital grounds. This room was child friendly and had the appropriate amenities.

The hospital had developed a service user and carer involvement strategy designed to increase patient and carer participation. There was a plan to create ward

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

champions to give patients more of a voice alongside ward champion mentors to support the role of the ward champion. There was also a plan to introduce a "buddy system" on the rehabilitation wards, so new patients had a fellow patient who could offer them informal support. Patients were encouraged to maintain independence as much as possible, such as personal hygiene, laundry and cooking skills.

The Head of social work had arranged quarterly carer's groups to provide the opportunity for carers to gain mutual support from each other as well as support from the social work team, hospital director and the clinical services manager. The social work team also offered one to one support sessions with carers to discuss more individual patient and carer needs. Some carers we spoke with had attended this, but there were mixed views on it. Some said the group was very good however one carer felt the carers were not really being listened to by staff.

The wards had regular community meetings which patients were encouraged to attend. The hospital held a monthly service user forum, at which patients from each ward were able to represent their peers in discussing matters relating to their care and the facilities at the hospital.

Patients were able to give feedback on the care they received via the ward community meetings held fortnightly on each ward. Quarterly service user forums, feedback forms and the compliments and complaints box were also available to patients. We observed a community meeting on one ward that six patients attended. This meeting was attended by the ward manager and several members of staff.

Patients were asked to complete an exit questionnaire prior to leaving the ward. We saw copies of completed questionnaires on Thoburn ward. At the time of the inspection, the feedback from patients was not being analysed or reviewed.

All patients could access advocacy services via 'Advocacy Experience' based within the hospital. Detained patients could access the independent mental health advocacy service provided by 'Darlington Advocacy for Disability'.

There were appropriate involvement of families and carers in patient care. The MDT would routinely invite families and carers to care program approach (CPA) meetings (this is the process used to organise and review patients care), mental health tribunal hearings, specific ward rounds or any other meetings as appropriate.

Some patients had been involved in the recruitment process and had helped select new members of staff.

We found that staff endeavoured to involve patients in most aspects of their care where possible. Staff noted patients' preferences and how they would like to be treated when distressed or their mental health was relapsing. However, it was unclear whether staff had formally documented this as an advanced statement of their wishes.

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

Good

We have reported on long stay rehabilitation wards and the acute ward for adults of working age together within this report.

Access and discharge

Patients were referred to the wards from all parts of the country. The hospital provided long-stay rehabilitation services and specialist personality disorder services. In addition to this the hospital provided acute inpatient services for patients whose own local area hospitals required short-term management whilst a local bed was found. Therefore, most admissions were planned in advance and the placement secured prior to admission.

The average bed occupancy for the period April 2014 – June 2015 for each ward was,

- Dalton Ward, 49% (opened in April 2015)
- Hazelwood ward, 90%
- Linden ward, 56%
- Oak ward, 98%
- Thoburn, 81%

Oak ward and Hazelwood ward had reduced its number of beds from 15 to 10 in April 2015.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Patients did not move between wards during their admission. During the previous 12 months, the service had reconfigured some of its wards to distinguish between patients with psychotic illnesses and those with a personality disorder. Therefore, some patients may have moved into the pathway specific ward based on diagnosis and treatment needs.

The average length of stay varied, with some patients on Thoburn ward remaining on the ward for a very short time due to them going back to their 'home' area. Discharge planning commenced at the beginning of the admission process. Staff liaised with local area care coordinators and commissioners to design a discharge pathway suitable for the individual needs of the patient. Discharge was often delayed due to a lack of safe and suitable alternative accommodation for patients to move on to. We saw care plans that include a section on 'making plans'. These identified patients' goals for the future including discharge planning. For patients admitted to the ward for detoxification programmes, approximately 10% of patients were discharged to residential rehabilitation units. The remainder were discharged to community substance misuse teams.

Staff reported good links with commissioners to secure appropriate living arrangements following discharge for patients; however, they acknowledged that out of area discharge planning could be difficult.

Patients were able to access their bedroom on return from home leave and we saw no issues with bed management. One patient who had made very good progress spent five days a week in their new community placement. This was an example of collaborative working with community teams to facilitate effective discharge from the ward.

