The Priory Hospital Keighley

Quality Report

2 Burley Ct,
Steeton
Keighley
BD20 6TU
Tel: 01535 657350
Website: www.priorygroup.com

Date of inspection visit: 08/02/2016
Date of publication: 14/06/2016

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?	**Good**
Are services effective?	**Good**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
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 Keighley as good because :

- Patients were happy with the care they received at The Priory Keighley. They felt as though staff were supportive and listened to them. We saw meaningful interaction between staff and patients. Staff worked alongside families and carers and carers spoke positively about the hospital. An advocate attended the hospital twice weekly and patients knew how to access this service.
- The hospital maintained safe staffing levels and had procedures in place for any shortfalls in staff. The hospital did not use any agency staff, and relied upon regular bank staff to cover shifts. Staff were positive about working at The Priory Keighley describing to inspectors how supporting their teams were. We saw effective multi-disciplinary working across the wards. The GP and an external pharmacist attended the hospital regularly to support patients in their care. The hospital employed a range of disciplines including nursing staff, occupational therapists and psychologists.
- We found robust monitoring of physical health throughout the hospital. All patients' physical health needs were embedded into their care plans and staff had appropriate care to facilitate those needs. Medication management throughout the hospital was overall strong. We saw examples of regular consultations with external pharmacy for support in various things, i.e. medication manipulation. The documentation around medication was clear and robust, patients had individualised care plans for their medication which was comprehensive and easy to understand.
- We saw a range of therapeutic activities provided for patients. They had a daily activity planner which included weekends. The hospital provided two hours patient protected time. This meant all ward staff had two hours protected time with patients which enabled more face to face contact. The hospital had access to psychology, however, staff felt it wasn't utilised by patients as effectively. Patients in the neurodegenerative ward had access to a sensory room. This room stimulated patients and supported them therapeutically.
- Staff were up to date with their appraisals and had regular supervision. The hospital was undergoing a transition of implementing clinical supervision within their management supervision. Staff felt that clinical supervision was helpful. Staff were up to date with training, and support was provided to staff to progress within the organisation. The hospital staff told us that they tried to avoid using physical restraint and preferred to use verbal de-escalation techniques.
- The hospital had updated its policy in line with the changes to the Mental Health Act code of practice. Staff understood the basic principles of the Mental Capacity Act. Staff carried out regular capacity assessments and held best interests meetings.

However,

- We found not all post medical observations had been documented after a patient had been administered medication. This is when patients are monitored for side effects after taking medication.
- We found a Mental Health T3 document had not been reviewed by a Second Opinion Authorised Doctor within the time given for it to be reviewed.
- The prayer/multi-faith room was also utilised as a visitor's room. We felt this restricted its use as a prayer room because it could not be accessed if patients had visitors.
- We could not find the controls drug register in the clinic room where the controlled drugs are kept, however staff provided us with it once requested.

Summary of findings

Contents

Good

The Priory Hospital Keighley

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults;

Neurodegenerative ward.

Summary of this inspection

Background to The Priory Hospital Keighley

The Priory Keighley is a 43 bed mental health independent hospital. It offers long term rehabilitation to men and women with complex mental health needs. Having complex heath needs could mean patients at the hospital have more than one diagnosis, have mental health issues with substance misuse or mental health issues with physical health issues. The Priory Keighley also specialises in dementia care, providing support for people who are suffering neurodegenerative conditions, like Huntington's, Parkinson's and Alzheimer's disease.

The Priory Keighley is registered with the Care Quality Commission to carry out the following regulated activities,

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

The hospital is comprised of five wards:

- Ingrow/Winfield a 16 bed female long stay/ rehabilitation ward incorporating a 4 bed step down unit (Winfield).
- Oldfield/Steeton an 18 bed male long stay/ rehabilitation ward incorporating a 6 bed step down unit (Steeton).
- Oakworth a nine bed male neurodegenerative ward specialising in dementia care.

Our last comprehensive inspection of this location was published in February 2013. At the time of the inspection the Priory Hospital Keighley was registered with the CQC as 'The Willows' which was under a different provider. The Willows were compliant in all the standards. There were no compliance actions or changes to practice needed.

The last Mental Health Act review was on 3 August 2015. The reviewer made recommendations and The Priory Keighley had made the required improvements.

Our inspection team

Team leader: Hamza Aslam, Care Quality Commission (CQC) Inspector.

The team that inspected the service comprised of three CQC inspectors, a specialist dementia nurse, a specialist learning disability nurse and a pharmacist. An expert by experience (someone who has developed expertise in relation to services by using them or through contact with those using them) was also part of the team.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

During the inspection visit, the inspection team:

Summary of this inspection

- Visited all five wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- Spoke with ten patients who were using the service and two carers.
- Spoke with the registered manager, quality director and the managers for each of the wards.
- Reviewed five PRN (when required) medication care plans.
- Reviewed 27 patient medication cards, and medication care plans.
- Case tracked one patient on the neurodegenerative ward.
- Observed two MDT meetings and one 'Your Voice' community meeting.
- Received feedback from the local safeguarding authority
- Spoke with 20 staff members including doctors, nurses, occupational therapists, healthcare assistants and psychologists.
- Collected five patient comment cards.
- Looked at a range of policies, procedures and documents relating to the running of the service.
- Reviewed up to date staff training records and staff files.
- Looked at 10 care plans and risk assessments across the hospital.
- Reviewed a sample of 20 mental health records, which included T3 forms and Deprivation of Liberty Safeguard Applications.

