The Priory Hospital Bristol

Quality Report

Heath House Lane
Stapleton
Bristol
Avon
BS16 1EQ
Tel:0117 952 5255
Website:www.priorygroup.com

Date of inspection visit: 18 April – 21 April 2016
Date of publication: 26/07/2016

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

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

Summary of findings

Overall summary

We rated The Priory Hospital Bristol good because:

- Staffing levels were established based on the number of patients and on the clinical needs of patients. We saw evidence that although there were some vacancies across the wards, the service had ensured that either permanent, bank or agency staff covered all shifts. The hospital used agency staff that were familiar with the wards and had medical cover should patients need a psychiatrist.
- We saw evidence that staff had reported incidents, and that these incidents had led to learning within the hospital. Learning from incidents was reviewed by the Priory group's quality improvement lead and were fed back to staff through meetings and an internal staff newsletter.
- We saw that there had been adaptations to the ward environment to meet the needs of people with dementia to make the ward safer. Wards all had access to outside space, and there was access for patients with different mobility needs. We found that changes had been made to make sure the wards complied with same sex accommodation guidelines. Patient's beds were kept for them while they were on leave.
- Staff were experienced and had access to training to help them meet the needs of their patients. This included specialist training on eating disorders, and on alcohol misuse. Patients had access to staff from a range of disciplines and staff ensured that the treatment on offer was based on national guidance.
- The care records we reviewed showed care plans that covered a variety of the individual patients needs and patients told us they were involved in their care. This meant that they received health checks on admission, as well as annual health checks and that staff could engage other local healthcare providers to meet the patients' needs. For example, staff referred patients for podiatry and dentistry.
- Staff were caring and respectful in their approach to patients. We saw examples of staff interacting with patients in a positive way, helping to respect their dignity and involve them in the care they received. Staff were aware of patients' needs and the environment and this helped them to ensure that they cared for patients appropriately. Staff on Oak Lodge wore dressing gowns at night to help reduce the distress of patients with dementia.
- Staff ensured that patient's spiritual and dietary needs were met. They were clear on the process on how a patient would make a complaint and we saw evidence that patients had the opportunity to feedback on the service, as well as become involved in recruiting staff.
- We saw that staff had good morale. They spoke positively of the hospital manager and the deputy hospital manager. The deputy visited the wards daily and all of the staff were aware of the senior management within the hospital.
- Staff on the wards followed the Priory groups' governance systems. These systems allowed them to get data on their performance, which led to quality improvement targets. Lotus ward had received accreditation with the Royal College of Psychiatrists quality network for eating disorder services. There were also research projects taking place on that ward in partnership with local universities.

However:

- There were multiple ligature points on both Upper and Lower court. Identified ligature points did not have adequate management plans and the ligature assessments did not identify all ligature risks. Governance arrangements did not demonstrate planned improvement to areas where there were ligature risks on Lower and Upper Court. We bought this to the attention of the hospital director who undertook an audit of some areas that had been missed off the annual audit. Staff on Garden View did not have a good understanding of ligature risk and did not recognise risks on the ward.
- Visiting arrangements did not ensure the safety of patients on Lower Court as visitors were allowed in patient bedrooms, including male visitors in female areas.
- Audits did not identify all infection control risks on Garden View. Bed mats, which were used to cushion potential falls out of beds, were stained and had unpleasant odours.

Summary of findings

- We identified de-facto seclusion occurring on Garden View for one patient. We asked that this be referred to the local safeguarding team. The ward manager addressed this without further delay.

The hospital had taken some action to address concerns that had been raised at the previous inspection. We found that it had made amendments to the environment on the long stay/rehabilitation wards to remove worn carpets. We also saw documented evidence of mental capacity decisions being undertaken appropriately, as well as appropriate storage and administration of medication on Oak Lodge. The hospital had also made changes to adhere to the guidance on mixed sex accommodation and we saw evidence of care records containing a good personalised risk assessment.

However, we were concerned that multiple ligature risks on Lower and Upper Court that had not been properly assessed or identified by the provider.

This is a breach of regulation 12 of the Health and Social Care Act 2008 and as a result, we issued a warning notice on the 29th April 2016, requesting compliance with regulation 12 by the 13th May 2016. Following this notice, the hospital had submitted an action plan to address this.

Summary of findings

Contents

Good

The Priory Hospital Bristol

Services we looked at

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

Summary of this inspection

Background to The Priory Hospital Bristol

The Priory Hospital Bristol is an independent hospital registered (at the time of inspection) to provide care and treatment for up to 68 adults with mental health conditions. At the time of inspection, there were building works under way to split one of the wards into two, which would lead to there being five extra beds. The hospital admitted patients detained under the Mental Health Act. The hospital was split into two halves: long stay/ rehabilitation wards and acute mental health inpatient units. The hospital also provided a range of outpatient based therapy services.

The following core services were provided at the hospital:

- Long stay/rehabilitation wards.
- Acute mental health inpatient units.
- Eating disorder service.

The long stay/rehabilitation wards for working age adults consisted of:

- Garden View: a 10 bed female ward for people with complex mental health care needs that would accept referrals for adult females of any age.
- Hillside: a nine bed mixed gender ward for people who required mental health rehabilitative care.
- Oak Lodge: a 10-bed male ward for people with dementia. This ward would accept admissions for men of working age as well as older people if the patient was appropriate for the care environment.

The acute mental health inpatient units consisted of:

- Lower Court: a 21 bed acute ward for men and women, who required care and treatment for mental health issues. Lower Court is primarily for National Health Service (NHS) patients. Lower court was currently undergoing renovation works. The ward was to be spilt into two smaller wards by creating a five-bed extension and was due for completion mid-June 2016.
- Upper Court: an eight bed acute ward for men and women who required care and treatment for mental health issues that could have been complicated by alcohol or drug use. Upper Court is primarily reserved for private paying patients.

The Eating disorder service is:

- Lotus ward (previously called Rosewood ward): 10-bed ward for men and women who required treatment for eating disorders.

Priory Bristol has a registered manager on site and is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Accommodation for persons who require treatment for substance misuse

The last inspection was the 10 and 11 February 2015 but we did not give it a rating at that time. At the past inspection we had said the provider must improve in six areas to ensure;

- risks were identified and care plans were updated when new risks were identified
- that the environment in the long stay/rehabilitation wards was safe
- that management plans for ligature points (a ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation) reflected the ligature risks in the ward environment
- that mental capacity assessments were fully completed and documented
- that medication was stored and administered correctly on Oak lodge
- that the hospital must adhere to the Mental Health Act Code of Practice guidance on mixed sex accommodation

We also said that the provider should ensure staffing levels were improved to allow the safe observation of patients on Lower Court.

Summary of this inspection

Our inspection team

Team leader: Luke Allinson, Inspector

The inspection team comprised;

- two Care Quality Commission (CQC) inspection managers
- five CQC inspectors
- a Mental Health Act reviewer
- two specialist nurse advisors, one who had experience of working with patients within an acute psychiatric environment and one with experience of working with adults in long stay rehabilitation services.

Why we carried out this inspection

We inspected this service as part of our on-going 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 Priory Hospital Bristol.

