Priory Healthcare Limited

The Priory Hospital Roehampton

Inspection report

Priory Lane
London
SW15 5JJ
Tel: 02088768261
www.priorygroup.com

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, 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 to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

Overall summary

Priory Hosptial Roehampton provides inpatient child and adolescent mental health services. The service provides mental health care and treatment for children and young people aged between 12 and 18.

Our overall rating of this service stayed the same. We rated it as good because:

- The ward environments were safe and clean. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided some treatments suitable to the needs of the children and young people and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- Managers ensured that permanent staff received training, supervision and appraisal. The ward staff worked well together as a multidisciplinary team.
- Staff treated young people with compassion and kindness, respected their privacy and dignity, and understood the individual needs of young people. They actively involved young people and families and carers in care decisions.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

However,

- The service did not always provide safe care. The wards did not have enough permanent nurses and doctors. The service did not always have sufficient staff to meet the safer staffing numbers. Agency staff were not always familiar with young people's needs. Permanent staff did not always have confidence in the competency of agency staff.
- The ward teams did not include the full range of specialists required to meet the needs of young people on the wards. There had been no psychologist in post almost a year.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Child and adolescent mental health wards	Good	Overall summary is provided on page 2

Summary of findings

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Summary of this inspection

Background to The Priory Hospital Roehampton

The Priory Hospital Roehampton is an independent hospital that provides care and treatment for people with mental illness. The hospital provides inpatient child and adolescent mental health services on Lower Court and Richmond Court. Lower Court provides care and treatment for up to 12 children and adolescents experiencing an acute episode of mental illness. Richmond Court provides care and treatment for up to six young people. Both wards accept both male and female patients.

The CQC last inspected the Priory Hospital Roehampton in March 2019. Inspectors rated inpatient child and adolescent mental health services as being good in all domains and good overall.

This was a focused inspection. We inspected both wards providing inpatient child and adolescent mental health services and looked at the relevant key questions in full. This enables the CQC to re-rate the service. The rating for safe has changed from good to requires improvement. The rating in the other domains remains good. The change to the rating for safe in this core service means that the hospital's overall rating for safe has changed from good to requires improvement.

The CQC arranged this inspection after it received whistleblowing reports from staff who were very concerned about the management of the services. The CQC has also received notifications from the hospital that indicated there were significant risks to patients' safety.

At the time of this inspection there was no registered manager. A hospital director had been in post for two months. The hospital director would be applying to become the registered manager.

How we carried out this inspection

Inspection activities

During this inspection we carried out the following activities:

- We carried out an unannounced evening visit to Lower Court and observed a handover meeting
- We carried out a review of the environment on Lower Court and Richmond Court
- We interviewed the hospital director, the director of clinical services and two ward managers
- We interviewed three healthcare assistants, seven registered nurses and two occupational therapists.
- We interviewed five young people and four parents.
- We reviewed policies, minutes of meetings, patients' records, performance data and other information relating to the running of the service.

Inspection Team

This inspection was carried out by three inspectors and an inspection manager.

Areas for improvement

Areas that the service must improve:

Summary of this inspection

The service must ensure that persons providing care and treatment to young people have the competence, skills and experience to do so safely. (Regulation 12(1)(2)(c))

Areas that the service should improve:

The service should ensure it deploys a full range of specialists required to meet the needs of patients including a clinical psychologist.

The service should ensure that it has systems in place to ensure that bank and agency staff receive an induction and that they are competent to deliver the care required and meet the needs of the young people.

The service should ensure that bank and agency staff are sufficiently aware of rules and boundaries of the ward to ensure consistent, safe care and treatment for patients.

The service should ensure that the food provided meets patients' needs and preferences.

The service should review how to ensure that garden areas are sufficiently safe to provide patients with unrestricted access.