What people who use the service say

The patients we spoke to during our inspection were mostly positive about their experiences at The Priory Keighley. Patients highlighted the ward environment and feeling safe. However two out of five patients reported on the Care Quality Commission comment cards that they were unable to do the activities they wanted due to staff being busy.

One patient on the neurodegenerative ward spoke highly of the service. He said that the ward staff tailored care specifically round his needs.

Both the carers we spoke to were happy about the services their family members received at The Priory Keighley. They made references to the quality of the wards, and levels of care that the hospital provides.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as **good** because :

- The clinic room and communal ward areas were clean and well maintained.
- The hospital had appropriate staffing levels and did not use agency staff.
- The hospital prioritised patient safety by mitigating any blind spots across all wards and staff having easy access to ligature cutters.
- All staff knew how to report incidents and were confident in using the hospital incident reporting systems. .
- Staff produced detailed risk assessments and updated them regularly as the patients risk profile changed.
- There was adequate medical support throughout the week including a 24 hour, seven days a week on call service.
- Staff mandatory training was above 90%, these included, clinical risk assessment 91%, safeguarding adults 97% and crisis management 92%.
- Appropriate processes were in place to support informal patients leaving the hospital at their own discretion.

However,

- Staff were being involved in cleaning duties when it may not have been within their role.
- Staff on the rehabilitation wards did not always observe the correct post medication observations for patients.
- The controlled drugs register was not in the clinic room with the controlled drugs, however, staff brought it to us when we requested it.

Are services effective?

Good

We rated effective as **good** because:

- All staff had received their annual appraisals in the last 12 months.
- Medication management throughout the hospital was at a good standard.
- We found patients' care plans, personalised, up to date and reviewed in a timely manner.
- Physical health monitoring throughout the hospital was very good; it was an integral part of patient care. The neurodegenerative ward, which specialises in care for dementia

Summary of this inspection

and other diseases, took additional steps to support its patients' physical health by employing a duel trained registered general nurse and having the local GP attend the multidisciplinary team meetings.
- The hospital had a range of disciplines within the staff team which included psychology support and occupational therapy.
- We observed good multi-disciplinary working, including meetings which had the full complement of different professionals.

However,

- We found not all staff that were responsible for partaking in clinical audits did so.
- We found the hospital did not always consult with the second opinion authorised doctor in a timely manner to review documentation.

Are services caring?

Good

We rated caring as **good** because:

- We observed that staff were caring towards the patients.
- The hospital went extra lengths to support family and carers on the neurodegenerative ward, which specialises in dementia care.
- Patients overall were happy with the service they received.
- The carers we spoke to felt that the hospital supported its patients and met their needs.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because :

- The discharge dates on the rehabilitation wards electronic records were the same. We did not see any records of individual discharge dates for patients.
- We saw little evidence of discharge planning within the care plans. This meant that patients did not have clear goals to work towards.
- We saw minutes of a Care Programme Approach (CPA) meeting outlining a patient's progress and to be moved to a stepdown ward. The following meeting minutes six months later, showed no evidence of the patient's progress being discussed, or whether he was going to be stepped down.

However:

- The neurodegenerative ward, which specialises in dementia care, had a low stimulus lounge area and provided its patients with a sensory room.

Summary of this inspection

- All the wards had appropriate facilities that were well maintained.
- We saw staff engaging in variety of activities with patients.
- Patients had access to snacks and hot drinks throughout the day.
- The hospital had a pre assessment of patients prior to coming to the hospital. This reduced the likelihood of inappropriate admissions.
- The hospital provides supported community housing for patients stepping down from the main rehabilitation wards.
- Complaint procedures were readily available for patients on the ward notice boards.

Are services well-led?

Good

:We rated well-led as good because:

- The hospital promoted feedback from patients, carers and its staff for continual improvement.
- We saw good governance with policies that had been updated accordingly in line with legislation changes.
- We saw staff members able to demonstrate the hospitals vision and values through their practice.
- The hospital had an appropriate service plan for its neurodegenerative ward that specialised in dementia care.

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.

At the time of this inspection there were 41 patients staying at The Priory Keighley, 38 of which were detained under the Mental Health Act 1983.

The provider ensured systems were in place to adhere to the Mental Health Act. The Priory Keighley reviewed their adherence to the Mental Health Act during the clinical governance committee meetings. The hospital ensured that its policies were up to date in line with the changes in the Mental Health Act guiding principles and new code of practice. These changes came into effect April 2015.

Patients had access to IMHA (independent mental health advocacy) services. IMHAs are independent of mental health services and can help people get their opinions heard and make sure they know their rights under the law. IMHA can make a big difference to people's experience of detention and are highly valued by people who use services.

All five wards had information boards containing comprehensive and appropriate information for patients. This included contact details for the Care Quality Commission

Patients had their rights read to them upon admission and then monthly by a qualified member of staff. We found this information verified on patient records.

Mental Capacity Act and Deprivation of Liberty Safeguards

During our inspection we found two patients were authorised under the Deprivation of Liberty Safeguards and one patient had an application pending. We found appropriate documentation for the applications had been made.

The hospital held regular best interest meetings which had full complementary of multi-agency staff. The responsible clinician assessed patients' capacity to make decisions appropriately and in a timely manner.

Staff had a sound understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards and could evidence it within their practice.

Patients had access to IMCA (independent mental capacity advocacy) services. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

All wards were either male or female only, with en-suite bathrooms and so met with the guidance on same sex accommodation. Male and female patients were not allowed on each other's ward. The only time patients on both wards came into contact was on weekend activities outside of the hospital or passing each other in the public areas within the hospital. The Priory Keighley did not implement seclusion and therefore had no seclusion facilities.