All patients were subject to the Care Programme Approach (CPA). CPA reviews happened more frequently in preparation for discharge from the ward.

The facilities promote recovery, comfort, dignity and confidentiality

There was a full range of rooms and equipment on the wards to support treatment and care. Each ward had an activity room where arts and crafts would take place. Outside of each ward there was a small gym room, activities of daily living kitchen and a number of therapy and meeting rooms. We found that there was no fridge temperature monitoring in the daily living kitchen. On Oak ward there was a newly developed relaxation room with a vibrating sofa, mood lighting and visual effects. There was a plan to create relaxation and de-escalation rooms in all wards in the near future.

Each ward had a structured plan of daily activities for patients to engage in. These included activities such as arts and crafts, walking groups, book club, gardening, bingo, sewing, health and fitness and creative writing. Outside of the wards there was a central activities programme for those patients able to leave the ward. This consisted of the same activities but allowed patients from other wards to mix and some activities were arranged within the local community. Patients and staff explained that they would prefer more variety in activities. Not all patients felt the activities were relevant to their needs and some felt they were not age appropriate, for example making jewellery with children's plastic beads. On Linden ward, staff commented there were not enough activities for male patients to engage in. Some patients felt there was a lack of activities at weekends.

Each ward had a quiet lounge area that patients could use if they needed space away from other people. Thoburn ward had a female only lounge that complied with the Department of Health's guidance on mixed sex accommodation. All wards had access to visitor rooms outside of the wards and there was a family room in another building that was child friendly, bright and airy. The family room had a variety of toys for children and facilities to make a hot drink.

Every ward had access to outside space for patients 24 hours a day. This consisted of a tarmacked area with grass and a smoking shelter. The area was surrounded by high fences and appeared oppressive. We were told by the Head of support services that environmental improvements were planned to take place.

Clinical outcomes for patients on the ward were monitored through the DBT diary cards, levels of observation, use of restraint, as required medication, health of the nation outcome scales (HONOS) and symptom checklist 90.

Some patients had their own mobile phones and could make private phone calls in their bedrooms. There were patient phones located in the wards but not all patients felt they were private. Patients could use the cordless office phone if necessary.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

The food provided to patients was of good quality and healthy. We examined menus over four weeks and found them to be of good nutritional value. Patients complimented the food and a wide variety of choice was available.

Patients had options available to store securely their personal possessions. Some patients had their own keys to their bedrooms and could keep their possessions there. Alternatively, patients could store their possessions in the security cupboard where items such as sharp objects were kept. To access this cupboard, patients needed to ask a member of staff which they could do 24 hours a day. On Linden ward, patients had their own lockers in the dining room where they could store snacks and drinks. Each ward also had a locked kitchen area where individual food and drink could be stored. Access to tea and coffee making facilities and kitchen facilities for light snacks were available 24 hours a day. On Linden ward, all cups were locked away and patients needed to ask a member of staff for a cup if they wanted to make a drink. We were told this restriction was due to the behaviour of a patient who was at risk of drinking too much fluid. Staff had asked patients to keep their own personal cups, however patients had declined this, preferring staff to keep the cups locked away.

Some patients needed to ask staff to lock and unlock bedroom doors based on risk assessment. One patient told us that they had something stolen from their room and that they now had their own bedroom key. Patients told us they had recently been given lockable cabinets in their bedrooms. However, patients also told us they did not have keys to these cabinets. This was discussed at the ward community meeting on the day of the inspection. Staff responded to this issue and said they would be issuing keys for the cabinets soon.

Meeting the needs of all people who use the service

For patients requiring disabled access the building design was appropriate to meet these needs. The main entrance was wheelchair accessible with no steps and wide doorways. All rehabilitation wards were single storey and the lounge areas had an open plan layout. On Thoburn ward a lift was available for access to the first floor. Two bedrooms were available on the ground floor on Thoburn ward for disabled patients.