The service should continue its efforts to ensure that managers listen to the concerns of staff and ensure that staff feel supported and valued.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Child and adolescent mental health wards	Requires Improvement	Good	Good	Good	Good	Good
Overall	Requires Improvement	Good	Good	Good	Good	Good

Good

Child and adolescent mental health wards

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

Are Child and adolescent mental health wards safe?

Requires Improvement

Our rating of this service went down. We rated it as requires improvement because:

- The service did not employ sufficient nursing staff and relied on agency staff to maintain safe levels of staffing. Between December 2020 and March 2021, agency staff completed between 64% and 72% of nursing shifts each month. Four agency nurses were employed on a locum basis. The service booked locum staff to work at the hospital for at least four weeks. During February and March 2021, there were four shifts on Lower Court on which there were no permanent or locum nursing staff. Also, during this time, permanent health care assistants (HCA) completed only 40% of HCA shifts, with 20% covered by bank staff and the other 40% covered by agency staff. We reviewed the rota for Lower Court for the week beginning 12 April 2021. This showed that 17 nurses and 31 HCAs worked on Lower Court during that week. Of these 48 staff, 12 were permanent, five were locum staff, nine were bank staff and 22 were agency staff. We reviewed the staffing rota for Richmond Court. This showed that during 23 day shifts in April, there was only one nurse on duty on nine occasions. Staff, young people and parents all raised concerns that agency staff did not have sufficient knowledge and understanding of young people's needs to ensure their safety. Five of the 12 staff we interviewed expressed concerns about agency staff. They said it could be hard working with agency staff as they were unfamiliar with the ward and the needs of the young people. They said this created additional pressure for permanent staff including permanent health care assistants (HCA) who said they had to take on a lot more responsibility when both registered nurses were from an agency. Some young people said they did not feel safe at night when unfamiliar staff were on duty. During a night shift in February 2021, a serious incident occurred on the ward involving a number of young people absconding and a significant number of police officers being called to the ward. The staff rota for that shifts shows that although additional staff had been assigned to the ward to mitigate a heightened level of risk, only two of the 13 staff were permanent. Both these permanent staff were HCAs. The other staff were a mixture of locum and other agency staff who had varying degrees of experience of working on the ward. During a handover meeting, inspectors noted that staff were not familiar with each other, to the extent that they did not know each others names. This meant that young people were potentially at risk due to staff being unfamiliar with the young people and not knowing how to respond when incidents arose. This problem was exacerbated by high levels of vacancies. On Lower Court, there were vacancies for a charge nurse and staff nurse. Four further vacancies for staff nurses were filled by locum staff. There were four vacancies for HCAs. Of the nine HCAs in post, three had worked on the ward for less than two months. This meant there was a lack of experienced staff working on the ward.