Staff on the rehabilitation wards were able to observe all parts of the ward. The position of the staff office enabled staff to see onto the ward and communal lounges, and mirrors on the wall of the male ward aided staff visibility of the ward further. Blind spots occurred if patients went into the laundry room or kitchen. Staff told us that they mitigated risk on a patient by patient basis, e.g. staff would support a patient to use the laundry room if they were at a higher risk.

The neurodegenerative ward, which specialised in dementia care, was in the shape of the letter 'L'. Staff were unable to see down the corridor due to the location of the office. The hospital mitigated this risk by installing CCTV onto the ward. This CCTV did not record; however, it gave a live stream to staff. One member of staff always had a tablet computer on their person with the live feed showing. We witnessed this in practice.

The support services manager and the ward manager carried out comprehensive anti-ligature audits. We discussed the audit with the hospital director and the provider's quality director as we found patients on the rehabilitation wards were all given the same risk rating, as were patients on the neurodegenerative ward. We were assured that patients' individual risks had been considered because the audits had been carried out by two staff one of which had a senior clinical position. Staff members knew where the ligature cutters were located. They were easily accessible within the staff office.

The clinic room was fully equipped and provided access to emergency drugs. The staff checked resuscitation equipment regularly. A qualified member of staff was the infection prevention lead in the hospital. We observed staff washing their hands in line with infection prevention principles in preparation for lunch time.

Most wards were clean and kept to a good standard; however, we found some areas that needed addressing. We brought this to the attention of the support services manager. We found on one of the rehabilitation wards staff had identified the levels of cleanliness as an issue. Staff aimed to rectify this by implementing their own procedures to keep the levels of cleanliness high. As such, staff were involved in cleaning duties when it may not have been within their role.

On Oakworth (neurodegenerative) ward we found the patients' wheel chairs and hoists in one corner of the communal lounge. We found this to be unsafe putting both

patients and staff at risk of trips and falls. Ward staff and senior management acknowledged this issue and informed us that they had received authorisation to create safe storage space for the equipment. This work is yet to commence.

The provider had a full list of cleaning materials which showed when and how they should be used. There was a risk assessment and what should be done should an accident occur with one of the products. Staff followed the clinical waste management policy using appropriate coloured waste disposal bags.

The hospital installed a nurse call system throughout its wards with call buttons. Staff could identify where the alarm activated and respond. All members of staff carried personal alarms.

Maintenance checks were carried out within recommended timescales. Staff carried out monthly checks of the nurse call system, window restrictors, and beds including profiling beds. Water outlets were tested for legionella, boilers were checked and there was an up to date annual boiler service. Environmental health had inspected the service and had graded it with a five star rating.

Safe staffing

The hospital staff work a 12.5 hour day, with each shift inclusive of a 25 minute hand over. The following nursing staff were in post at the time of the inspection (whole-time equivalent) WTE :

- 16 qualified nurses and 3 ward managers.
- 38 health care assistants including. Each rehabilitation ward had one none qualified team leader and senior health care assistant.

During the same time period:

- Qualified nurses vacancies 1 WTE
- Nursing assistant vacancies 0.5 WTE

Two consultant psychiatrists covered the hospital wards Monday to Friday 9am – 5pm. The hospital had a duty rota for an on call doctor 24 hours a day, seven days a week. The duty on call doctor provided care on the weekends if required. A consultant who provides specialist dementia visited the neurodegenerative ward once a month, however, the consultants who covered the rehabilitation wards supported the neurodegenerative ward during the interim The nursing staff told us that they were satisfied with medical cover on the weekends.

There were dedicated chefs providing cover for seven days, and housekeeping staff working five days, Monday – Friday. The support service manager was responsible for these staff.

The hospital provided its patients a range of support from occupational therapists, occupational therapy assistants, a psychologist and psychology assistants. The hospital had one consultant psychologist that worked between two sites, and two full time assistant psychologists. They offered both one to one times for patients or group work. Staff found that patients did not make full use of the psychology intervention.

All members of the occupational therapy team have a caseload of between five and eight which is dependent on their skills and best fit to the patient needs. For example, one staff member is good at arts and crafts and another is at cooking. Currently all 41 patients are allocated to the occupational therapy team.

The total number of shifts using bank staff during the periods of September 2015 and December 2015 was 143.5 on the rehabilitation wards and 42 on the neurodegenerative ward. Staff sickness was low averaging 2.5% across all wards. The hospital did not use agency staff. Staff told us that the same bank staff were used to maintain continuity of care.

The hospital implemented protected patient time (PPT) where by all staff on the wards had to stop any administrative work and spend time with patients. This happened for two hours a day between 1:30pm and 3:30pm. Nursing staff found this helpful as it enabled them to spend protected 1:1 time with the patients. During our inspection we saw that staff across the wards engaging with patients in a meaningful manner. Patients told us that staff were visible on the wards at all times

The hospital put in extra provisions where they needed it. The male rehabilitation ward had one patient who needed dialysis treatment, the hospital put in an extra health care assistant on the days he required dialysis. Oakworth (neurodegenerative) ward only had one nurse and one nursing assistant for the night shift. Staff assured us this was enough cover, and that they had a provision for two

nursing assistants if required. The ward manager at Oakworth expressed how closely the hospital works to support each other. All staff felt they had adequate cover for their shift.

The staff training records indicate that staff were 93.7% compliant with their mandatory training. Record showed that staff were 100% compliant with medication handling, clinical supervision and doctor's annual appraisal. Eighty-two per cent of staff completed their Clozapine dose titration. All staff attended the full PMVA (Prevention and Management of Violence and Aggression) training as part of induction.