During the inspection visit, the inspection team:

- inspected all of the wards at the hospital, looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with nine patients who were using the service and an ex-patient
- spoke with all of ward managers for each of the wards, as well as the hospital director, deputy hospital director, and hospital medical director
- spoke with 17 staff including, registered nurses, health care assistants, psychiatrists and an occupational therapist
- held five staff focus groups
- spoke with a district nurse, visiting the wards
- collected feedback from nine patients using comment cards
- looked at 38 care records for patients, including ten related specifically to the Mental Health Act
- looked at six prescription charts of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that they were well cared for and that all staff treated them with respect. They said that staff included them in their care and that there were enough activities. The comment cards we received from patients were positive about the service.

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:

- There were multiple ligature points on both Upper and Lower Court that were not adequately mitigated. There was no ligature risk assessment and management plan for some parts of the environment (these were completed when we brought it to the attention of the hospital manager) and the ligature assessments present had not identified every ligature point on each ward. Senior ward staff on Garden View could not explain a ligature risk or identify them appropriately on the ward.
- Visiting arrangements did not always ensure the safety of patients on Lower Court as visitors were allowed in patient bedrooms, including male visitors in female areas.
- Environmental audits on Garden View had not identified potential infection risk areas and damage within the ward. Patients who were at risk of falling out of bed had mats beside the bed to cushion a fall. These were stained and had unpleasant odours. We found a broken toilet that had been repaired with tape. Varnish on two beds and a sink had worn away exposing the wood underneath. Infection control audits had not identified these issues.
- On Garden View, the seat of the bath hoist had a ragged edge underneath which meant bacteria could lodge in these areas and the bottom of the seat could not be cleaned thoroughly.
- Patient risk assessments had conflicting information in them on Oak Lodge and Hillside. Patients that were identified as presenting a risk in one section of the care records, did not present the same risk in another part of the care record.Accurate risk information is important in maintaining the health and safety of the patients and the staff involved in delivering care. Accurate risk information helps prevent or minimise future risks.

However:

- Staffing levels were good, there were no shifts that were not filled by either permanent, bank or agency staff. This helped to ensure patients' needs could be met.

Summary of this inspection

- Medicines management systems were effective. For example, in ordering medicines appropriately and ensuring fridge temperatures were within an acceptable range. Audits were in place to insure staff could address any issues.
- Staff adopted least restrictive principles and practices. Staff would attempt to address potentially critical situations with low-level interventions such as talking and distraction techniques.
- There was a good sense of relational security on all wards. Staff were knowledgeable about the patients, their individual needs and the risks that they may pose. Good relational security enhances the safety of all ward members.
- There was an effective plan in place to meet the requirements around same sex guidance.
- Adaptations to the environment of Oak Lodge had been made to meet the needs of patients' with dementia.

Are services effective?

Good

We rated effective as good because:

- Adherence to the Mental Health Act and Mental Capacity Act was good and there were systems and processes in place to ensure this.
- Patients had physical health and risk assessments on admissions. These included a review of nutrition and hydration needs and putting plans in place to meet these.
- We saw care plans that contained the information needed to meet patients' needs were easy to follow and showed evidence of patient participation.
- The general practitioner visited regularly. All patients had an annual health check in accordance with the guidance given by the national institute for health and care excellence (NICE) and staff supported patients to appointments when needed to.
- Lotus ward provided treatment in line with NICE guidelines surrounding interventions and treatment for patients with an eating disorder. For example, in goals for weight gain and access to therapies.
- The wards used a number of methods to monitor effectiveness. This included outcome measures and audits.
- There was a full range of mental health disciplines available. Staff had experience in specialist areas to help the different patient groups and they knew patients well. For example, specialist training in eating disorders, and in alcohol and substance misuse.

Summary of this inspection

- There were good links with outside agencies and NHS staff we spoke with were complimentary about the staff team.
- The service had regular reflective practice sessions for staff. This allowed them to have space to reflect on their clinical practice and improve their clinical skills.

Are services caring?

Good

We rated caring as good because:

- We saw that patients were well cared for and all staff treated them with respect and dignity. They told us that staff were kind and respectful.
- Staff could demonstrate they knew what the needs of the patients were, and how to meet them. This helped them ensure that they could treat patients in line with their wishes.
- Patients were involved in developing their own care and treatment plans.
- Patients who had been discharged from the service were involved in staff recruitment and spoke positively of how they were involved by the hospital.
- Patients were invited to visit the ward prior to admission to ensure that they felt it would be a good placement.

Are services responsive?

Good

We rated responsive as good because:

- Facilities were comfortable and clean. All wards were accessible to patients with limited mobility, including those using wheel chairs. There was a lift to the wards located upstairs.
- There was access to a range of professionals, including nurses, psychologists, psychiatrists, occupational therapists and counsellors.
- Upper Court delivered an alcohol misuse specific therapy programme. This programme aimed to educate and raise awareness about alcohol abuse and support patients to abstain from using alcohol.
- Patients could decide the time they would be discharged or moved to another ward.
- Patients could visit other wards to socialise and there was a wide range of activities which included time spent in the community.
- There was a choice of meals each day. Dietary and religious needs were catered for. Patients were involved in choosing the menu and we saw an example of where a patient's choice had been included.

Summary of this inspection

- Information on making a complaint was on display. Patients' could also complete feedback forms. Learning from complaints was discussed at team meetings.

Are services well-led?

Good

We rated well-led as good because:

- There were opportunities for ward managers to develop their skills.
- Staff we spoke with could tell us about the vision and values of the hospital and how this related to their own ward.
- Morale was high amongst staff. There were regular forums that enable staff to feedback about working at the hospital. Staff were complimentary about the senior management team and working for the priory group. We had seen positive changes since the new hospital manager had been in post.
- Staff felt confident to raise concerns and knew how to use the whistle blowing policy.
- Ward managers were clear about how to highlight risks.
- Most of the governance systems in place were effective in ensuring good care for patients. For example systems to monitor medications errors.
- Ward managers collected information on performance, audited care plans, risk assessments and incidents. This information was used to help guide future quality improvement plans.

However:

- Governance systems did not ensure that all areas of ligature risk were identified. The arrangements did not demonstrate planned improvement to areas where there were ligature risks. There were no ward based risk registers and ward managers did not directly contribute to the hospitals risk register.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- Staff were able to describe their understanding of the MHA and the Code of Practice.
- Detention papers filled in correctly were scrutinised and errors rectified promptly.
- Staff completed monthly Mental Health Act audits.
- Advocacy was provided by an external agency. The advocate visited the wards once weekly.
- Patients had their rights explained to them on admission; if staff felt a patient did not understand them, they would refer them automatically to an independent mental health advocate (IMHA).
- We saw evidence that capacity was assessed when a patients detention was renewed and when medication was altered. Consent to treatment forms were attached to medication cards.
- There was support available for ward staff from Mental Health Act administrators who checked for new admissions on a daily basis and conduct monthly audits.
- The wards displayed information on patients' rights under the Mental Health Act.
- We saw evidence that 88% of staff had been trained in the Mental Health Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff had training on the Mental Capacity Act (MCA) and on each ward; at least 75% of staff had received it. All of the staff had received MCA training on Lower Court and Lotus ward. Eighty-three percent of staff had received MCA training on Upper Court.
- There was a policy on MCA including deprivation of liberty, which staff were aware of and could refer to.
- Staff were able to describe their understanding of the five statutory principles of the MCA.
- Capacity assessments were decision specific. Where patients lacked capacity, we saw evidence that best interest meetings were held and involved family members. We saw good recording of decisions around patients' capacity to consent that included the assumption of capacity.
- Staff worked within the MCA definition of least restrictive practice.
- Audits of the MCA were completed monthly.
- We saw posters that identified a Deprivation of Liberty Safeguards and capacity champion on the wards.