However,

Good

Child and adolescent mental health wards

- All wards were clean, well equipped, well furnished, well maintained and fit for purpose. The service was completing a redecoration of Lower Court to improve the environment. Overall, both wards were clean and tidy. Furniture was in good condition. Staff had completed audits of potential hazards, such as audits of ligature anchor points and blind spots. These audits included details of how staff were mitigating these risks. Most bedrooms had ensuite facilities. The service had installed closed circuit television (CCTV) throughout the ward. Cameras in bedrooms could be activated if the young person was presenting a high risk. Staff completed checks of the environment during each shift.
- Permanent staff had completed basic training to keep young people safe from avoidable harm. The hospital provided an extensive range of 57 courses that were mandatory for some or all permanent staff. Overall, compliance with mandatory training was 81% on Lower Court. Training for agency staff was provided through their agency.
- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Doctors completed a risk assessment for each young person shortly after their admission. Details of the arrangements to manage risks were recorded in a 'keeping safe' care plan. Staff routinely managed young peoples' risks through observations. Staff checked on all young people at least twice an hour. Staff placed high risk patients on close observations at all times. Staff could also activate cameras in bedrooms or restrict daytime access to bedrooms if the young people were presenting a high risk. Staff used physical interventions on 42 occasions in February 2021, 18 occasions in March and 13 occasions in April. As part of the strategy for reducing restrictive interventions, staff monitored the reasons for using restraint. This showed that in 62% of incidents involving the use of restraint, staff intervened to prevent the young person harming themselves. A further 17% of restraints prevented young people from harming others. Twenty percent prevented young people from harming property. Staff used rapid tranquilisation on Lower Court on 16 occasions in February 2021, nine occasions in March and four occasions in April. Staff used restraint only after attempts at de-escalation had failed. Ward managers met once a month to review the 'Reducing Restrictive Interventions' strategy.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. In February 2021, staff raised 12 safeguarding referrals on Lower Court. Staff had training on how to recognise and report abuse and they knew how to apply it. On Lower Court, 92% of staff required to complete training in safeguarding children had done so. Eighty-three percent of these staff had completed training in safeguarding adults. The hospital employed a social worker in the role of safeguarding lead. Managers reviewed information about safeguarding referrals each month at clinical governance meetings.
- Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records. All patient information was stored on an electronic patient record. Entries on the record were clearly written.
- The service used systems and processes to safely prescribe, administer, record and store medicines. The hospital held a monthly medication management committee meeting each month. This was attended by directors of clinical services, ward managers and the pharmacist. The committee reviewed monthly audits of prescriptions, clinic rooms and prescribing errors. Staff regularly reviewed the effects of medications on each young person's physical health. The consultant psychiatrist and multidisciplinary team met with each young person once a week to review the effects of medication.
- The number of safety incidents in Lower Court had fallen during the two months prior to the inspection. Most safety incidents involved deliberate self-harm. In February 2021 there had been 95 incidents of self-harm. This had fallen to 42 in March and 36 in April. Most of these incidents involved superficial harm such as scratching. In March 2021, three incidents were classified as serious incidents. These all involved young people absconding from the ward. Staff managed incidents well. Staff recognised incidents and reported them appropriately. Staff reported incidents on an electronic incident record. Staff usually held a debriefing session after incidents. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Ward managers and clinical directors held a 'Learning and Outcomes Group' every two weeks to review investigations into incidents and agree action to address any concerns that had been raised. Minutes of these meetings were shared with staff and discussed by nurses and healthcare assistants at their weekly team meetings.

Good

Child and adolescent mental health wards

Are Child and adolescent mental health wards effective?

Good

Our rating of this service stayed the same. We rated it as good because:

- Staff assessed the physical and mental health of all young people on admission. These assessments covered the young person's history prior to admission, the reason for admission and the results of a physical health check. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery oriented. All the patients' records included four care plans relating to staying safe, maintaining connections with their family and friends, maintaining their mental health and maintaining their physical health.
- Staff provided some care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. The children and young people admitted to the service had severe and complex needs that could not be managed in the community. Doctors prescribed medicines recommended within national guidance. The service provided some evidence-based therapeutic interventions. For example, therapy assistants facilitated dialectical behavioural therapy groups once a week. The service provided creative therapy groups such as art therapy.
- They ensured that young people had good access to physical healthcare and supported young people to live healthier lives. Staff carried out physical health checks every two weeks. Staff responded to specific physical health needs. For example, nurses completed a food and fluid chart for a young person who was restricting their food intake. All young people had a care plan for maintaining their physical health.
- Staff used recognised rating scales to assess and record severity and outcomes. For example, staff measured patients' outcome using the Health of the Nation Outcome Scale for Children and Adolescents and the Childrens Global Assessment Scale. They also participated in clinical audit, benchmarking and quality improvement initiatives. For example, staff completed audits of health and safety, medicines management and reducing restrictive practice. Audits were discussed in clinical governance meetings and action was taken to address concerns identified in these audits.
- Managers made sure that permanent staff had a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. All permanent staff said their manager provided supervision each month. Permanent staff also received clinical supervision from an external specialist. Managers provided an induction programme for new staff. Staff induction took place over ten days. It involved a two-day training course, meeting people from different teams within the hospital, completing online training and shadowing experienced members of staff.
- Staff from different disciplines worked together as a team to benefit patients. Members of the multidisciplinary team (MDT) met each day to review any changes to patient's presentation. The MDT conducted a more thorough review of each young person once a week. The ward team had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation. For example, the ward manager and their deputy participated in clinical governance meetings and its sub-committees. The service maintained contact with community services in each young person's local area to facilitate discharges from the ward.