Assessing and managing risk to patients and staff

The Priory Keighley had 29 incidents of restraint between the months of June 2015 and December 2015. All these incidents occurred on the rehabilitation wards. Three members off staff from different grades told us that restraint is very rarely used. They told us that if restraint is ever used, low level guided restraint is optimised, for example, ushering someone to a room. Staff across all the wards had a good understanding of least restrictive practice, they told us about how they would carry out observations and physical health checks (if required) in the event of a patient restraint. This is set out as best practice under NICE (National Institute for Health and Clinical Excellence) guidelines NG10. Staff told us that they tried to scale down the situation by using softer techniques such as verbal de-escalation. The hospital did not practice restraint in the prone position; no prone restraint was recorded in the last year. The hospital did not implement seclusion; the Priory had no incidents of seclusion in the last year. The hospital mitigated the risk of admitting patients they were un able to manage by thorough pre-admission assessments.

In addition to pre-admission assessments, staff informed us how patients were risk assessed on admission. They told us that patients had an initial 72 hour risk assessment, during which they were on regular observations. Hospital staff completed a formal personalised risk assessment after this 72 hour period. This was in line with the company policy.

The hospital enabled informal patients to leave at will. This was facilitated on an individual basis. Patients could either have their own fob to leave the hospital at their will or they could ask someone to let them leave.

During this inspection we reviewed five patients pro-re nata (PRN) which means when required medication care plans. We found all PRN care plans to be detailed, patient centred and had all been reviewed.

We reviewed 18 medication cards on the rehabilitation ward. We found the majority of patients on high dose anti-psychotic medication. There was documentation detailing the clinical reason for prescribing the medications above the usual levels recommended in the British National Formulary (BNF). The hospital had the appropriate medication management plans in place for these patients. There was clear evidence that the responsible clinician managed this. Where patients were self-administering medication, a clear risk assessment had taken place to assess the patient's suitability. We found this in the medication file. Staff told us if it was safe for patients to self-administer medication then the hospital staff would facilitate it.

We found robust medication and physical health management on the neurodegenerative ward. This ward managed the patients' physical health closely. We found the ward to have excellent links with the local GP (general practitioner) surgery. The GP attended ward MDT (multi-disciplinary team) meetings and liaised closely with the hospital for high levels of patient care. We observed an MDT meeting on this ward and saw a patient needed his medication to be changed. The GP made arrangements for the change in prescription within an hour of the meeting.

This ward utilised pharmacy input appropriately. A patient needed their medication manipulated (i.e. crushed), we saw documentation that the ward consulted with a pharmacist prior to making a decision.

Qualified nurses undertook the responsibility of auditing the medication across the wards. An external pharmacy company also carried out audits within the hospital as well as providing pharmacy support.

Staff training for safeguarding children and adults was above 97% for the hospital. Staff were able to recognise the basic signs of abuse and knew the procedures if they had any concerns. The Priory Keighley had a visiting policy which identified a section for children visiting the hospital. Children would not have access to the ward areas, however, the hospital had visiting room provisions in place.

On Oldfield (male rehabilitation) ward a patient had received rapid tranquilisation. We found one record of

Long stay/rehabilitation mental health wards for working age adults

Good

physical health monitoring post administration. NICE guidelines recommend patients be observed hourly until they appear physically well. There was no documentation in the care notes to suggest that the patient had been assessed as being physically well before observations could be stopped.

Another patient on this ward was prescribed an Olanzapine depot; he did not have the necessary post dose observations as recommended by the manufacturer. The manufacturer recommends patients to be monitored every half an hour for three hours for 'post injection syndrome'. The patient had a care plan in place for observation every 30 minutes for the first 3 hours but we did not see evidence of full observations being taken place on the care record.

We brought these issues to the attention of the manager, and were informed all observations are taken place in line with recommendation. It was acknowledged that the record keeping should have been more appropriate. Overall the medication management was good throughout the hospital

We requested to see the controlled drugs register which could not be located in the clinic room on the male rehabilitation ward. Staff found the register after our pharmacist requested it. Best practice from NICE suggests controlled drug registers should be kept with the controlled drugs so nurses can record administration of medication after it is given. Control Drugs registers should be stored with the medicines on the ward and held for two years after the last entry outlined by the Misuse of Drugs Act 2001. The Accountable Officer for the hospital was the registered manager. An accountable officer manages the governance around controlled drugs to ensure safe medication management and practice. The accountable officer is someone who is in a senior position within the organisation and does not routinely handle or supply drugs.

Track record on safety

The Priory Keighley had 31 serious incidents requiring investigation between the months of December 2014 and December 2015. Twenty of these incidents occurred on the female rehabilitation ward and only four on the neurodegenerative ward. On the rehabilitation wards there was a common trend of abusive and violent altercation between two service users. We saw evidence of increased observations when patients became violent or aggressive.

A common theme of patient feedback during interviews was they felt safe at The Priory, in addition two comment cards we received reflected how safe patients felt.

Reporting incidents and learning from when things go wrong

The provider had good systems in place to record and monitor incidents. After each incident, a post incident crib sheet was filled in and a post incident review form. We saw records of incidents and the subsequent investigation. A graph was produced which showed the type of incident on a month by month basis. This enabled the provider to see at a glance if there were any themes and trends emerging. Clinical governance meetings and staff meeting minutes showed that the hospital discussed these incidents and were learning from them.

We reviewed the medication errors for the past three months and found that staff reported all four errors appropriately, notifying the correct organisations. Any nurses included in the errors were retrained in medication management.