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

Good

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

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

Requires improvement

Safe and clean environment

- Lower and Upper Court wards did not have clear lines of sight. Lower Court had installed ceiling mirrors to aid with observation. However, these were all located at the top end of the ward around communal areas and the ward reception area. They did not provide clear sight into the long bedroom corridor on Lower Court. There were recesses on both wards near the bedroom doors causing blind spots.
- On Hillside and Oak Lodge, the layout did not allow staff to observe all parts of the ward. However, staff managed these areas well through relational security (the knowledge and understanding staff have of a patient, the environment, and the translation of that information into appropriate responses and care). Staff would increase patient's observation level to improve patient safety. Observation levels began with staff checking patients every four hours and increased to one to one support.
- The hospital did not adequately manage the ligature points on both Upper and Lower Court wards. Seventeen bedrooms had numerous ligature points (a ligature point is anything that a person could use to attach a cord, rope or other material for the purpose of hanging or strangulation) including en-suite taps, door handles, headboards, angled wardrobe doors and pictures on the walls. The 17 bedrooms did not have anti-barricade doors (anti barricade doors ensure that patients are not able to block access to their bedrooms and allow staff easy access in an emergency). However, the hospital had adapted four high dependency bedrooms to reduce ligature points. Staff had not audited the main corridor for ligature points and had areas that were out of staff view. There were multiple doors with exposed door closures, handles and locks that patients could use to harm themselves. The main corridor had a sink with taps and exposed pipework that patients could use as ligature points. There were areas of the ward where patients were able to conceal themselves that staff could not easily observe. For example, behind double doors leading to the general lounge. We found that freestanding furniture with ligature point handles were on both wards and that staff had not added these items to the annual ligature audit. On Upper Court, staff had also not identified the window hinges that posed a risk on the audit and had not assessed the main corridor. Upper Court also had two ligature free bedrooms. However, there were headboards in both that could be used to hook a ligature behind. We brought this to the attention of the hospital manager and they then conducted the audit. Lotus ward had reduced ligature risks through such measures as appropriate door handles and closures and collapsible curtain rails. Staff had identified ligature risks in the annual audit.
- The hospital director completed a risk assessment in 2015 of all ligature points throughout the ward. However, these did not include an effective ligature risk assessment or management plan. The hospital director

had used the Priory ligature risk assessment but this did not identify all risks on the ward. Ligature risks were identified on a standard form and a generic statement had been entered beside each identified risk.

- On Garden View, neither the ward manager nor the nurse in charge were able to explain what a ligature risk was or what those risks were on their ward.
- Both Lower and Upper Court complied with same sex guidance in that all bedrooms were en-suite and both wards had identified female only lounges. Staff allocated bedrooms in such a way on both wards to ensure that females and males did not occupy the same areas. However, on the day of our visit we found that Lower Court had allowed a male relative to visit a female patient in her bedroom unsupervised in an area that was occupied by female patients. Lotus ward currently only had female patients so adhered to same sex accommodation guidance. It also had a female only lounge should the hospital admit a male patient.
- Garden View and Oak Lodge were all male wards. Hillside was a mixed gender ward. All bedrooms were en-suite and a separate female lounge was available near to the female bedrooms. A door separated the male and female bedrooms. Staff left the door unlocked between 0800 - 1500 hrs so that patients could mix. A member of staff was always located in the female area while the door was open and we observed that this happened.
- The clinic room on Garden View was clean and well equipped. There were locked cupboards fixed to the wall for storing medicines that could only be accessed by nursing staff with the correct key. The clinic room had air conditioning, which ensured that medicines were stored within the necessary temperature range to maintain their effectiveness. Staff had labelled, dated and signed sharp item disposal bins correctly. The clinic had suitable arrangements for the disposal of clinical waste.
- Oak Lodge and Hillside shared clinic facilities and the clinic room was clean and well kept. There was a sink available for handwashing, as well as adequate space available for preparing medication. Processes were in place for the disposal of medicines safely. There was no examination couch in the treatment room and staff advised us that they would examine patients the patient's bedrooms.
- There was a fully equipped treatment room on lower court and a separate room for the administration of medications. Staff checked the medication fridge temperatures on a daily basis on all wards and we saw records to show that these were completed. The clinic room in Upper Court was small but orderly and well maintained. Staff on Lower Court had their own resuscitation equipment and staff on Upper Court would use that equipment in an emergency. We saw records to show that staff regularly checked emergency equipment on all wards. However, we saw that the air conditioning unit on lower was leaking onto clinic surfaces and that medication trolley. This could have posed a contamination risk. We bought this to the attention of the ward manager who contacted maintenance.
- Emergency drugs on Hillside and Oak Lodge were on a resuscitation trolley. These drugs were in a sealed container which had the date of the expiry recorded on it. Staff carried out checks daily. However, we identified that staff had signed for two items that were not on the trolley. Staff had signed that there were ten 10 ml ampules of saline when there were only eight. The trolley paperwork said there should be orange intramuscular needles on the trolley but when none were present.
- We were concerned during a visit in December 2014 as not all controlled drug entries were signed by two staff. We checked the controlled drug register during this inspection and identified that two nurses had signed all entries.
- There was no seclusion room at the hospital and we found no evidence to show that patients were being secluded on the acute wards (the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving), in other rooms. Staff increased patient's level of observation if they presented a heightened level of risk.
- All three acute wards were well maintained and had comfortable, clean furnishings. On Oak Lodge and Hillside, the environment was clean and tidy throughout. The hospital had new carpets laid in the corridors, in the last 12 months following the last CQC inspection. We saw how patients rooms had been personalised which included individually decorated doors to each bedroom.
- Signage and handrails on Oak lodge had been adapted specifically for patients with dementia. This included pictures representing toilets or bathrooms, and brightly

coloured handrails. There were four sensory boards along the corridor and throughout the day, we saw patients engaging with these. The end wall of the main corridor had a full-scale picture of a poppy field. Patients and carers had helped design this. The ward manager showed us the purchase order for brightly coloured toilet seats, which they had purchased. These adaptations to the environment have been identified as helping people with dementia.

- Staff on the three acute wards adhered to infection control principles and we saw staff on Lower Court washing their hands effectively. At the entrance to all clinical areas, there were hand gel dispensers for staff and visitors to clean their hands. However, on Garden View, we identified a number of infection control risks that were not on the infection control audits. Patients who were at risk of falling out of bed had mats beside the bed to cushion a fall. There were stains on three of these mats and one had debris between the mat and the bed frame. Staff had folded one mat; the mat was stained and had an unpleasant odour. One patient had a toilet rise with a broken handle, which staff had repaired with tape. However, the wood was exposed and it would not be possible to clean this aid fully as dirt and bacteria could lodge between the tape and exposed frame.
- Equipment on all wards was well maintained and electrical check stickers were visible and in date. Staff had carried out audits of the condition of patients' beds on hillside ward. This audit had not identified that the varnish on two beds had been worn away leaving exposed wood. The surface was not impermeable and could not be cleaned thoroughly. We saw that the wood around the basin in the assisted bathroom had degraded. We asked to see the infection control audit and saw that it had not identified these issues. The ward manager told us infection control audits were carried out monthly.
- On Garden View, the seat of the bath hoist had a ragged edge underneath which meant bacteria could lodge in these areas and the bottom of the seat could not be cleaned thoroughly. In Oak Lodge, there was an assisted bathroom. However, on the day of the inspection the hoist was broken. The ward manager showed us the request for repair and explained how the process for maintenance work occurred in collaboration with the facilities department.
- There was a patient call system in each bedroom and communal area with alarms that signalled in the office and main corridor. Staff carried personal alarms linked to the main hospital system. Staff ensured that patients could access alarms in their bedrooms and communal areas.

