The Priory Hospital Southampton

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

Overall summary

We carried out a focused inspection of Kingfisher ward, the child and adolescent mental health ward at the Priory Hospital Southampton in 6 October 2020

As this was a focused inspection, we did not cover all key lines of enquiry and therefore we did not re-rate the service during this inspection. Therefore the ratings from the previous inspection in 2019 remain the same.

Kingfisher ward is a 12 bedded mixed-gender ward for young people aged between 12 and 18 years old.

The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the 1983 Act.
- Treatment of disease, disorder or injury.

Summary of findings

We inspected the ward due to an increase in serious incidents and concerns that the service was potentially admitting young people whose risks were higher than a general child and adolescent mental health ward can manage. Throughout August 2020, there had been a significant increase in serious incidents reported to the Care Quality Commission compared to previous months. The incidents included repeated occurrences of self-harm, predominately by swallowing foreign objects, and young people absconding from the ward.

During the inspection we looked at relevant aspects of the key questions, are services safe, effective and well-led. We focused our attention on how the service managed incidents, how it learnt from incidents, and how it was meeting the needs of all people who use the service.

We found that:

- Staff assessed and managed risks to patients and themselves well in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. When incidents had occurred, staff held debriefs with the young person(s) involved.
- Staff managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers ensured that these staff received training, supervision and appraisal.
- The service had been recognized by a provider collaborative governance operational and assurance committee for ensuring that all staff during the peak of the pandemic still received regular supervision.

However:

- Although nursing staff developed a care plan for each young person that met their needs, they were not holistic as they did not include the input from the multidisciplinary team or agreed interventions. These were recorded elsewhere in the young person's care and treatment record.
- The provider's admission, transfer and discharge policy did not contain a clear acceptance and exclusion criteria. This may lead to inappropriate admissions to the ward.
- Although staff and young people confirmed debriefs occurred following an incident, it was rarely documented. This means that it wasn't clear that young people had received a debrief or check-in following an incident. A young person also commented that staff only debrief the young person(s) involved in an incident and not others on the ward who may have been negatively affected.

Summary of findings

Contents

Good

The Priory Hospital Southampton

Services we looked at
Child and adolescent mental health wards

Summary of this inspection

Background to The Priory Hospital Southampton

The Priory Hospital Southampton is an independent healthcare provider of therapeutic and recovery focused residential treatment as well as day care and outpatient services. The hospital provides specialist inpatient services for adults with acute mental health needs; adults with eating disorders and children and adolescents (young adults) with acute mental health needs. The hospital provides care to a mixture of NHS, self-funded, and insurance funded patients. The young people and eating disorder patients were all NHS funded.

There are three wards at the hospital:

• Kingfisher ward is a child and adolescent mental health ward, mixed sex ward with 12 beds;

• Sandpiper ward is an acute ward for adults of working age, mixed sex with 17 beds;

• Skylark ward is an eating disorders ward, mixed sex with 11 beds.

The hospital provides the following regulated activities:

• Accommodation for persons who require treatment for substance misuse;

• Assessment or medical treatment for persons detained under the Mental Health Act 1983;

• Diagnostic and screening procedures;

• Treatment of disease, disorder or injury.

A registered manager was in post at the time of inspection.

We last inspected in September 2019 and rated the service good overall, with caring rated as outstanding.

Our inspection team

Our inspection team comprised two inspectors, one specialist advisor who was a nurse with experience of working in child and adolescent mental health wards and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

How we carried out this inspection

As we did not cover all key lines of enquiry in this focussed inspection, the rating from the previous inspection still applies and this inspection did not include a rating.

We conducted an unannounced focused inspection looking at specific areas of one key question:

- Is it safe?

We have also commented in this report on specific areas of two other key questions based on what we found during the inspection:

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

During this inspection, the inspection team:

- visited Kingfisher ward
- spoke with the ward manager
- spoke with four staff remotely, including two nurses and two healthcare support workers.
- spoke with one young person remotely
- spoke with stakeholders of the service
- looked at six care and treatment records of young people
- reviewed 14 incident reports and
- looked at a range of policies, procedures and other documents relating to the running of the ward.

Summary of this inspection

What people who use the service say

As this inspection took place during the COVID-19 pandemic, we arranged phone calls to speak to any young people who wished to speak to us the day after the on-site inspection.

We spoke with one young person remotely.

They told us that their admission to the ward was good but communication with staff could be improved. They commented that they hadn't received a copy of their care plan. They explained that they felt safe on the ward and that most staff were supportive. They also said that there were quite a lot of therapy groups and activities available.

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?