A serious incident had taken place prior to the inspection whereby a patient became very unwell. Staff on Ingrow/ Winfield (female rehabilitation) ward told us how well they were supported by management after the incident. Staff informed us everyone was debriefed and offered additional support if required.

The hospital held itself accountable to errors made and was transparent. Staff adhering to their responsibilities under the Duty of Candour evidenced this by apologising to patients over four medication errors that occurred. We did not see formal written apologies given to patients in writing.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Long stay/rehabilitation mental health wards for working age adults

Good

Patients across the hospital had good care records. We found at times they appeared standardised; however they included all the appropriate information required.

We observed eight care records at random during the inspection for physical health monitoring, all of which were consistent. The wards from across the hospital had physical health monitoring, including hydration and nutrition observations for patients in place embedded into the plans. They also included medication monitoring and any risks associated with the patient. We saw an example of a patient who had dialysis treatment, the care plan reflected this patient's needs adequately and what staff needed to do. In addition we reviewed five care plans at random for outcome measures. All five care plans had HoNOS (Health of Nation Outcome Scales) completed.

We reviewed five pro renata (PRN) care plans on the rehabilitation wards, all of which were personalised, up to date and all reviewed regularly.

The hospital provided supported, semi-independent community based residential units for patients moving from the rehabilitation wards. Staff told us it enabled the continuation of care, it allowed for a seamless transition between an inpatient setting to a community setting. The RCPSYCH (Royal College of Psychiatry) suggest in 'the guidance for commissioners of rehabilitation services' that a 'good' service will provide community provisions such as this.

We case tracked one record on the Oakworth (neurodegenerative) ward. Case tracking allows us to see how a patient's care is documented through all their records from admission to their current point. The records showed a cohesive plan of care from admission to the current point. The hospital staff evidenced his changing needs clearly though the care plans.

We saw different tools used, as part of assessment and planning. Staff on Oakworth ward used a PALs (Poole Activity Level) assessment; as part their of dementia care mapping. The rehabilitation wards used the 'Recovery Star'.

Best practice in treatment and care

Staff were able to identify the National Institute of Health Clinical Excellence (NICE) as guidance to support their practice. However, we found no evidence of staff being able to make reference to anything specific within the guidance. They identified places within the hospital where they could access NICE documentation to support them. Staff also said they would be happy to speak to an appropriate member of staff for advice on clinical guidance.

During our inspection it was clear the hospital optimised physical health care throughout its wards. The Priory Keighley had close links with the local GP who attended the hospital on a regular basis.

The hospital provided access to psychology across the wards; however they found it wasn't a provision that was utilised effectively. Patients were reluctant to access psychological support provided by the hospital.

Qualified hospital staff carried out clinical audits; however, ward managers on the rehabilitation wards gave conflicting information about their participation in clinical audits. One ward manager stated that they were involved in the monthly clinical audits of care plans, risk assessments and medication. The other ward manager stated that they did not involve themselves within the audits. An external pharmacy carried out audits in the hospital for medication management. We saw examples of the audits they undertook.

Skilled staff to deliver care

The Priory Keighley had a good range of skill mix across its wards. The neurodegenerative ward, specialising in care for dementia had nurses that had specialised in dementia care mapping. They also employed a nurse who had a RGN (registered general nurse) status which enabled the ward to continue to actively monitor physical health with the right skill set. Occupational therapists were available across the hospital and carried out regular assessments on patients.

The senior occupational therapy assistant worked long days but all the other occupational therapists and occupational therapy assistants worked 8.30am to 5pm, Monday to Friday

The hospital allowed for staff to develop in certain areas of expertise if appropriate for the hospital. We found staff had training at the University of Bradford for dementia care mapping.

The senior management told us the provider wants to nurture their staff so that they can have career progression and better staff retention. We spoke to a nurse and a healthcare assistant who were given the opportunity to

develop their careers within the hospital and subsequently became a charge nurse and a senior healthcare assistant. They told us that the management had been fully supportive towards their development.

However, the nursing staff on the rehabilitation ward said they would like better access to learn psychological therapies themselves, for example solution focused therapy, cognitive behavioural therapy and motivational interviewing. They felt they could utilise this with patients more effectively as they had built up a rapport with them and work with them to improve their motivation.

All staff had a one week induction with a six month probationary period when joining the hospital. The hospital expected staff to meet targets by the end of their induction to ensure that staff had the appropriate knowledge around policies and procedures to work within the hospital.

All staff were up to date with their appraisals and supervision. Prior to our inspection there had been a recent change towards clinical supervision from management supervision. Staff below ward manager level received clinical supervision on a monthly basis and management supervision on a needs led basis, for example where concerns had been identified. Ward managers and above received management supervision to monitor targets and key performance indicators and to provide managerial support. We found staff did not fully understand the differences between the types of supervision. We challenged the importance of regular management supervision for all staff. However, the quality director assured us staff would receive this form of supervision when necessary and we found staff files which documented performance issues, how the hospital would resolve it and any disciplinary issues that were on going. Staff told us that they preferred clinical supervision to management supervision and most staff we spoke to associated management supervision with disciplinary related issues.

Multi-disciplinary and inter-agency team work

We saw good multidisciplinary working throughout the wards. The hospital provided access to a range of psychosocial interventions for patients. Occupational therapists and occupational therapy assistants completed regular assessments with patients and arranged social and therapeutic activities. Occupational therapists did not work at weekends and so the nursing staff delivered the activities. The hospital had regular support from psychology, with a consultant psychologist two days a week and two full time assistant psychologists. We found that patients did not utilise the psychology provision as well as possible. Some staff felt that patients were reluctant to engage with the psychology team. The hospital allowed for group work and individual sessions of psychology to suit the patient's needs.