Safe staffing

- The hospital had established staffing levels for all wards. Staffing levels were reviewed and decided on an annual basis. These were known as "staffing ladders" (a chart that showed the number of staff depended on the number of patients). Lower Court had recently recruited in preparation for the ward extension. At the time of inspection, Lower Court had 12 whole time equivalent (WTE) registered nurses in post, which left a vacancy of one WTE nurse. There were 19 WTE healthcare workers in post on lower court, which left a vacancy of one WTE healthcare worker. Upper Court was fully staffed with five WTE registered nurses in post and eight WTE healthcare workers in post, which was over their set level of seven. Lotus ward had six WTE registered nurses in post, which was under their budgeted establishment of seven. This meant they had one WTE vacancy. There were 12 WTE healthcare workers staff in post which was in line with their established levels. Patients we spoke with did not complain of problems with staffing levels. Garden View had five and a half whole time equivalent (WTE) registered nurses in post, and had no nursing vacancies. There were 12.8 WTE healthcare workers in post on Garden View, which left a vacancy of two WTE healthcare workers. Oak Lodge had five and a half WTE registered nurses in post and 14 WTE healthcare workers in post. There were no vacancies on Oak Lodge. Hillside had three WTE registered nurses in post, which was under their budgeted establishment of five and half. There were 12 WTE healthcare workers staff in post which was in line with their established levels.
- Lower Court, Upper Court and Lotus wards run a two shift system, 7am-7.30pm and 7pm- 7.30am. Garden view, Oak Lodge and Hillside wards ran a two shift system, 7:30am-8:00pm and 7:45pm-7:45am. This left half an hour for handover on the acute wards and fifteen minutes on the rehabilitation wards. Staff we spoke with did not say that there was not enough time to handover between shifts. Lower Court staffing levels were five staff throughout the day and four staff throughout the night

with two registered staff on each shift. Upper Court had three staff on duty during the day and two staff on duty at night; one of these staff members was a registered nurse. We reviewed rotas over the past four weeks on both wards to confirm this was the case. Lotus ward had staff two registered mental health nurses and two healthcare workers (HCWs) per day, and three staff at night (one registered mental health nurse and two HCWs).

- All wards used agency staff. All ward managers told us that agency staff received a hospital induction and local orientation to the ward and we saw records to show that this was the case. All ward managers told us that where possible they use the same agency staff for familiarity and consistency and we saw records to show that this was the case.
- All ward managers told us that they are able to adjust staffing levels to address clinical demand. Lower Court reported they had filled seven shifts over February, March and April with registered agency staff. For the same period, they had filled 164 shifts with health care agency workers. Upper Court reported filling 19 shifts with registered agency staff over February March and April. For the same period, Upper Court reported filling 20 shifts with health care agency staff. Lotus ward had filled 15 shifts with agency staff for registered nurses for this period. Forty-nine HCA shifts had been filled with agency staff for the same period on Lotus ward. Garden View reported they had used 411 hours of bank and agency cover in February, March and April 2016. Oak Lodge reported using 69 hours of bank and agency cover in the same three-month period. Hillside had used 187 hours of bank and agency cover in February, March and April 2016. There were no shifts on any of the wards that had shifts where there were staffing gaps due to sickness, absence or vacancies that were not covered by bank or agency staff.
- All ward managers told us that staff rarely cancelled escorted leave or ward activities because of staff shortages. Patients we spoke with said that there were a good number of activities.
- There were enough staff on duty on all three wards to carry out physical interventions safely. We reviewed ward rotas to show that this was the case.
- There was medical cover throughout the day and on call arrangements were made on a week by week basis. Medical staff that live far from the hospital site were able to stay off site in accommodation near to the hospital.
- Staff on Lower Court had completed 85% of their statutory and mandatory training. On Upper Court, staff had completed 88% of their mandatory training. Staff on Lotus ward had completed 94% of their mandatory training. On Hillside, overall staff had completed 90% of their mandatory training and on Oak Lodge 93% of staff had completed their training. Staff had completed 95% of their mandatory training on Garden View.
- There were sufficient health care support workers during the day and at night to support patients. The numbers varied according to the individual needs of the current patients who required one to one observations. Patients told us that there were usually enough staff at weekends and nights to cover the one to one observations. Patients said there were enough healthcare assistants to enable them to complete activities.
- Staffing levels were set each year under a scheme called staffing ladders, which were displayed, in the office. We reviewed three months duty rota. The number of agreed staff on the staffing ladder was the same as on the duty rota. We also identified that ward would increase the number of staff on duty when required for example to cover one to one support.

Assessing and managing risk to patients and staff

- All wards reported no incidents of seclusion or segregation over the past six months. We found no evidence to suggest that patients were being secluded in their bedrooms or any other area of either ward.
- Lower Court reported 20 incidents of restraint in the past six months, involving 14 different patients. Upper Court reported none. Lotus ward reported 11 episodes of restraint involving three different patients. There were no incidents reported of prone restraint on any of the wards. Staff were skilled in de-escalation techniques and able to describe how they would only use restraint as a last resort. We witnessed a patient becoming aggressive with staff and saw how they managed this incident by using de-escalation techniques such as giving the patient space and listening to their concerns. We saw the policy for the management of violence and

aggression. Staff were able to explain how to record incidents of violence, aggression and restraint. Information provided by the Priory, before the inspection, reported there had been 17 restraints involving six different patients. On the other wards the staff reported very few restraints and the information we received prior the inspection confirmed this.