However,

- The ward teams did not include the full range of specialists required to meet the needs of patients on the wards. The service employed nurses, a consultant psychiatrist, ward doctor, healthcare assistants, therapy assistants and occupational therapists. However, the service had not had a clinical psychologist in post for almost a year. This meant that some young people were not receiving the therapeutic treatments they required and, consequently, spending longer in hospital than necessary. For example, one young person had been on the ward for over one month and had

not received any individual therapy. This also meant there was a lack of clinical leadership in relation to psychology within the multidisciplinary team. We raised our concerns about this with the hospital director. They said that they were interviewing candidates for the post of psychologist in mid-May 2021. The ward manager also said that locum therapists specialising in cognitive behavioural therapy and dialectical behavioural therapy were due to start shortly.
- Managers did not have sufficient systems in place to support and assess the competency of temporary staff. Whilst the service provided supervision to permanent staff, these staff made up only around 25% of nurses and healthcare assistants that worked on the ward each week. The service did not provide supervision to bank and non-locum agency staff. There were no formal systems for assessing the competency of these staff. These staff were also not included in weekly nurses meetings.

Are Child and adolescent mental health wards caring?

Good

Our rating of this service stayed the same. We rated it as good because:

- Most staff treated patients with compassion and kindness. Young people said that staff were caring and helpful and that some staff had been a very important part of their recovery. They respected patients' privacy and dignity. They understood the individual needs of young people and supported young people to understand and manage their care, treatment or condition. Young people met with the multidisciplinary team each week and felt that staff listened to the things they said in these meetings. Young people felt involved in decisions about care and treatment, such as decisions about going on leave.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. Each ward held community meetings for young people each week. At these meetings young people could raise any concerns about their experiences on the ward. young people on Richmond Ward felt that staff responded to concerns that were raised in these meetings although young people on Lower Court said they had to raise issues a number of times before they were addressed. The hospital encouraged young people to complete feedback forms when they were discharged. Managers reviewed this feedback in clinical governance meetings. They ensured that young people had easy access to independent advocates. An advocate had regular contact with young people on the ward.
- Staff informed and involved families and carers appropriately. Parents had regular telephone contact with the service and knew the permanent staff well. Parents had held meetings with consultant psychiatrists. Staff telephoned parents after ward rounds and any incidents to provide an update on plans for care and treatment. The service facilitated leave to families whenever this was possible. One parent said that when the nurses told them something they didn't entirely understand, the consultant psychiatrist phoned them back to give a full explanation, which they found very helpful.

However,

- Some young people said that some agency staff were less caring and supportive Overall, young people did not like working with staff who were unfamiliar. Young people said that agency staff were often unfamiliar with them and did not understand their needs. They also said that agency staff did not apply the rules and boundaries of the ward consistently. One young person said that some agency staff had made inappropriate comments.

Good

Child and adolescent mental health wards

Are Child and adolescent mental health wards responsive?

Good

Our rating of this service stayed the same. We rated it as good because:

- The design, layout, and furnishings of the ward supported patients' treatment, privacy, and dignity. Lower Court was laid out over two floors. Communal areas, meeting rooms, some bedrooms and offices were on the ground floor. Bedrooms for young people presenting a lower risk were situated on the first floor. Bedrooms on the first floor did not have ensuite bathrooms and, therefore, this floor was single gender, and the bedrooms were allocated to female patients only. Areas where young people did not have ensuite bathrooms were designated for male or female patients only. In some areas of the ward, the decoration appears tired and somewhat dated. This was being addressed through a programme of refurbishment. Furniture in bedrooms and communal areas appeared to be in good condition. New furniture had been installed in the dining room. young people could keep their personal belongings safe. There were quiet areas for privacy such as bedrooms and the de-escalation area.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and the wider service. All complaints were discussed in clinical governance meetings. This included discussions about any themes that had emerged from complaints and any lessons learned. The minutes of these meetings were distributed to staff across the hospital and discussed in nurses' team meetings.