We saw excellent examples of interagency working on the neurodegenerative ward. The multidisciplinary meeting we observed had the full complement of staff from external agencies including care-coordinators, commissioners, and the GP. It also included, nursing staff, psychology and occupational therapy. A multidisciplinary meeting is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients. This ward had close ties with the local GP who attended the multidisciplinary team meetings on a regular basis. Where possible the patient would attend. The responsible clinician or nursing staff supported patients' views if they were unable to attend.

We did not observe any handovers. However, we saw evidence of comprehensive patient handover documents that provided detailed information to staff covering the next shift. Some of the information included, current risks, changes in medication, fluid and nutrition charts. We found that the documentation for the handovers were not the same for all the wards. Staff reassured us that they communicated the same information on all handovers when we raised this as an issue. Occupational therapists were also included in the handovers.

Adherence to the MHA and the MHA Code of Practice

Thirty-eight of the 41 patients at The Priory Keighley were detained under the Mental Health Act. Seven patients of these patients were on the neurodegenerative ward. Staff across all the wards had good understanding of the Mental Health Act, Code of Practice and the guiding principles. At the time of the inspection 87% of staff had completed their mandatory training for the Mental Health Act.

On the rehabilitation wards the documentation and paperwork were mostly compliant with the Code of Practice. Patients had risk assessments completed prior to Section17 leave. Staff read patients their Section 132 rights on admission and monthly thereafter. Nursing staff

Long stay/rehabilitation mental health wards for working age adults

Good

documented this. We found the hospital did not always follow best practice under the MHA (Mental Health Act) guiding principles for requesting a second opinion appointed doctor (SOAD). We saw one example where a SOAD had given one year validity of treatment on a T3 form, in 2014. There was no evidence of a Section 61 requesting a SOAD to review this treatment.

Patients had access to independent mental health advocacy services (IMHAs). IMHAs are independent of mental health services and can help people get their opinions heard and make sure they know their rights under the law. IMHA can make a big difference to people's experience of detention and are highly valued by people who use services. All the wards provided easy to read posters for patients to have access to advocacy services.

Staff across the wards had access to support from the hospitals Mental Health Act Administrator. Staff identified this as a support mechanism. Senior staff discussed issues around Mental Health Act, Codes of Practice during the clinical governance meetings. We saw evidence of this in the minutes of the meeting. The hospital updated its Mental health Act Code of Practice policy in April 2015 in line with the changes in the revised code of practice.

Good practice in applying the MCA

Staff had a 94% completion rate in the Mental Capacity Act mandatory training. During our inspection the Deprivation of Liberty Safeguards was pending for one patient on the rehabilitation ward, and authorised for two patients on the neurodegenerative ward, specialising in dementia care.

We attended a multi-disciplinary team meeting on this ward which had the full complement of staff from different agencies. Best interest decisions were being discussed during the meeting. We felt it to be very effective and showed positive interagency working.

The Deprivation of Liberty Safeguards documentation was up to date across both services. The hospital staff carried out best interest and capacity assessments on a regular basis across the wards where necessary. A sample of seven records showed all the patients at some point had a best interests meeting completed as part of a multi-disciplinary team. Staff had recorded this appropriately. On the neurodegenerative ward we saw records of regular best interests meetings held, examples of best interest decisions held were in relation to a patient's finances and physical health care.

Nursing staff and health care assistants on the neurodegenerative ward had a high level of understanding around the principles of the Mental Capacity Act. Staff on the rehabilitation wards showed a sound understanding of the Act, a senior health care assistant was able to identify the five principles considered when assessing ones capacity. Staff were able to identify someone to go to for support if needed.

Senior staff discussed issues around Mental Capacity Act during the clinical governance meetings. We saw evidence of this in the minutes of the meeting.

Patients had access to IMCA (independent mental capacity advocacy) services. IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

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

Good

Kindness, dignity, respect and support

During the inspection, we saw warm, professional and caring interactions between staff and patients. Staff were respectful towards patients, knocking before entering their rooms, and prioritising patients' needs first when talking to inspectors. We observed a patient asking a member of staff if they could join them for the 'take away evening' that was planned. We also saw staff interacting with patients during a range of activities, for example karaoke, painting and informal conversations. This showed the good rapport built between staff and patients.

A common theme that we found from speaking to patients was that they felt safe within the hospital.

We saw the hospital go to extra lengths on the neurodegenerative ward, which specialises in dementia

Long stay/rehabilitation mental health wards for working age adults

Good

care, to care for their patients. The hospital facilitated transport to collect and return a family member so that the patient could have lunch with them. This was on an ad hoc basis.

The involvement of people in the care they receive

We saw that the hospital throughout its wards tries to work in collaboration with its patients. Care plans were offered to all patients, some chose to keep a copy others didn't. Patients care plans were done in collaboration with them, and in some cases family members were involved. On the neurodegenerative ward we found one carer had a copy of the care plan.

We spoke to two carers during the inspection who were very positive about their experiences at the hospital. One carer described the hospital working closely with them when caring for the family member and involving them in decision making. Another carer said that the hospital was a "god send".

Patients had community meetings called "Your Voice". We observed a meeting where we saw patients able to talk about various things they would like to see on the ward, things they'd like to do differently and things that are working well.

We spoke to three patients who said that they thought the food provided at the hospital could be more varied and culturally diverse. A member of staff also mentioned the lack of variety in food at times.