- The Priory Group had devised their own risk assessment tool that was used by all wards. This provided staff with a template to help ensure they did not miss important factors in determining a patient's risk. We looked at nine care records on Lower Court and six care records on Upper Court with specific regard to risk assessments. All patients had a risk assessment on admission. We saw that these individual risk assessments were of good quality. However, we reviewed six risk assessments on Hillside and Oak Lodge and the quality varied. For example, some risk assessments were contradictory. Four out of six records we reviewed identified that patients presented a risk in one section of the care records and then stated that the same patient did not present that same risk. One risk assessment completed the day before our visit, showed that staff had assessed a patient as not presenting a risk but had a care plan to manage this issue. Staff advised us that the risk was still present and that the ward manager who audits the risk assessments would have picked up this error. We were advised this would be rectified. In all six records we reviewed on Garden View, we also saw good risk assessments that linked to care plans and that guided the staff on how to manage the risk. All patients had a risk assessment in place that staff reviewed and updated at ward round.
- We found no evidence of blanket restrictions on either Upper or Lower Court. Patients had access to snacks and drinks 24 hours a day. Access to fresh air on Lower Court was not restricted. Staff facilitated access to fresh air on Upper Court as doors were locked and the courtyard was downstairs. Some patients had their own swipe cards so they were able to let themselves in and out. Staff tightly monitored access to food and drink on Lotus ward due to the medical need of each patient and they had documented this in the patients care plan.
- Four of the patients on Lotus ward were not detained under the Mental Health Act and the two that we spoke with told us that they were free to go in and out as they chose, as they were not legally detained. Staff had explained this to them.
- All staff were expected to complete the observation and engagement policy training. We reviewed the live observation records on Lower and Upper Court and found these to be up to date and complete. During our visit, we saw that one patient left the ward without proper authorisation and staff were quickly able to realise this had happened due to their adhering to the observation policy.
- Staff only used restraint after all other efforts to de-escalate situations had failed. Staff were able to explain that they would use the least restrictive way of making sure that patients remained safe. Staff told us they used the national institute of national excellence (NICE) guidance in relation to the use of rapid tranquillisation.
- There were no incidences of rapid tranquilisation for current patients at the time of our inspection on any of the three wards. Lower court stocked Flumazenil, which is a drug that reverses the effects of Lorazepam, should complications arise. Lorazepam is a medicine used to rapidly tranquilise patients who are posing a significant risk to themselves or others.
- There were good medicine management practices in place on all three wards. The hospital had an external pharmaceutical provider who visited the wards weekly. The visiting pharmacist completed audits and reported any administration or prescribing errors through an electronic recording system. The ward manager on Lower Court had also implemented a medication checklist that the registered staff completed.
- Visits by relatives and children took place off the ward in a designated area within the hospital. This took place in the hospital main building, which had security systems in place (alarms, restricted exits) and if there was a risk, a member of clinical staff would be nearby.

Track record on safety

- In the 12 months between January 2015 and January 2016 there had been 13 serious incidents across Oak Lodge, Garden View and Hillside. These incidents

related to the presentation of the patients living on the wards and reflected a positive reporting culture. The hospital had taken appropriate steps following these incidents.

- The hospital placed incidents in categories, with 'type four' incidents being described as 'allegations or incidents of physical abuse and sexual assault or abuse'. 'Type one' incidents were described as incidents involving 'unexpected or avoidable death or severe harm of one or more patients, staff or members of the public'. There had been one 'type one' serious incident on Upper Court in previous year. On Lower Court, there had been nine 'type four' serious incidents in the previous year. On Lotus ward there had been one 'type four' incident recorded over the previous year.
- Following a serious incident on Upper Court the hospital had installed CCTV, had reviewed the therapies department role in relation to the observation of patients and made amendments to the observation and engagement policy which staff were trained in.
- On Lotus ward, we saw the development of a new protocol for the administration of nasal gastric tubes (tubes used to feed patients that refuse to eat and go in the nose and down into the stomach) during daytime hours only following an incident.

Reporting incidents and learning from when things go wrong

- Staff reported incidents on an electronic computer system. All staff we spoke with knew how to report incidents on the system. These reports contained detail about both the event and any injuries sustained by staff or patients. The manager reviewed all incidents and forwarded them to the clinical governance team.
- We saw evidence that staff reported incidents appropriately. For example, patient on patient assaults and medication errors. Incidents were reviewed at the clinical governance meeting. The hospital also had a designated quality & compliance manager on-site who oversaw incident reports and reviewed trends and themes.
- The hospital had established monthly quality improvement meetings to look at incidents in detail, which the multidisciplinary team attended. The staff team shared the outcomes and lessons learnt from this process through handovers, reflective practice sessions and individual supervision. The manager ensured the service was open and transparent by explaining to patients if things went wrong. For example, we saw a letter to a patient about an aspect of the care, which the staff team acknowledged, could have been better. The ward managers attended risk and serious incident meetings, which were organisation wide. This information was disseminated through staff meetings. However, there had been a number of ligature deaths throughout the Priory group but staff we spoke to could not explain ligature risk with us.
- The staff team recorded learning from the findings of previous incident investigations in their staff meeting minutes. Staff we spoke with confirmed they knew about improvements that had been made to practice. For example, improvements made to the recording and maintenance of patients' fluid charts.
- Staff we spoke with on all wards told us that they would always share with patients and other people when things have gone wrong. When we spoke with the senior managers at the hospital, they were aware of the need to be open and honest with patients following an incident and we saw evidence before the inspection that they were acting in line with their duty of candour.
- All wards held monthly staff meetings. Managers used the staff meetings to cascade any information around lessons learned. Following a serious incident on Upper Court, we saw examples of how the service and security had been improved.
- Staff told us that managers offered them debrief and support after serious incidents. Following a serious incident on Upper Court, staff told us that they had been supported by the organisation. Staff on Lotus ward told us that a monthly reflective session took place to ensure staff felt adequately supported following incidents. The wards psychologist led this. Four staff we spoke with told us they had the opportunity to have a formal de-brief after a serious incident and that they could access additional human resource (HR) support from the Priory if needed.

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

Good

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We looked at six care records on Upper Court and nine care records on Lower Court with specific regards to risk assessment and the associated care plans. All of these records had risk assessments completed on admission and staff regularly and routinely reviewed them. All had care plans that addressed the identified risk. Care plans were up to date and staff were involving patients in the care planning process. All of the records that we reviewed showed patients had physical health assessments on admission. On Lotus ward there was a standardised admission process that included an assessment of each patient's physical and mental health. An assessment of each patient's needs took place within 72 hours after admission. The ward dietitian was involved in the assessment and prepared a personalised meal plan based on the patients' current nutritional needs.
- Patients had physical health and risk assessment completed on admission. Patients nutrition and hydration needs were assessed and action taken if there were concerns. At the last inspection, we were concerned about the quality of the charts as they were not consistently completed so did not provide staff with reliable information. At this inspection, the records had improved and were completed appropriately by the staff team.
- Care planning on Lotus ward included specific areas such as diet, physical health and psychosocial needs. We saw that these were determined by individual patient need. There were specific care plans related to patients who had been reliant on naso-gastric feeding, including the circumstances in which restraint was used and these had been agreed with the patient.
- The hospital used an electronic care record as the main patient record. Staff scanned and uploaded physical documents (letter, paper assessments forms, and test results). Computers and physical files were kept in locked offices.

Best practice in treatment and care

- Upper Court supported patients with drug and alcohol dependency and provided therapy programmes and treatment for this. On Upper Court, patients subject to drug and alcohol detoxification were receiving appropriate treatment and staff regularly monitored their physical health.
- We looked at six prescription charts on Upper Court. Staff had completed all of them correctly with no omissions or mistakes. Medication errors were audited weekly by an outside organisation. This had reduced prescribing errors. We also saw that medicine management was in line with national guidance on the Upper and Lower Court.
- The hospital employed a dietician who was available to wards for guidance and support. Staff could refer patients for podiatry through local general practitioners and staff sourced access to dental care for patients in the local area.
- Lotus ward (the ward for patients with eating disorders) had a dining room and separate lounge area. Meal times were protected time and the dining room was reserved for dining only during allocated mealtimes, as recommended by the Royal College of Psychiatrists' standards for adult inpatient eating disorder services.
- On Lotus ward, plans for weight gain were in line with the national institute for health and care excellence (NICE) guidelines. NICE guidelines suggest weight gain should be around 0.5-1kg a week in inpatient settings to allow a safe weight gain.
- Lotus ward used the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) protocol to improve the physical monitoring of patients.
- Patients could access psychological therapies as part of their treatment and psychologists were part of the ward team. These therapists helped to advise staff on how to manage challenging behaviour. Staff focus was on recovery-based care.