On Linden ward, there were two patients with mobility problems and some adaptations to their bedrooms had been made to promote independence. Extra grab rails had been fitted and wheelchairs had been provided. However, one patient needed more specialised adaptations, which the ward manager explained would cost approximately £100,000 to complete. This patient had been assessed as not suitable for this current placement due to their high physical health needs. However, it was not possible to manage their mental health needs in the placement that had been identified for them. Therefore, this patient did not have the correct adaptations to meet their physical health care needs. Further assessment and reviews were ongoing to resolve this issue. We observed this patient being discussed in the daily senior management team meeting and were assured staff were taking appropriate steps to maintain the patents independence as much as possible.

Information leaflets were available on the entrance to each ward and were given to patients when necessary or when asked for. Patients were given information leaflets prior to admission and these were available in different languages if appropriate. The hospital could request an interpreter or signer if necessary via a central referral system.

Information relating to treatments, local services, patient's rights and how to complain was available on a notice board on each ward. Leaflets were available regarding diagnosis and treatment options and there was a box to place comments relating to complaints. Information was given verbally in ward community meetings relating to the complaints process and treatments or activities.

During the admission process, patients were asked about any special dietary requirements relating to religious or ethnic needs. Meal choices always included a vegetarian option and any cultural needs were taken into account on an individual basis.

The hospital did not have a multi-faith room. However, patients were provided with bibles or other literature to help meet their spiritual needs and a private room could be made available to pray. Patients were supported to attend the local church.

Listening to and learning from concerns and complaints

During the period July 2014 – June 2015 there were 48 formal complaints across the wards, of which 18

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

complaints were upheld or partially upheld. The majority of complaints came from Hazelwood and Oak ward. None were referred to the Independent Sector Complaints Adjudication Service or Ombudsman.

A review of a sample of compliant records showed accurate recording of information and updates to the complainant if it was evident that the initial timescale for completion was not going to be met. There was evidence that complaints were managed appropriately and the tone of correspondence was appropriate and respectful.

Patients told us they knew how to make a complaint and would feel confident to do so. However, one patient said they would not feel confident to make a complaint in case "it ends up coming back to you". Patients stated that they could speak directly to staff if they were unhappy about any aspect of the service and that there was also the complaints box to use. Staff confirmed that patients could raise issues during the ward community meetings.

Staff were able to give examples of the complaints process and how the senior management team directly oversaw some complaints and discussed them with patients.

Some patients told us they felt they had opportunities to give feedback on the service. This was through questionnaires they had been asked to complete, 'walk arounds' by senior staff, patient forums and community meetings.

Our review of records, discussions with patients, carers and staff confirmed that it was easy for people to complain or raise a concern and that there was openness and transparency in how complaints were dealt with.

Are long stay/rehabilitation wards and acute wards for working age adults well-led?

Good

We have reported on long stay rehabilitation wards and the acute ward for adults of working age together within this report.

Vision and values

Staff were aware of the hospitals values and were able to explain these in their own words. A copy of the hospital values was visible within the hospital main areas.

The senior management team maintained a visible presence on all the wards by completing regular 'quality walk arounds'. This allowed the senior management team to meet patients and staff informally to build better working relationships. All staff spoke in high regard of the senior management team and described them as supportive and effective. Many told us the hospital had significantly improved over the past 12-24 months.

Good governance

Ward systems were effective in ensuring that staff received mandatory training as there was a competent electronic system in place to calculate and record training required and completed. This information was overseen by ward managers who could identify if any training was outstanding.

We were told that monthly staff supervision did not happen as regularly as it should, due to capacity of staff to undertake this. Overall compliance for the hospital was recorded as 71% January- March 2015, 79% April- June & 75% July- September 2015. Staff shortages within the nursing team had made the delivery of supervision difficult. There was a plan in place to train more staff in the delivery of supervision and offer choice of supervisor. We were told this would be in place by January 2016.

Records showed that 98% of staff had received an appraisal. Revalidation of doctors records showed this was up to date for the two doctors that had been in post for a while and dates had been assigned for those doctors newly recruited.

Ward managers felt they had enough autonomy and authority to complete their work effectively.