Good

- Staff assessed and managed risks to young people and themselves well. They anticipated, de-escalated and managed behaviours that placed people and others at potential risk of harm. Staff used restraint only after attempts at de-escalation had failed.
- The admissions team followed up with the referrer if there were any gaps in risk information at the point of referral and all young people received a thorough initial assessment when admitted to the ward. All staff involved in the referral process were consistently able to describe an exclusion criteria for admission to the ward based on risk.
- The service managed young people's safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The ward teams included or had access to the full range of specialists required to meet the needs of young people on the wards. Managers ensured that these staff received training, supervision and appraisal.

However:

- The provider's admission, transfer and discharge policy did not contain a clear acceptance and exclusion criteria and there was no local policy to provide additional guidance. This may lead to inappropriate admissions to the ward.
- Although staff and young people confirmed debriefs occurred following an incident, it was rarely documented. This meant that it wasn't always clear whether young people had received a debrief or check-in following an incident. A young person also commented that staff only debriefed the young person(s) involved in an incident and not others on the ward who may have been negatively affected.

Are services effective?

Good

- Nursing staff developed care plans and updated as needed. Care plans reflected the assessed needs were personalised and recovery-oriented.

However:

Summary of this inspection

- Although nursing staff developed a care plan for each young person that met their needs, they were not holistic as they did not include the input from the multidisciplinary team or agreed interventions. These were recorded elsewhere in the young person's care and treatment record.

Are services caring?

We did not inspect this key question as part of this inspection.

Outstanding ☆

Are services responsive?

We did not inspect this key question as part of this inspection.

Good ●

Are services well-led?

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for young people and staff.
- The service had been recognized by a provider collaborative governance operational and assurance committee for ensuring that all staff during the peak of the pandemic still received regular supervision.

Good ●

Good

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Good

Assessing and managing risk to patients and staff

Staff assessed and managed risks to young people and themselves well in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. Staff knew about any risks to each young person and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, young people.

Staff completed risk assessments for each young person on admission, using a recognised tool, and reviewed this regularly, including after any incident. Prior to admission, the admissions team followed up any gaps in risk information at the point of referral and a thorough assessment was completed with each young person who was admitted to the ward. However, the provider's policy relating to referral and admission did not contain a clear acceptance and exclusion criteria. The service also did not have a formal local exclusion criteria but staff involved in the referral process were able to articulate a consistent set of exclusion criteria. This meant that the service could receive inappropriate referrals, for example those with higher risk levels than a general child and adolescent ward can manage, and without a formal policy to refer back to, inappropriate admissions may occur.

Reporting incidents and learning from when things go wrong

Staff managed young people's safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Staff raised concerns and reported incidents, including serious incidents and near misses, in line with provider policy.

Staff debriefed and supported young people after any serious incident. However, this was rarely documented so it was difficult for staff to be sure a follow-up check had occurred. In addition, young people only received a debrief following an incident they were involved in, but other young people may have been affected by what they witnessed or heard during an incident.

Managers investigated incidents thoroughly.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to young people's care. There was evidence that changes had been made as a result of feedback. For example, following a rise in a particular type of self-harm, a local procedure was introduced to manage these incidents more effectively.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Good

Child and adolescent mental health wards

Staff assessed the physical and mental health of all young people on admission. We reviewed six care and treatment records. Nursing staff developed care plans that reflected young people's assessed needs and were recovery-oriented. These were reviewed and updated when young people's needs changed. But care plans were not holistic as they did not include details from the multidisciplinary team or agreed interventions. These were recorded elsewhere in the young person's care and treatment record.

Are child and adolescent mental health wards caring?

Outstanding ☆

We did not inspection this key question as part of this inspection.

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

Good

We did not inspection this key question as part of this inspection.

Are child and adolescent mental health wards well-led?

Good

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for young people and staff. Leaders had identified and had developed a focused action plan to improve the quality of care provided to young people, for example the ward manager had already taken steps to address the lack of multidisciplinary team input into young people's care plans.

The service had been recognized by a provider collaborative governance operational and assurance committee for ensuring that all staff during the peak of the pandemic still received regular supervision.

Outstanding practice and areas for improvement

Outstanding practice

The service had been recognized by a provider collaborative governance operational and assurance committee for ensuring that all staff during the peak of the pandemic still received regular supervision. Line managers had maintained a 100% completion rate.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure care plans are truly holistic and include input from the wider multi-disciplinary team and agreed interventions.
- The provider should consider revising the admission, transfer and discharge policy to include an explicit acceptance and exclusion criteria.
- The provider should ensure that debriefs with young people following an incident are documented.