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

Good

- The ward staff assessed patients using the health of the nation outcome scales (HoNOS) which measures patients' progress by establishing their current health and then reviewing against this.
- The hospital undertook a series of annual audits including infection control, Mental Health Act and Mental Capacity Act compliance and patient restraints.

Skilled staff to deliver care

- All three wards had access to a range of disciplines including consultant, nurses, health care assistants, occupational therapy, physiotherapy, speech and language therapist, reflexologist, and a psychologist. There was not a social worker on the team but the manager had advertised the post.
- All new staff had an organisational induction. Local orientation would happen on a ward-by-ward basis and all new Health care assistants were completing the care certificate. The hospital planned to roll the care certificate out over time to existing permanent health care staff. Staff on the wards and at the whole hospital focus group spoke positively about the new induction
- All wards had monthly supervision. We saw records for the past three months on all wards to show that this was the case. A group supervision session was offered each month and this included reflective practice led by the psychologist. We saw the management information reporting system, which managers used to monitor compliance with this, training and appraisal. The managers ensured that staff received clinical and managerial supervision monthly and annual appraisals. The compliance rate for both was 100%.
- Upper Court ward supported patients with drug and alcohol dependency. Staff on Upper Court were trained in alcohol therapy treatment. There had also been specialist training in eating disorders for staff on Lotus Ward.
- A dietician worked 30 hours a week on Lotus ward. This is in line with the Royal College of Psychiatrists' standards for adult inpatient eating disorder services. Staff told us they felt input from the dietician was good.
- The ward managers and nurse in charge addressed poor performance, for example, only accepting agency staff who met the required standards. The hospital operated a 'foundation for growth' training programme enabling staff to develop their skills through an e-learning programme. Ward managers were able to explain what action they would take in the event of staff not performing their duties as expected. We saw information relating to staff performance issues and were able to see how the hospital was addressing these issues proactively.

Multi-disciplinary and inter-agency team work

- Staff told us they were clear about the roles and responsibilities of visiting NHS professionals in delivering patient care. For example, advice about; tissue viability, palliative care, and wound dressings. We spoke with two visiting NHS staff that were very complimentary about the care and the skills staff had at the Priory hospital.
- Staff held ward rounds weekly on all three wards. Staff on Lower and Upper Court documented patients views prior to ward round through a new initiative called the pre-ward round sheet. Staff told us that they had created this to enable patients to be involved in their care and treatment as patients were not always able to attend ward round, either due to time constraints and or issues surrounding patient's health. Staff told us that it had been especially helpful for patients with communicative or cognitive issues. Each patient had a multidisciplinary ward round every two weeks. Those attending included the consultant, nurses, senior healthcare assistant, psychologist, occupational therapist assistant, speech and language therapist and the patient. The care records showed evidence of multidisciplinary working. Health care assistants spoke positivity about the introduction of the senior healthcare assistant to these meetings. Doing this meant the team had additional access to information about the day-to-day care of patients.
- Handovers happened twice a day on all three wards, once in the morning and once in the evening at the changeover of staff.
- Staff told us a general practitioner from a local practice attended the Priory every Tuesday and visited the wards on rotating basis each week.
- Staff told us that they did not always receive all the information about patients from NHS trusts prior to someone's admission. Staff told us that notice to discharge NHS patients back into the care of the NHS was often short, causing an abrupt discharge for patients. Staff told us that this had been upsetting to patients.

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

Good

Adherence to the MHA and the MHA Code of Practice

- Records confirmed that 88% of staff had received training on the Mental Health Act.
- Staff received training on the changes to the new Code of Practice. Staff told us that the provider provided both face to face and on line training and that Mental Health Act training was included in the staff induction process. Staff told us that support was available from other mental health act administrators via a support group that consisted of administrators from within the priory group and local NHS mental health trusts. Staff told us there was policy and quality team within the priory group they could go to for implementation of the MHA and corporate solicitors for legal advice.
- Ward managers told us that each morning they were contacted by Mental Health Act administrators to check for admissions and then collected the detention paperwork. We saw evidence that original detention papers were stored safely in a locked filing cabinet, and that detention papers were scrutinised and errors rectified promptly.
- Staff told us there were monthly MHA audits. These audits looked at detained patients, checked that leave forms and consent to treatments were in place, that renewal of detention, second opinion appointed doctor (SOAD) requests were actioned promptly and conversations with responsible clinicians (RC) documented. The audits also looked at tribunals, manager's hearings and consent to treatment. Staff told us they reported the outcomes of the audits back to the clinical governance group.
- We saw evidence in care notes that capacity was decision specific. Staff showed us that capacity was assessed at section renewals and medication changes. Staff told us that patients had consent to treatment forms attached to their medication charts and we saw evidence of this.
- Staff told us that patients have their rights under the Mental Health Act (MHA) read to them on admission. If the patient was unable to understand after three attempts, staff automatically referred them to the independent mental health advocate (IMHA) service. Staff showed us a spreadsheet that set up an automatic reminder when patients' rights were due. We saw evidence of completed rights forms in the mental health act office and in care notes.
- We reviewed 10 care records with specific regards to consent to treatment and capacity across Upper and Lower Court. Where necessary, all of the records we reviewed had a capacity assessment completed within a week of admission. Evidence in care records showed that capacity assessments were decision specific.
- Detention papers were stored in a locked filing cabinet. We reviewed 10 records across Upper and Lower Court and where applicable, detention papers filled in correctly, were scrutinised and any errors rectified promptly.
- Staff completed monthly MHA audits. For example, audits checked that leave forms and consent to treatments were in place. Staff told us that they reported the outcome of audits back to clinical governance and we saw records to show that this was the case.
- All patients had access to advocacy. There were regular visits on a Tuesdays and at other times by arrangement. Independent Mental Health Advocates (IMHA) were available when needed. We saw posters displayed across the hospital advertising advocacy services.

Good practice in applying the MCA

- All staff had received Mental Capacity Act (MCA) training on Lower Court. Eighty-eight per cent of staff had received MCA training on Upper Court. All staff had completed MCA training on Lotus ward. On Garden View, and Oak Lodge 100% of staff had received MCA training. On Hillside 82% of staff had received training.
- There is a policy on MCA including Deprivation of Liberty Safeguards (DoLS) which staff are aware of and was available for them to read. Staff we spoke with on all wards were able to verbalise their understanding of the five statutory principles of the MCA.
- We reviewed 10 care records across Lower and Upper Court with specific regards to mental capacity and all records had capacity assessments. Capacity assessments were decision specific and Staff had assessed mental capacity following each change of medication and renewal of detention. Where patients lacked capacity, we saw evidence that staff held best interest meetings and involved family members in these meetings. There was good recording of decisions regarding patients' capacity to consent in ward rounds.

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

Good

We saw that in patient records staff had assumed capacity and supported patients to make decisions. Staff invited patients to ward round. However, not all patients chose to attend.