All staff we spoke to could explain what was meant by 'duty of candour', although not all staff could tell us if there was a duty of candour policy. We saw a flowchart in the ward offices explaining the duty of candour process. None of the staff we spoke to had attended any training on duty of candour.

Shifts were not always covered by a sufficient number of staff of the right grades and experience. This issue was discussed regularly with the senior management team during daily morning meetings and placed on the hospitals

risk register. Ward managers attempted to mitigate this situation by allowing nursing staff on wards with a full complement of staff to work on other wards where staffing levels were lower. Ward managers also explained that they offered over-time to qualified nurses who were familiar with the ward and also used regular bank staff. In the longer term, the senior management team were attempting to improve the recruitment and retention of qualified nurses by considering a number of option including, recruiting overseas, using agency short term contracts and inviting previous staff to come back. The hospital had also developed a new salary structure for qualified nurses with a four-year plan to increase the salary based on achieving certain milestones in development.

Despite pressures at times with staffing levels, staff were able to maximise shift-time on direct care activities and spent less time in the office completing administrative duties. We observed staff spending time with patients and staff described a streamlined recording system that allowed them to have more direct patient care. Patients gave a mixed picture regarding staffing and time spent with patients. On Oak ward, one patient remarked there were too many agency staff and that leave was sometimes cancelled due to a shortage of staff. Another patient stated there were always staff around. On Dalton ward, one patient said there was enough staff.

Staff regularly participated in clinical audits such as medication, reducing restrictive practice and ligature audits. These were completed by qualified nursing staff and senior management throughout the year.

Documentation relating to a seclusion episode on Linden ward was reported as missing at the time of our visit. We were assured by management that a search and investigation would be undertaken immediately.

Staff on Thoburn ward did not always give or repeat rights in a timely manner to patients following admission under the MHA. Sometimes there was a delay in repeating rights to those unable to understand on the first occasion.

The reporting of incidents was understood by staff and the correct procedures were followed to ensure oversight of patient safety. Ward managers and nursing staff were aware of which incidents to report and there was an effective system in place for staff to highlight any incidents. Staff reflected that there was a culture of over-reporting to ensure that no incidents were over-looked.

Overall, we found the hospital had the right systems and meetings in place to help ensure the service was of a high standard and that any issues could be resolved.

Leadership, morale and staff engagement

A local employee engagement survey completed in December 2014, found that out of 41% of staff who responded to the survey, 72% were satisfied overall in their employment. Sixty-five per cent said they would recommend the hospital as a place to work and 66% said they would recommend the service to a friend or relative who needed similar care or treatment. The hospital scored particularly highly in the following areas:

- Understanding of what is expected in role 94%
- Understanding how your work helps achieve the hospitals objectives 87%
- Plan to still be working for the Priory group in one years' time 76%.

The hospital scored particularly low in the following areas:

- Satisfied with training and development 56%
- Learning, training and development regularly reviewed 63%
- Health and safety wellbeing take seriously 66%.

Following these results the hospital developed an action plan in April 2015 to target five specific areas of concern to be fully completed by December 2015:

We found these objectives were under way during our inspection.

The staff sickness and absence rate for the hospital was 5% overall. Ward level data was not available at the time of inspection. Ward managers for Dalton and Linden wards stated there were no issues with staff sickness and they had no staff absent from work due to any work related illnesses. On Oak ward, the ward manager explained that staff sickness had improved and was down to approximately 12.5 hours a week. She felt this was due to a better recruitment system and the current staff were more suited to their posts.

Staff we spoke to stated they understood how to be a whistle blower and that they felt confident to do this without fear of victimisation. Staff described an open and honest culture where the senior management team were highly visible with an open door policy.

Long stay / rehabilitation wards and acute wards for working age adults

Requires improvement

Staff on all wards described good morale, job satisfaction and felt empowered in their roles. Most staff stated there had been major changes throughout the hospital over the past 12 months and they felt happier, although they were aware improvements were ongoing. Staff generally had a positive outlook and felt involved in the change process.

Ward managers explained how leadership courses were available to them and that they were booked onto these courses in the coming months.

We observed effective team working and staff described good peer support. Thoburn ward did not have a full range of dedicated mental health disciplines attached to the ward. Staff confirmed that referrals for psychology, social work and occupational therapy could be made if deemed appropriate.

There was an open and transparent attitude towards patients if things went wrong. Ward managers and nursing staff were able to give detailed examples of reportable incidents and how patients were kept informed and explanations given if necessary. The senior management team were directly involved when an apology to a patient was needed.

Staff were offered the opportunity to give feedback on services and input into service development. The hospital had implemented a monthly "your say forum" for staff to express their views. The employee engagement action plan published in April 2015 also recommended the following improvements in relation to improving communication between the senior management team and staff,

- daily key message emailed to staff
- MDT-led monthly team meetings
- Bi-monthly listen to improve sessions with the hospital director
- Communication noticeboards in all areas.
- Develop a hospital communication strategy

Staff told us about the 'pride awards' and 'employee of the month'. A member of staff from Hazelwood ward had been awarded the employee of the month and we were told that this had been celebrated on the ward.

Staff spoke highly of the new Clinical Services Manager and said he had spent lots of time visiting the ward, getting to know staff and patients. All staff we spoke to told us they enjoyed working on the wards. Staff on Hazelwood ward were particularly positive about the DBT training they had attended and felt it had equipped staff to deal more effectively with the needs of patients on the ward.

Commitment to quality improvement and innovation

Senior management had supported the implementation of a fully compliant DBT model on the Hazelwood ward by enabling all staff to attend relevant training. This included members of MDT, ward manager and clinical leads attending higher level DBT training and all other staff working on the ward attended a three-day training programme. Staff from Oak ward were undertaking this training at the time of our inspection.

Staff on the wards had access to peer supervision and a reflective practice group led by psychology staff.

The wards were not part of an accreditation scheme. However, there were plans to action this in the next calendar year.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staffing levels and skill mix are in line with the provider's relevant tool so that patients receive safe care and treatment at all times.
- The provider must ensure establishment levels are reviewed following any ward merges or changes.
- The provider must ensure that people detained under the Mental Health Act are being read their rights under Section 132.
- The provider must ensure there is a process for referring patients who lack capacity to the independent mental health advocacy service.
- The provider must ensure patients' views regarding section 17 leave are recorded and that patients receive copies of section 17 leave forms or agree conditions.
- The provider must ensure that if seclusion is undertaken, there are cogent and well-documented reasons for any departure from the guidance of the Mental Health Act Code of Practice. Records of seclusion intervention and monitoring must be comprehensive and available for audit and review.
- The provider must ensure it has completed the process of adjusting its policies to reflect the changes of the updated Mental Health Act code of practice

Action the provider SHOULD take to improve

- The provider should clarify its system for recording risk assessment in relation to patients going on section 17 leave.
- The provider should ensure that all records relating to seclusion are securely stored and maintained.
- The provider should review the range of mental health disciplines and workers that provide input to Thoburn ward to ensure the needs of patients are met.
- The provider should ensure that all patients admitted to hospital have a full physical health check recorded.
- The provider should ensure that risk assessments on Thoburn ward always consider historical risk factors.
- The provider should ensure that staff fully involve patients on Thoburn ward in their care planning.
- The provider should ensure the process for recording and auditing medicine stock is fit for purpose.
- The provider should ensure that all staff receive supervision as per their policy.
- The provider should ensure the temperature of the fridge in the activities of daily living kitchen is recorded regularly.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require treatment for substance misuse Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Staffing levels for qualified nurses were not always in line with the required establishment. The establishment on Thoburn ward had not been revised following its merger with another unit. This was a breach of regulation 18(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Patients were not having their rights under Section 132 of the MHA explained to them. Patients' views regarding section 17 leave were rarely recorded and patients did not receive copies of section 17 leave forms or agree conditions. There was no process in place to refer patients who lacked capacity to the IMHA services. The provider had not completed the process of adjusting its policies to reflect the changes of the updated Mental Health Act code of practice. This is a breach of Regulation 9 (3)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

A patient was secluded in their bedroom which did not comply with the Mental Health Act (MHA) code of practice.

This was a breach of regulation 12(1).