However,

- Young people on Lower Court and Richmond Court said that the food could be better. They said they had raised these concerns, but they were not sure whether any changes would be made.
- Young people did not have unrestricted access to outside space. The garden adjoining Lower Court was empty and uninviting. The door to the garden was locked due to there being low fence and recent incidents involving young people absconding. The service was planning to make improvements to the fences around the garden to allow young people unrestricted access.

Are Child and adolescent mental health wards well-led?

Good

Our rating of this service stayed the same. We rated it as good because:

- 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 ward managers were both experienced registered nurses. The ward manager on Lower Court had previously worked as a deputy ward manager on a child and adolescent unit that specialised in working with young people with eating disorders. Staff gave positive feedback about the ward managers. One young person said the new ward manager on Lower Court had made a big difference and that they were very much involved in the day-to-day running of the ward.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team. The hospital aspired towards putting people first, being supportive, acting with integrity, striving for excellence and being positive. Staff displayed information about these values in offices and communal areas of the hospital. Staff

demonstrated these values in their work. For example, young people said that permanent staff were caring and committed. When staff talked about their motivations and the things they liked about working on the ward they were very focused on caring for young people. For example, staff said they focused their work on getting to know young people, they enjoyed the lively nature of working with young people and they learned new things each day.

- Most staff we spoke with during the inspection felt respected, supported and valued. Before the inspection, staff made five whistleblowing reports to the CQC. Staff raised concerns about there being a bullying culture, racism towards black staff, staff sickness and high staff turnover. Staff said that when they raised concerns, they were either ignored or accused of having a negative attitude towards their work. Although the hospital had investigated these matters and found no evidence of discrimination or bullying, some staff interviewed during the inspection stated that some colleagues had felt bullied and felt that when they tried to raise these matters, manager had not responded appropriately. Since these reports were made, a new ward manager and hospital director had been appointed. The hospital director had sought to address these concerns through introducing a programme of initiatives aimed at improving communication across the hospital, improve staff well-being and improve working environments. This included introducing a programme of breakfast meetings on the wards at which directors could engage directly with nurses and healthcare assistants. All staff said they felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well. The hospital held a monthly clinical governance meeting attended by senior staff. At these meetings staff discussed matters relating to the overall running of the services such as health and safety, medicines management, staffing, safeguarding and incidents. Staff provided information on all these matters in the form of structured reports. Data in these reports was clearly presented and easy to understand. The hospital's risk register was also reviewed at these meetings. The entries on the risk register reflected the concerns raised by staff during the inspection. For example, the risks with the highest score related to the recruitment of registered nurses, high staff turnover, increasing patient acuity and the recruitment of therapists.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. All information about patients was stored on an electronic patient record. Records were well organised and staff could access information easily.

However,

- Governance processes did not fully address the over reliance on agency staff. The service had introduced some incentives for permanent staff to carry out additional shifts and, therefore, reduce the number of temporary staff working on the wards. However, throughout this inspection, staff raised concerns about the competency of agency staff, young people said they did not feel safe when staff they did not know were on duty and these staff did not receive formal support or supervision.
- Some staff did not feel respected, valued and supported. Some staff continued to feel aggrieved that concerns about agency staff were not listened to, felt that morale continued to be low and were concerned that a number of experienced colleagues were leaving.

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
Nursing care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not ensure that persons providing care and treatment to young people have the competence, skills and experience to do so safely. (Regulation 12(1)(2)(c))