- Staff on all wards said that they worked within the MCA definition and that restraint was always a last resort and proportionate to any proposed harm. Each patient had a capacity assessment completed within a week of admission. We saw that a record had been stored on care notes and a hard copy kept with detention papers.
- There was a policy and quality team within the Priory Group where staff could seek advice about the MCA.
- There were no DoLS applications on any of the three acute mental health inpatient wards at the time of inspection.
- Staff completed audits of the MCA monthly and looked at any ongoing DoLS applications. Staff told us they reported these audits back to clinical governance and we saw evidence to show that this was the case.

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

Good

Kindness, dignity, respect and support

- We saw staff on all wards interacting with patients in way that was kind, respectful, good humoured and discreet. This included us seeing senior management staff engaging positively with patients. We saw that staff listened to patients and helped build positive therapeutic relationships with them while they were caring for them.
- All patients we spoke with told us that they were treated with respect by staff. We saw thank you cards and emails displayed on Upper and Lower Court that described how happy patients had been with their care and treatment.
- During our inspection, we had a good sense of the relational security (staffs' understanding of patients and the environment to help them deliver good care) on Lower and Upper Court. Staff we spoke with or observed talking about patients in the nursing office were knowledgeable about patients individual needs and treatment plans. This knowledge of the patients and their environment helped staff to treat patients with dignity and respect while they cared for them.
- Staff on Oak Lodge told us that at night they would wear dressing gowns to help patients understand that it was night-time and help them feel more at home and less distressed.

The involvement of people in the care they receive

- Staff orientated patients on admission to the three wards and provided patients with information on what to expect during their time at the Priory hospital.
- We reviewed six care records on Upper Court and nine care records on Lower Court. We found that patients had contributed to their care plans. Patients told us that they were involved in developing their own care plans. We saw evidence of an advance decision, staff had organised activities based on this.
- All wards held community meetings weekly and we saw records to show that this was the case. Patients could give feedback on the service and suggest changes. An example we saw on Lotus ward was how patients had invited catering staff to attend a meeting to discuss and adapt portion sizes.
- We saw records to show that ex-patients of the hospital had since been involved in the recruitment of staff. In addition, when we spoke with an ex patient, they were positive about their experience with the service, as well as their involvement in service development.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- Between November 2015 and April 2016 Lower Court had an average bed occupancy rate of 68%. In the same period, Upper Court had an average of 56%. Lotus ward had an average of 84% bed occupancy for the same period. Occupancy rates were 85% on Hillside, 94% on Oak Lodge and 97% on Garden View. This meant that

patients could access a bed when they needed them. A local NHS trust had also 'block booked' a five beds on Lower Court to allow access for NHS patients in the local area. The hospital had quarterly meetings with the trust to discuss any issues that had arisen, as well as liaising directly with the patients care co-ordinators.

- Neither Lower nor Upper Court had any delayed discharges. Lotus ward reported one delayed discharge due to their awaiting a suitable placement within the community. Patients and their carers could decide what time they were discharged or moved. One patient had moved from Garden View to Hillside but returned to Garden View each day to socialise with the patients. Very few patients were discharged from Oak Lodge or Garden View. For most patients these wards were seen as appropriate long-term placements.
- There were no out of areas patients on any ward due to the hospital accepting referrals across the country.
- Staff on all wards reported that there was always a bed for patients returning from leave.
- Patients were not moved between wards in the hospital during an inpatient episode unless it was for clinical reasons.
- When facilitated by the hospital, discharge happens at an appropriate time of day. However, staff described to us concerns they had about the notice they received from NHS hospitals who wanted to return patients back into their care.
- When required, staff moved male patients to a psychiatric intensive care unit (PICU) at another Priory hospital site. The Priory Group do not have a female PICU so when a female PICU was required; staff sourced this elsewhere, either through another private provider or through the NHS.
- Staff did not delay discharge for anything other than clinical reasons. Patients on Upper Court were self-funding and therefore were usually admitted with a period of inpatient stay pre-planned.

The facilities promote recovery, comfort and dignity and confidentiality

- There was a fully equipped treatment room on Lower Court that was separate to the where medications were stored. Upper Court was smaller; therefore, patient examinations would take place in bedrooms. Patients could attend the therapy centre. However, other professionals would see patients on Lower Court that were unable to leave the ward either in other communal areas of the ward, the ward round room, or the patient's own bedrooms. Staff told us that it was difficult to find rooms to see patients for one-to-one work. There was also access to dedicated, quiet, therapy rooms for use in the substance misuse treatment programme.
- All wards had female only lounges and a communal lounge. Lower Court had an additional lounge, which led out into the courtyard. Patients on Upper Court had visits off the ward in other areas of the hospital such as the dining room. We were told on Lower Court that visits would take place either off the ward or within communal areas of the ward. However, we were concerned to find that on the day of our visit, relatives on Lower Court were visiting patients in their bedrooms and were unsupervised in bedroom areas. We found one female patient being visited by a male relative, unsupervised and surrounded by other female patient bedrooms. We were aware of an incident prior to inspection where a patient had been the subject of alleged abuse by a relative whilst visiting in their bedroom unsupervised. We reviewed one care record where one patient had barricaded themselves in their bedroom whilst they had relatives in the bedroom with them.
- There was a telephone for patients to use on all wards. Subject to risk assessment, patients could have their own mobile phones. Those that did not have their own mobile phone could use the wards cordless phone to make private phone calls.
- Lower Court had direct access to outside space. However, Upper Court and Lotus ward were located on the first floor. Outside space was accessed through the stairwell or via lift. Subject to risk assessment, some patients had their own swipe cards so they could enter and exit at their leisure. Staff would let out or escort other patients. Patients told us that there was never a problem on Upper Court having requests to go outside met. Garden View was located on the ground floor, arranged around an enclosed garden. The two upstairs wards, Oak Lodge and Hillside, also had gardens. All wards had an office, bedrooms, lounges, quiet room and a large kitchen diner.

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

Good

- Food was of good quality and patients were happy with the choices available. Cooks prepared fresh food each day, on site. All patients said that they enjoyed the food. There was a choice of meals and picture menus were available for when communication was difficult.
- Patients had access to hot and cold drinks, and snacks 24 hours a day. Due to the nature of Lotus ward (staff cared for patients with eating disorders there), access to snacks was controlled.
- Patients on all wards were able to personalise their bedrooms. For example, we saw photographs of relatives and plants. On Oak Lodge and Garden View, patients could have an individualised bedroom door. All patients on Lotus ward could have a key to their bedroom and could gain access at any time. All bedrooms were fitted with secure storage for patients.
- There were activities available at weekends, including games and walks in the grounds. We saw a poster advertising weekly activity programmes. This included walks, cooking and art groups led by the occupational therapy assistant. Time to do these activities was protected each morning for two hours. Patients told us they looked forward to them. Staff told us that they rarely cancelled planned activities because of low staffing levels.

Meeting the needs of all people who use the service

- Access was available for people with different levels of mobility. There was a stair lift up to Lower Court and wheelchairs were stored at the entrance and exit to both Lower and Upper Court and Lotus ward.
- Information leaflets about care and treatment were on display for patients but only in English. Staff told us that they would source other material in different languages from the internet.
- All three wards displayed information relating to complaints, advocacy and treatment options. Patients' individual needs were met, including their cultural, language and religious needs. We saw information relating to the visiting priest and we were told by staff that when other religious representatives were required this would be sourced locally.
- Staff told us that when needed, they could get interpreters locally and through the internet.
- We saw a range of dietary options to meet all dietary requirements including religious and ethnic preferences. Patients were involved in choosing the food. There were discussions at patients meetings. One patient said they liked fish and chips; the cook put it on the menu. Patients had the opportunity to cook for themselves.