Patients knew how to access advocacy support and an advocate attend two days a week making themselves available for patients.

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

Requires improvement

Access and discharge

Prior to admissions, the ward manager had a pre assessment with the patients to identify their suitability to the ward. This reduced the chances of having an admission that was not appropriate for the hospital.

The Priory Keighley ensured patients would have a bed available on return from leave. Management reassured us of this by describing the admissions policy. The Priory Keighley is not an emergency service resulting in planned admissions.

The Priory Keighley have evidenced patient discharges over the last year. The rehabilitation ward had eight discharges in the last 12 months. However, it has 10 patients who have been there over three years and three patients over five years. The Royal College of Psychiatry state that a 'good' high dependency rehabilitation inpatient service such as The Priory should have an average of one to three years length of admission. It is acknowledged that patients with complex needs and co-morbidities may require stay for longer than 3 years and this is outlined in the 'Guidance for commissioners of services for people with complex mental health needs'. Some of the patients in The Priory were under a home office section and the Ministry of Justice can only grant discharge for these patients.

Each of the rehabilitation wards provided a step down ward attached to it to develop the patients' recovery. This provision supported patients with more autonomy and a view to move from the ward.

We found the care records on the rehabilitation wards had the same discharge date. We brought this to the attention of management; they informed us that this was due to an administration issue and was not the planned date. We did not receive any figures around planned discharges or delayed discharges. We also found little evidence of discharge planning in patients care plans. The Mental Health Code of Practice 1.16 states, "Care plans for detained patients should focus on maximising recovery and ending detention as soon as possible" and 33.10: "…the planning of after-care needs to start as soon as the patient is admitted to hospital."

We found one CPA (Care Programme Approach) meeting record outlining consideration for a patient to be moved to the step down ward. The CPA is for patients who are suffering mental health problems and/or have complex needs. It involves the patient and a range of professionals who assess, plan, coordinate and review their care.

We reviewed the meeting records for the next CPA which took place 6 months later; there was no indication of the patient's progress. We saw no evidence of the decision to

move the patient being reviewed, or evidence to suggest the patient became unwell and therefore had to remain on the main ward. This lack of continuity in the CPA could have affected the timeliness of the discharge.

The facilities promote recovery, comfort, dignity and confidentiality

We found the hospital to have appropriate facilities for its patients. The rehabilitation wards had living areas for both their main ward and step down ward. The lounges were homely, had a warm atmosphere and were well kept. We saw that on both male and female wards the lounges were well utilised and a lot of patients were spending their time there. We did not see any dedicated quiet areas for patients to go to if they needed space. Staff told us that patients often went to their room when they needed their own space. None of the patients we spoke to raised this as an issue. The hospital did have a dedicated visitor's room for patients to meet family members.

The neurodegenerative ward, which specialises in dementia care, had a calm atmosphere, and was low stimulus. At the time of the inspection most patients stayed in their bedrooms due to their physical health needs and mobility issues. Patients who were cared for in their rooms had it within their care plans. We saw most of patient care provided within their bedrooms. The two patients that we spoke to were happy with the lounge area and ward. The ward also provided a sensory room with different apparatus that reflected light in different formats, for example optical fibres and lava lamps. The ward used this well-equipped room for therapeutic purposes. The garden area on this ward provided a pleasant outside area for the patients. The hospital has plans to create a sensory garden; the ward manager showed us where this would be.

Patients had access to snacks and drinks twenty four hours a day seven days a week. The hospital provided adapted kettles in the lounges for patients in wheelchairs.

Patients had assessments completed by the occupational therapist to measure their abilities in the kitchen; this determined whether they could cook meals independently or with support. The wards also had garden areas for patients to spend time in. This space was primarily used for smoking.

On the rehabilitation wards we saw examples of personalisation in the patients' bedrooms. We saw posters, decorations and shelves with personal belongings. This gave the hospital a less linear feel. Similarly, on Oakworth (neurodegenerative) ward we saw all the patients had memory boxes at the front of their bedrooms to help them remember their room. These boxes contained memorabilia from their past, for example pictures of family, friends, items. The ward had one patient whose history was not known on admission. The ward staff had made every effort to create a memory box for this patient with very little information.

We observed a community meeting and saw that it was patient orientated and it took into consideration what patients wanted. Staff told us that the hospital had more structured activities during the week; however, on the weekends the activities were more flexible. Staff gave us an example where patients had visited Blackpool on the weekend as a group activity.

The main activity groups included art, baking, pamper group, out and about, sports in the community, healthy living, independent living, group shop and cooking. The dementia ward delivered complimentary therapies; patients on the rehabilitation wards could also receive these but were encouraged to do it within the community where appropriate.

Patients had access to utilise a cordless phone, however, there was no dedicated private area for patients to make calls.

Meeting the needs of all people who use the service

The hospital provided access for patients requiring disabled access. The male rehabilitation wards were situated on the first floor; the ward had a lift access when required. Patients on the neurodegenerative ward had more mobility issues; the hospital provided appropriate facilities to meet their needs. The ward had ramp access to the garden area and support railings were positioned throughout the ward. The hospital provided garden areas for all the wards; the gardens were independent of each other.

Staff provided patients with a booklet on admission regarding their rights. We found that this was not an easy read document and it contained a large amount of information. We thought that this may not be appropriate for all patients. Other information was available for patients who required it in different formats, including another language. The hospital had access to specialist services such as signers if this was required.

Long stay/rehabilitation mental health wards for working age adults

Good

The inspection team received a mixed response on what patients thought of the food. Some patients stated that they enjoyed it and it was to their taste but, others wanted more culturally diverse foods to suit their taste. The hospital provided food for patients according to religious requirements where needed.

The hospital had visitors room which was also the prayer/ multi-faith room for patients. We thought this was inappropriate and that the room should serve one purpose. The room would be unavailable for prayers if the room was being utilised for visitors. The room however, did provide religious texts for different religions and a prayer mat.

Listening to and learning from concerns and complaints

The Priory Keighley reported eight complaints between the months of February 2015 and September 2015. Three complaints were against the Priory Keighley Hospital and all three of these were upheld. Four complaints were received against the rehabilitation ward and Oakworth ward received one. None of these were upheld. In addition none of the complaints made in this period were referred to the Independent Sector Complaints Adjudication Service or the Ombudsman.

The hospital provided leaflets for patients on their information boards to let them know how to make complaints or raise issues. Staff told us that the advocates who come into the hospital often support patients to make a complaint if they need help. The patients that we spoke to knew how to make a complaint and were happy to address issues. Staff were aware of how complaint procedures worked and knew when things had to be escalated.

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

Good

Vision and values

Staff had awareness of the organisations vision and values. These were addressed during their induction period. The quality director told us the organisation would like to embed the visions and values with the support of corporate staff. The hospital had engagement days where members of the corporate team would visit staff on the hospital site to talk about the organisations vision and values. The board reviewed this every six months.

The hospital director displayed a clear knowledge and understanding of the wards and areas of improvement the hospital could make, for example better retention of staff and increasing support services for the weekend.

Most staff that we spoke to were able to demonstrate the values Priory Keighley try to uphold through their practice,

- Putting People First
- Being A Family
- Acting With Integrity
- Striving For Excellence
- Being positive

Good governance

The provider had a service action plan in place for Oakworth (neurodegenerative) ward. The plan covered various items including developing the induction programme, a dementia resource pack and dementia specific environmental audit specialist tool.

Comprehensive clinical governance meeting minutes were observed covering various topics such as changes in legislation, areas of risk and patient feedback. A nominated person was required to carry out the actions in line with the dates for completion.

The hospital director carried out a weekly 'quality walk round', there was a different theme each week, for example staffing, environment, service users and documentation.

The provider carried out various audits of the service, including complex care notes data monitoring, and the monitoring of the physical health care of patients. There was a full annual audit schedule which was adhered to.

Patients named nurses completed a documentation checklist, this was to ensure patients care records contained up to date information and the preparation for multi-disciplinary team meetings, care programme approach reviews were instigated in good time. The hospital has a risk register that was current and up to date. This was utilised well for understanding current issues and future planning.

Leadership, morale and staff engagement

Long stay/rehabilitation mental health wards for working age adults

Good

The provider had developed a talent pool which was used to give staff the opportunity for progression within the organisation. Staff we spoke to had been promoted through this provision.

We saw minutes of the 'listening lunch' for staff which had produced 'you said, we did' posters. This was an opportunity for staff to have a safe space to bring up any concerns or issues. We saw an example of where staff had requested more information about Priory benefits; as a result staff were given access to the new Priory benefits online portal. Also a member of the management had instigated an action plan as a result of the listening lunch. The plan included, details of what the objective was, what progress had been made to date, how had quality improved, a quality achievement rating, staff satisfaction achievement rating, and whether the first milestone been achieved.

The staff we spoke to felt comfortable to raise concerns, and felt confident to whistle-blow without victimisation. We found staff worked well as an MDT, it was evident in their practice and our observations that communication throughout the disciplines was received equally.

Staff understood the principles of the Duty of Candour, and knew their responsibilities in providing an apology if errors ever occurred. We found evidence of apologies being provided to patients in the event of four medication errors.

Commitment to quality improvement and innovation

The hospital provided platforms for both patients and staff to contribute towards how the wards operate. These gave way to innovative practice, areas of improvement, patient and staff satisfaction. It embedded the organisations values of being a 'family' and 'putting people first'.

The hospital director completed the NHS safety thermometer which looked at how many pressure ulcers, falls with harm, catheters and urinary tract infection and venous thromboembolism (VTE) there had been. The data we saw showed there had been none in the period from October 2015 to January 2016.

The neurodegenerative ward had excellent provision with the local GP and the hospital overall had good multi-agency working. This allowed for collaborative and responsive patient care. We saw a full complement of staff during the multidisciplinary meeting, and the positive impact this can have in patient care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider **must** ensure patients on the rehabilitation wards have appropriate person centred discharge planning in place as well as individual discharge dates.

Action the provider SHOULD take to improve

- The provider **should** ensure that staff on the rehabilitation wards record all post medication observations accurately and include the appropriate detail of information.
- The provider **should** ensure all detention documentation, and medical documentation is up to date and reviewed accordingly.
- The prayer room **should** always be available for patients use for this purpose.
- The provider **should** ensure that staff work within their professional remits and not undertake tasks that are not appropriate for them.
- The provider **should** have access to a 'Controlled Drug Register' on the rehabilitation ward at all times.
- The provider **should** ensure that wheel chairs and hoists on the neurodegenerative ward are stored away safely to prevent injury to patients and staff.
- The provider **should** ensure that the continuation of care is reflected in the care programme approach meeting minutes and made clear as to what decisions have made and why

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 9 HSCA (RA) Regulations 2014 Person-centred care Patients did not have individualised discharge dates. Patients care plans did not have adequate discharge planning embedded into their care. We saw a patient's progress was not followed through onto the review meeting under the care programme approach (CPA) meetings. This was a breach of regulation 9 (3) (a) and (b)