Listening to and learning from concerns and complaints

- During 2015 there were seven complaints made at Lower Court, three of which were upheld following investigation. In the same year there was one complaint made on Upper Court, which was not upheld. On Lotus ward for the same year there were six complaints made, five of which were upheld. None were referred to the ombudsman. There was one complaint on Hillside, one on Oak Lodge and two at Garden View in the last twelve months. None had been upheld. No complaints had been referred to the Ombudsman.
- Patients we spoke with told us that they knew how to complain and were happy to do so if needed. Complaints information was available on notice boards and within the patient information pack, which was shared with carers. Monitoring and feedback about complaints was a standing item for the hospital clinical governance group.
- Staff we spoke with were able to demonstrate their understanding of the complaints procedure, explain how they would handle complaints, and say to whom they would escalate complaints to. Managers reviewed staff's understanding through training, supervision and appraisals. Learning from complaints would be discussed at team meetings and changes made.

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

Good

Vision and values

- The senior staff we spoke with were aware of the priory group values and how they contributed towards the ward philosophy. They told us they appreciated being part of the wider service group where they could access information and support about areas such as dementia

care. All the staff spoken with and those who attended the hospital wide focus group said they understood the vision and direction of both the organisation and the hospital. All staff we spoke with were able to show their understanding of the organisations visions and values, which were displayed on the wards.

- Team objectives reflected that of the organisations and all three wards had their own ward philosophy displayed.
- Staff spoke positively about the leadership team on their individual wards.
- Staff we spoke to knew who the senior managers were in the hospital, that they were visible and approachable. There had been a recent change in hospital director and staff spoke positively about the visibility and the availability of the new director. We saw that there had been improvement since the change in hospital director, even though the relatively short time they had been in post. Staff also told us that the deputy hospital director visited the wards on a daily basis and the staff appreciated this. There was less knowledge of leadership across the Priory Group.

Good governance

- Staff on the wards had mostly received statutory and mandatory training.
- All staff on the wards had completed their appraisal. Supervision occurred monthly.
- Systems were in place to ensure that all shifts had staff either through permanent, bank or agency staff to cover shifts with staff of the right grade and experience.
- Staff participated actively in clinical audit. Staff told us that there were key performance indicators that were sent from the Priory Group to the hospital for them to monitor. These included monitoring the percentage of patients allocated to a consultant, the presence of risk assessments and physical health plans and number of incidents of restraint.
- Incidents were reported appropriately and systems were in place to allow learning from these. We saw evidence of learning following serious incidents. We also saw evidence that changes had been made to meal portion sizes following concerns being raised by patients.
- Staff understood when and how to raise a safeguard alert. Staff took prompt action when we identified a potential safeguarding issue that they had not raised.
- Overall, Mental Health Act and Mental Capacity Act procedures were being followed.
- All three ward managers told us that they have sufficient authority to make decisions within their wards; none had dedicated administration support but did have access to a ward clerk.
- The hospital held a daily meeting in the morning where all the ward managers met to discuss immediate issues and concerns. This ensured that information relevant to the provision of care was shared promptly and that there was regular communication between ward managers.
- Neither ward manager for Upper and Lower Court knew about the hospitals risk register and neither contributed to it. The hospital kept a risk register. The top three risks identified by the hospital were staff terms and conditions of employment, staffing and the budget.

Leadership, morale and staff engagement

- The hospital had completed a staff survey in October 2015. Scores ranged between 95% and 37% of staff agreeing with a positive statement about the service. Questions based around staff morale and teamwork scored highest. However, when asked if staff would recommend the priory group as a place to work, 45% said that they would. Thirty-four percent of staff said that they would not recommend the priory group as a place to work.
- Overall sickness rates on Lower Court for the month of February 2016 were 5%. For March, they were 9% and for April they were 6%. Upper court reported 3% for February, 11% for March and 1% for April 2016. Lotus ward reported 4% sickness rates in February, 10% in March, and 3% in April 2016.
- Ward mangers collected data monthly on performance and sent this to senior managers. These included audits on care plans, risk assessments, incidents and complaints. The organisation monitored manager's completion of audits.
- There was evidence of clear leadership from the managers. The managers were accessible to staff and were proactive in providing support. All staff spoken

with were very complimentary about the ward managers style and enthusiasm. The culture was open and encouraged staff to bring forward ideas for improving care. For example, they had recently included senior healthcare assistants at the MDT meetings.

- The staff we spoke with were positive about working at the hospital. They told us they felt able to raise concerns, report incidents and make suggestions for improvements. They were confident their line manager would listen to them.
- There were no current bullying and harassment cases specific to any of the wards was bought to our attention during this visit.
- Staff knew about the hospitals whistleblowing process and all were happy to raise concerns without fear of victimisation if necessary.
- The ward managers on Lower and Upper court were due to undertake a residential ward management development programme. The manager on Lotus ward had completed this and spoke very highly of its content and the positive impact on their work.
- The ward managers were clear about the process for highlighting any significant risks and ensuring the hospital director could include these on the hospital risk register. However, there was no ward risk registers.

Commitment to quality improvement and innovation

- Staff we spoke with told us that research continued to play an important role in the on-going development of the service. An example we were given was the use of colour throughout Oak Lodge to assist patients in identifying specific areas. Lotus ward took part in peer reviews with other similar services and had been accredited with the Royal College of Psychiatrists quality network for eating disorder services.
- Lotus ward had started a piece of research in conjunction with a local university to look at the experiences of dance movement psychotherapy from the perspective of healthcare staff and practitioners. There was also research underway looking at group poetry therapy for clients recovering from anorexia nervosa.
- The hospital had a quality improvement plan that was based on the hospitals performance and there was involvement from the Priory groups' local quality improvement lead in setting objectives. This quality improvement lead would also review learning from incidents to help ensure that learning was not lost.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must take action to ensure that ligature points and risk of ligature use are minimised. The provider must take action to ensure that there are adequate governance processes and systems in place that identify ligature points and risks. The provider must ensure that where ligature risks are identified actions to reduce opportunity for harm is time bound and completed.
- The provider must ensure all areas of the ward follow appropriate infection control procedures.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure all risk assessments clearly link to an appropriate care plan.
- The provider should ensure that there are consistently safe visiting arrangements.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA (RA) Regulations 2014: Safe Care and Treatment** Mats to cushion fall on Garden View were not cleaned. A toilet handle, and hoist seat were broken making it difficult to clean and presenting an infection risk. The varnish on two beds and a basin had worn away creating an infection risk. **This is a breach of regulation 12 (1)(2)(h)**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.** The provider had not assessed the risks to the health and safety of service users by not doing all that was reasonably practicable to mitigate any such risks. The provider did not ensure that the premises used by the service were safe to use for their intended purpose. There were multiple ligature risks identified on both Lower and Upper Court. Ligature audits failed to identify all ligature points. Fire doors on Lower Court were not adequately controlled and patients were able to abscond. **This was a breach of regulation 12 (1) (2) (a) (b) and (d) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment**