Woodbourne Priory Hospital

Quality Report

21-23 Woodbourne Rd, Birmingham B17 8BY
Tel:0121 434 4343
Website:www.priorygroup.com/location-results/item/woodbourne-priory-hospital---birmingham

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	**Good**
Are services safe?	**Requires improvement**
Are services effective?	**Good**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

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

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

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

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

Summary of findings

Overall summary

We rated Woodbourne Priory Hospital as good because:

- Staff carried out environmental assessments and identified and removed areas of risk on most wards.
- Medications were stored safely and staff followed good management and administration processes on wards. There were adequate numbers of staff on wards and the provider could adjust staffing levels upwards as needed. Staff reported incidents and lessons were learned from incidents. There were good processes in place across all wards to share lessons learned.
- Staff completed comprehensive assessments of patients on admission. Doctors monitored patients' physical health regularly and following use of rapid tranquilisation. Care plans were holistic, recovery-orientated and included patients' views. Patients had access to a therapy programme while on the ward.
- Where patients were detained under the Mental Health Act 1983, their rights were protected and staff complied with the code of practice. There was a Mental Health Act administrator responsible for scrutiny of detention paperwork. Patients had access to Independent Mental Health Advocacy (IMHA). Mandatory training rates, including safeguarding training, overall were good across most wards.
- Staff were caring, friendly, and respectful towards patients. Staff had a good understanding of patients' needs and involved relatives in patients' care. Patients had the opportunity to give feedback to the service about their care and treatment.
- The governance structure that supported the safe delivery of services was good. Senior managers had good oversite and communicated well with ward staff. Staff knew how to use the whistleblowing process and felt able to raise concerns. Staff carried out quality walk arounds to ensure good quality services were maintained. Staff demonstrated the values of the organisation in their work.

However:

- Emergency equipment was found to be out of date on two wards, despite staff signing to say it had been checked. Maple and Rowan wards we found out of date equipment in the emergency bag on the ward, despite staff signing to say it had been checked.
- We found that the Mental Capacity Act diagnostic test was not present on the capacity assessment form. This meant that capacity assessments did not cover all areas required.
- Staff did not carry out routine audits of paperwork relating to the use of the Mental Capacity Act at the time of our inspection. We did not find that capacity to consent to treatment was recorded correctly in all records.
- Staff were not recording discharge plans comprehensively in care records on Maple, Beech and Aspen wards and patients we spoke with were unaware of their discharge plans.
- Risk assessments on Maple and Beech wards were not consistently recorded in a clear manner and care plans included jargon.
- Compliance rates for safeguarding adults and children training were very low on Maple, Beech and Aspen wards.
- Recording of staff supervision was not consistent across all wards and did not take into account managerial and reflective practice sessions.
- Not all staff were aware of the values of the organisation. The organisation had undergone a merger and rapid expansion in the 12 months before inspection and the values of the organisation had not yet been embedded.

Summary of findings

Contents

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Woodbourne Priory Hospital

Services we looked at

Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Specialist eating disorders services

Summary of this inspection

Background to Woodbourne Priory Hospital

Woodbourne Priory Hospital is owned by the Priory Group which merged with Partnerships in Care in November 2016.

Woodbourne Priory Hospital is registered to provide care and treatment to children, young people and adults with mental health conditions, including those whose rights are restricted under the Mental Health Act. The service is registered to provide the following regulated activities:

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

The service can accommodate up to 68 patients and comprises six wards. Mulberry Ward is a mixed gender inpatient child and adolescent mental health ward with 14 beds. Rowan Ward is a mixed gender high dependency ward for children and adolescents and has eight beds. Oak Ward is a female-only specialist eating disorder ward and has eight beds. Maple and Beech wards are mixed gender acute wards for adults aged 18-25 and have 28 beds. Aspen Ward is a male-only psychiatric intensive care unit for 16-25 year olds and has 10 beds.

All available beds on Maple and Beech wards, and five available beds on Aspen Ward are for patients admitted through Forward Thinking Birmingham.Forward Thinking Birmingham is an integrated community and inpatient mental health service for 0-25 year olds. It has been in place since April 2016. The service comprises five core partners consisting of :

- The Priory Group, Woodbourne Priory Hospital – inpatient beds for 18-25 year olds
- Birmingham Women's and Children's NHS Foundation Trust – clinical care and support for patients aged 0-18
- Worcester Health and Care NHS Trust– clinical care and support for patients aged 18-25 and early intervention services for 16-35 year olds
- Beacon UK – management of Forward Thinking Birmingham's Access Centre
- The Children's Society – Forward Thinking Birmingham's city centre drop-in service

The Care Quality Commission carried out a comprehensive inspection of Woodbourne Priory Hospital on 5 November 2015 and the overall rating was good. The service received one requirement notice in relation to regulation 17 HSCA (RA) Regulations 2014, good governance. The provider did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. The provider did not adhere to their policy on the management of mixed sex accommodation. Male and female accommodation was not allocated effectively. This was a breach of regulation 17(2)(b).

We inspected the service on 4 May 2016 and found the service compliant with the above regulation.

The service has had three Mental Health Act visits in the 12 months before this inspection.There was a registered manager and a nominated officer for controlled drugs in place at the time of inspection.

Our inspection team

Team leader: Maria Lawley, inspector.

The team that inspected the service comprised four CQC inspectors, one assistant inspector, one Mental Health Act reviewer, five specialist advisors and two experts by experience.

Summary of this inspection

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 and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited all six wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 27 patients who were using the service
- spoke with the registered manager and managers for each of the wards
- spoke with 47 other staff members including doctors, nurses, occupational therapists, psychologists and teachers
- received feedback about the service from care co-ordinators and commissioners
- attended and observed four multidisciplinary meetings, two business meetings and one multi-agency meeting
- observed five therapy groups across different wards
- collected feedback from 44 patients using comment cards
- looked at 32 care and treatment records of patients
- carried out a specific check of the medication management on all wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients on Maple, Beech and Aspen wards reported that most staff were caring, friendly and quick to respond to their needs. However, of patients we spoke with, three raised some concerns about attitude and treatment by individual staff members on Aspen Ward. Patients felt that most staff treated them well and communicated positively with them.

Most patients told us the wards were safe and comfortable. Two female patients on Maple Ward told us they felt unsafe with the ratio of males to females on the ward at the time of our inspection.

All patients we spoke with told us they felt the environment was too restrictive in relation to items they could bring on the ward or allowed to use and where they were allowed to go unsupervised. One patient felt their rights were not fully explained to them, but felt staff responded well to them. They told us the staff team as a whole were supportive and caring and they felt listened to.

On Rowan and Mulberry wards, patients we spoke with said that staff understood their individual needs. We were told that staff were sensitive and supportive, communicated effectively and took their time to develop a broad knowledge of patients, their support networks and the way they could support them. One patient told us that it was the little things that the staff group did which let them know that had listened to them, this included inspirational quotes hidden under objects to be found by patients when they were having a difficult time during their recovery.

Summary of this inspection

All feedback we received from patients that we spoke with on Oak Ward was without exception outstanding. Patients told us that the clinical team never gave up on them and that the levels of dedication, compassion, consultation and consideration of patient need by the staff team were incredible. One patient that we spoke with said that the Oak Ward staff team had given them their life back, and a life that they had never thought would be possible.

We received feedback from 44 comment cards. Most patients commented positively about staff. On Aspen Ward, most patients who commented told us the food on the ward was good. One patient told us they would have liked bigger portion sizes. Another told us they liked the food, but felt cultural variety could improve. On Maple ward, one patient said it was hard to get time to talk to staff after 4pm and they often had to wait until the night shift was on duty. On Oak Ward, patients and carers left feedback. Two carers fed back that staff went above and beyond what could have been expected.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Maple and Rowan wards we found out of date equipment in the emergency bag on the ward, despite staff signing to say it had been checked.
- We found a significant number of security checks on Beech Ward had not been completed between March 2017- June 2017.
- Compliance rates for safeguarding adults and children training were very low on Maple and Beech Wards, and in one instance on Aspen Ward. Safeguarding adults on Maple Ward was 11% and Beech Ward was 19%, Aspen ward was 50%. Safeguarding children on Maple Ward was 22% and Beech Ward 31%.

However:

- Sickness and turnover rates were low on most wards.
- Risk assessments on Oak, Mulberry and Rowan wards were detailed and person centred. Staff updated them frequently and they reflected recent changes in patient risk history.
- Medications were stored safely and staff followed good management and administration processes on most wards. A pharmacist visited the wards weekly.
- There were adequate numbers of staff on wards and the provider could adjust staffing levels upwards as needed. We saw staffing rotas that showed all shifts had been covered by either permanent, bank or agency staff between March and May 2017.
- Staff reported incidents and learned lessons were learned from incidents. There were good processes in place across all wards to share lessons learned.

Are services effective?

Good

We rated effective as good because:

- Care plans were personalised, holistic and recovery focussed. On Oak, Mulberry and Rowan wards, care plans reflected the patient's voice and showed clearly that they were involved in their care.
- Staff offered a range of interventions in line with guidance from National Institute of Health and Care Excellence guidelines.
- There was a commitment to the development of staff across the hospital; the service ensured staff were suitably skilled and qualified to work wards.

Summary of this inspection

- Health care assistants had been supported to obtain their care certificates. Specialist training had been designed for bank and agency staff working on Oak Ward to ensure they had the competency to support patients with an eating disorder.
- Staff had received appraisal across all wards. Staff accessed profession specific clinical supervision and monthly team supervision meetings were chaired by an external facilitator.
- Staff held weekly multidisciplinary meetings to review patient's progress and patients and carers were actively involved. The senior management team met with ward managers in a daily morning meeting to review all patient progress and discuss any issues on the ward.
- Where patients were detained under the Mental Health Act 1983, their rights were protected and staff complied with the code of practice.

However:

- We found that the Mental Capacity Act diagnostic test was not present on the capacity assessment form. This meant that capacity assessments did not cover all areas required.
- Staff did not carry out routine audits of paperwork relating to the use of the Mental Capacity Act at the time of our inspection. We did not find that capacity to consent to treatment was recorded correctly in all records.
- Care plans on Maple, Beech and Aspen wards included jargon and some patients and carers told us they were not involved in care plans.

Are services caring?

Outstanding ☆

We rated caring as outstanding because:

- Staff were caring, friendly, and respectful towards patients. Staff had a good understanding of patients' needs and involved relatives in patients' care.
- Patients across the hospital were able to become involved in decisions about the service and took an active role in the recruitment process of new staff.
- We saw many examples of staff engaging with patients in an outstandingly caring and compassionate manner during our inspection.
- Staff adapted their communication and approach to each individual patient.
- Patients were able to become involved in decisions about the service and took an active role in the recruitment process of new staff as part of a service user directed team recruitment and team performance programme.

Summary of this inspection

- On Oak Ward, all feedback received from carers and people that used the service was without exception outstanding. We found examples of patients engaging collaboratively with staff to engage in community based initiatives and support a local charity for eating disorders.

Are services responsive?

Good

We rated responsive as good because:

- When patients were discharged from wards, this was following a period of planning and preparation for patients in collaboration with the clinical ward team and was always scheduled for an appropriate time of day.
- We found evidence in all care records reviewed of the consideration of section 117 aftercare services for patients admitted to the ward and detained subject to the Mental Health Act.
- Staff supported patients to personalise their bedrooms during their stay on the wards.
- During the 12 months before our inspection, all wards had received compliments relating to their care and treatment during their hospital stay. There were no complaints received by the provider relating to the care and treatment of patients on Oak Ward.

However:

- Staff were not recording discharge plans comprehensively in care records on Maple and Beech wards. All but one of the patients on Maple and Beech wards we spoke with were unaware of their discharge plans.

Are services well-led?

Good

We rated well-led as good because:

- The governance structure that supported the safe delivery of services were good. Senior managers had good oversight and communicated well with ward staff.
- Staff knew how to use the whistleblowing process and felt able to raise concerns. Designated staff carried out regular quality checks of the hospital to ensure good quality services were maintained.
- Morale across all wards was excellent and staff told us they loved their jobs. Staff reported that they felt valued and respected by the ward managers and that a culture of mutual support, learning and reflection underpinned the approach of the clinical teams.

Summary of this inspection

- Senior managers were visible on the wards. Everyone we spoke with talked positively regarding their ward managers and the senior managers within the hospital.

However:

- Recording of staff supervision was inconsistent and did not take into account reflective practice sessions and management supervision.
- Not all staff were aware of the values of the organisation. The organisation had undergone a merger and rapid expansion in the 12 months before inspection and the values of the organisation had not yet been embedded.

Detailed findings from this inspection

Mental Health Act responsibilities

- A central team provided administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator examined each patient's Mental Health Act (MHA) papers on admission (as authorised by the hospital managers Mental Health Act code of practice 35.19). The Mental Health Act administrator carried out scrutiny of detention paperwork and the medical director scrutinised medical recommendations. Mental Health Act administrators offered support in making sure the Act was followed in relation to renewals, consent to treatment and appeals against detention. The administrator offered support to staff and visited ward daily to collect documentation and prompt staff of expiry dates. All of the staff knew how to access the Mental Health Act administrator if they needed advice.
- There were clear records regarding leave granted to patients and contingency plans and risk management; including terms and escort arrangements. Where only one kind of leave granted to a patient was included on the patient's records, the terms and conditions were clear. Where there was more than one type of leave granted to a patient, for example overnight leave, emergency medical leave or community leave, the terms and conditions were not separated and therefore unclear. Patients, staff and carers (where applicable) were aware of the what community leave they had and where to.
- The staff we spoke with demonstrated a good understanding of the Mental Health Act and its Code of Practice. Staff compliance for training in the Mental Health Act and its Code of Practice for the wards was: Beech and Aspen wards 100%, Mulberry Ward 96%, Rowan Ward 91%, Oak Ward 82% and Maple Ward 78%.All of the staff knew how to access the Mental Health Act administrator if they needed advice.
- Consent to treatment and capacity requirements were followed. Copies of medication authorisation certificates were attached to medication charts where applicable. This meant that nurses were able to check medicines had been legally authorised before administering any medicines.
- Patients' had their rights under the Mental Health Act explained to them on admission and routinely and regularly after, depending on the needs of the individual. In two of the 12 records we looked at for Maple and Beech wards, there were some minor omissions in the rights forms. On Beech Ward, we saw no record of how staff made sure that a patient with identified communication needs was supported to understand their rights. On Aspen ward, of the five care records we reviewed, two contained a partially completed rights form with no indication of when it would be completed or why it was not complete.
- There were regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits. Detention paperwork was filled in correctly, up-to-date and stored appropriately.
- Patients had access to the Independent Mental Health Advocate (IMHA), which was provided by Voice Ability. This service had been commissioned by the local authority, in accordance with the Mental Health Act Code of Practice 2015. The Independent Mental Health Advocate introduced themselves to patients following their admission. Uptake of the Independent Mental Health Advocate was low and staff told us that patients preferred to access the advocacy service provided by the National Youth Advocacy Service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with during our inspection had a good understanding of the Mental Capacity Act, five statutory principles and the definition of restraint including the restriction of a patients freedom of movement.

However, two staff on Maple and Beech wards were not aware of the statutory principles of the Act, in particular principle three, which outlines that people have the

right to make decisions that others might regard as unwise or eccentric. When given examples, staff were not always able to understand that patients can make unwise decisions and maintain capacity.

- Staff on all wards had completed training in the Mental Capacity Act with the exception of staff on Maple Ward where compliance was 78%. All staff on Mulberry and Rowan wards had up-to-date training in Gillick competence guidelines. The staff we spoke with demonstrated their understanding of Gillick competence by giving examples of when they had considered it.
- There was a policy on Mental Capacity Act, including Deprivation of Liberty Safeguards, which staff were aware of and could refer to. There were no Deprivation of Liberty Safeguards applications made in the last six months on any of the wards.
- We found that the Mental Capacity Act diagnostic test was not present on the hospital-wide used capacity assessment form. This meant that capacity assessments did not cover all areas required. The form did not contain a space or prompt to record how staff supported patients to make decision for themselves.
- On Aspen Ward, in records where a capacity assessment was required, one record contained a capacity assessment form including diagnostic test and space to record the support given to patient to make their own decision. However, we saw that a capacity assessment for one patient was not decision specific. On Maple and Beech wards, we found no record of discussion between the responsible clinician and the patient about treatment either at three months or at first administration of medication.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation. The provider had recently (two weeks prior to our visit) put arrangements in place to monitor adherence to the Mental Capacity Act within the hospital. Staff did not carry out routine audits of paperwork relating to the use of the Mental Capacity Act at the time of our inspection.
- Capacity to consent to treatment was not always recorded correctly. On Oak Ward, we found that two patients had been assessed as lacking capacity to consent in clinical notes, but recorded as consenting to medication treatment on the Mental Health Act authorisation certificate. This was raised with the responsible clinician and hospital manager at the time of our inspection and assessments repeated and correctly documented.

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

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

- The layout of Maple and Beech wards did not allow staff to observe all parts of the ward. The provider reduced blind spots (an area where people cannot be seen) using observations or supervision, closed-circuit television (CCTV) cameras and wall-mounted dome mirrors. There were some areas on Maple and Beech wards that were not covered by CCTV cameras, for example, the patient courtyard on Beech Ward or the consultant's office on Maple Ward. Staff had highlighted this to the senior management team as a potential risk. Staff took measures to ensure patients were kept safe in these areas using individual patient risk assessments, environmental risk assessments and observations.
- The layout of Aspen Ward allowed staff to observe the communal living area and a quiet lounge from the nurse's office. The corridor where the patients' bedrooms and the gym and activity room were located was a blind area. There were blind spots in the bedrooms and a blind spot in the seclusion room. Staff reduced blind spots with the use of observations and they had installed a domed mirror in the seclusion room to improve visibility.
- Staff completed an annual ligature risk audit for Maple, Beech and Aspen wards. Staff reviewed this regularly and when changes to the environment were made or new equipment was provided. A ligature is something used for tying or binding something tightly and can be used to self-harm. A ligature risk audit is a document that identifies places/objects to which patients intent on self-harm might tie something to strangle themselves.
- We found that there were loose electrical wires in the multi-faith room used by both Maple and Beech wards. We saw in the ligature risk assessment dated 30 December 2016 for Maple Ward and 18 January 2017 for Beech Ward that staff were to keep all cables boxed in to keep patients safe. We notified staff of this during our inspection.
- Aspen Ward was purpose built in 2016 and had been designed to remove ligature point risks. Fittings within the communal areas of the ward and patient bedrooms were non-weight baring and anti-ligature. Where staff had identified a potential ligature, this was reduced by use of observations, supervision of patients or CCTV located around the ward and monitored by staff.
- Staff had completed an external area ligature point audit in May 2017, which covered the main hospital, the car park and entrance area. The service's car park and driveway area were both covered by CCTV with signage in place to inform patients and visitors of its use.
- Staff had access to safety mechanisms such as access to anti-barricade unlocking systems and ligature cutters on all wards. Ligature cutters were replaced by staff after every use and there was a process in place to ensure this happened. All doors were anti-barricade and keys were readily available for staff to remove these in an emergency. We saw an anti-barricade door register that the provider asked staff to sign when they had completed training. Staff completed weekly and monthly checks on these and actions were identified and actioned where necessary.
- Maple and Beech wards complied with guidance on mixed-sex accommodation. There was access to a female-only lounge on both wards. Staff on Beech Ward told us their female only lounge was occasionally used

by male patients for therapeutic activities and we observed males in the female lounge during our inspection. Aspen Ward was a male only ward. All patient bedrooms had en suite bathroom facilities.

- There was no seclusion room on Maple and Beech Wards. Staff told us patients would be formally referred and transferred to the psychiatric intensive care unit (Aspen ward) if they required a period of seclusion. Aspen Ward's seclusion room had access to toilet facilities, outside space, a clock within view of the room and appropriate furnishings. Doors were robust and there were no apparent safety hazards. There was a window looking outside of the building where there was no access to the public or other patients or staff, except the garden maintenance staff. No one could see into the room from the outside as the window was fitted with an obscuring tint.
- All ward areas were visibly clean, had furnishings in good condition and were well maintained. Furniture was appropriate to the ward i.e. on Aspen Ward, it was weighted so it could not be used as a weapon and it was difficult to damage. The ward environments were bright and furniture was comfortable.
- There was evidence that the ward had been cleaned and we saw domestic staff on the ward during our visit. Cleaning records showed cleaning was completed regularly. We saw cleaning records for the month of June 2017 these were up-to-date and demonstrated that the environment had been regularly cleaned. One member of the housekeeping staff told us that the housekeeping team was short-staffed, but that as a team they managed. All patients we spoke with said that the ward environment was always kept clean.
- Staff adhered to infection control principles and we saw information displayed around the wards about hand washing. There were hand gel dispensers at the entrance of the ward and we observed staff using them correctly in line with infection control principles. There were facilities to wash hands in the clinic room. There were handwashing posters at all sinks.
- Across all wards we saw some staff had not adhered to the Priory's policy on Standards of Dress, Uniform and Personal Appearance which stated, nails should be short and unpolished and with regard to any piercing which is on view, the jewellery inserted in it must be removed. The policy stated, for any colleagues that may have contact with patients, only studs may be worn. This was in place to reduce the potential risk of direct cross infection between patients who staff may have contact with in a clinical setting.
- There was a clinic room on every ward available for staff to monitor patients' physical health and administer medication. The rooms were fully equipped. Staff had access to an examination couch, blood pressure machine, weighing scales and medication fridge. There were emergency drugs and resuscitation equipment available.
- Staff monitored room and medication fridge temperatures and ensured they were kept within a safe range. Fridges were kept locked. There were bins available for the safe disposal of medication and needles. Equipment was clean and in working order. All medications and equipment were within expiry dates. The emergency grab bag was available and checked nightly to ensure equipment was in date and working.
- On Maple Ward, we found that staff needed to move the fridge to access the oxygen cylinders. There was one defibrillator held on Maple Ward and was shared with Beech Ward. The two wards were adjoined and the bag could be accessed easily and quickly in the event of an emergency. On Maple Ward, we found two pieces of equipment in the emergency bag that were out-of-date. The ward manager immediately addressed this and ordered replacements.
- Staff told us nurses maintained and kept clinic room equipment clean. However, we did not see stickers on equipment in clinic rooms on any wards to indicate that it had been cleaned or when it had been cleaned, and wards did not audit the cleaning of equipment. On Maple and Beech wards, portable appliance testing (PAT) safety tested stickers were not visible; PAT certificates were held separately, centrally. Equipment on Aspen Ward was less than 12 months old and not due for PAT at the time of inspection.
- Staff completed environmental risk assessments for the wards. We saw audits completed on wards for April 2017 to June 2017 with actions completed.
- On each shift a member of staff was nominated as a 'security nurse'. The security nurse was responsible for carrying out environmental checks of the ward on every shift. This included personal alarm and fire checks and general safety of the ward. The nurse also carried a set of keys for all the doors in the building. However, we

identified a significant number of security checks were missing on Beech Ward from audits recorded by the security nurse during day and night shifts between 31 March and 18 June 2017.

- During our inspection of the ward environment, a room on Beech Ward that staff risk-assessed as needing to be locked at all times, was found to be open. We raised this with a staff member and the staff member immediately locked this room. We also raised this with the ward manager and senior management team who agreed that this room should always remain locked as it had been assessed as unsuitable for patient access at present.
- Fire checks were completed daily and a weekly test of the fire alarm system also took place within the hospital. There were trained fire marshals on all wards. Patients on all wards had a personalised evacuation plan indicating any assistance they might need in the event of a fire.
- All staff on the wards carried alarms that could be used to attract the attention of other staff in the event of an emergency or as a nurse call system. Staff were able to respond quickly in the event of an incident and staff from other wards could also respond to emergency alarms. There were nurse call systems in every bedroom for patients to use. However, on Maple and Beech wards, patient personal alarms only signalled an alert within the nursing office. This meant that if a patient required support when there was no staff available in the office, staff may be unaware of the patient's request for support. There was always a member of staff in the nursing office on Aspen Ward.

Safe staffing

- On Maple Ward, there were seven qualified nurses and 13 healthcare assistants. There were two vacancies for qualified nurses, both of which were being recruited to. On Beech Ward, there were six qualified nurses and nine healthcare assistants. There were two vacancies for qualified nurses. The staffing establishment for Aspen Ward was 10 qualified nurses and 18 health care assistants. The ward had four vacancies for qualified nurses and no vacancies for health care assistants at the time of inspection.
- Agency or bank staff covered 122 (15%) of shifts on Maple Ward and 91 (11%) shifts on Beech Ward between March and May 2017. There were 232 (27%) shifts covered by bank or agency on Aspen Ward during the same period. Wards booked the same members of bank and agency staff to ensure consistency for the patients and ward. All shifts had been filled by either permanent, bank or agency staff between March and May 2017.
- The overall staff sickness rate over a 12-month period up to March 2017 was 1.3% for Maple Ward, 1.1% for Beech Ward and 1.9% for Aspen Ward. The overall hospital sickness level over 12 months was 1.3%, this was low.
- Maple Ward had a staff turnover rate of 34% and Aspen Ward 28% during the period June 2016 to May 2017. This is partly reflective of the changes to the acute wards within the hospital and following the opening of Beech Ward in January 2017. This resulted in some movement of staff across the wards to share skills. Staff also told us that this turnover rate was due to significant changes in the patient group. Beech Ward had a staff turnover rate of 5%.
- The provider had estimated the number and grade of nurses required. The provider used a staffing ladder tool to determine number of staff on shift.
- Staffing levels had recently (May 2017) been reduced on the wards. On Maple and Beech wards, two nurses and two healthcare assistants were allocated to each ward for every shift. Both wards had recently been allocated an additional qualified nurse for review days and staff told us that this really helped to support the team.
- Staff said these changes to staffing numbers could be a challenge. They often requested more staff to support them on shifts where there were additional activities scheduled for the day, such as new admissions, escorted leave or therapeutic activities. Patients told us that escorted leave was regularly cancelled due to there not being enough staff available to support them on Maple and Beech wards. These reductions in staffing requirements also meant that ward managers were sometimes required to support with nursing duties on the ward. Ward managers told us they were able to adjust staffing levels to take account of case mix and daily activities and that they requested additional staff on most shifts to support the needs of the patients.
- Aspen Ward had reduced from six day staff to five. Staff told us they had noticed the reduction and there was increased pressure on completing clinical duties and less time to spend with patients. Staff ensured they facilitated patient's escorted leave, even if that meant

staff did not take breaks. The ward manager was able to increase staffing levels if needed to support with increased patient observation levels. We did not observe any issues raised by the number of staff on the ward at the time of our inspection. However, Aspen Ward was not at full capacity and one patient was in seclusion at the time of our inspection.

- On all wards there was always a qualified nurse on every shift and present in communal areas. Of the eleven patients we spoke with across the three wards, most had regular one-to-one time with their named nurse and felt that they were supported by staff. Staff and patients on Aspen Ward told us they had regular time to have one-to-ones, although these were not always at formally set times. However, two patients on Maple Ward, told us that staffing could be quite tight and staff were sometimes too busy to sit down and listen to patients. One patient on Beech Ward told us that they did not have access to one-to-one sessions to talk with a nurse.
- Two out of three patients we spoke with on Maple Ward felt there were not enough male staff to support the male patients on the ward. One staff member told us that the team felt safer when male agency staff were working on the ward. Two female patients on Maple ward told us they felt unsafe due to the ratio of males to females on the ward; there were more male patients on the ward then females at the time of inspection.
- There were enough staff to safely carry out physical interventions when staff from other wards responded to an emergency alarm. We saw staff respond to an emergency alarm on Beech Ward and this was done efficiently and quickly. Staff on Aspen Ward did not respond to alarms on other wards in order to maintain sufficient staffing levels for the safety of the ward.
- There was adequate medical cover 24 hours a day. A consultant psychiatrist provided medical input Monday to Friday between the hours of 9-5. Out of hours on call medical cover was provided through a rota system and details were held in the staff office of the on call arrangements and contact details. Staff and patients reported no concerns about accessing a doctor and stated that the system worked well.
- The average mandatory training rate for Maple Ward was 66%. The average mandatory training rate for Beech Ward was 86%. On both wards, staff were not up-to-date with their mandatory training in safeguarding adults (11% compliance for Maple Ward, 19% compliance for Beech Ward) safeguarding children and young people (22% compliance for Maple Ward, 31% compliance for Beech Ward). The providers target for mandatory training was 90%.
- On Maple Ward, less than 75% of staff were up-to-date with their mandatory training in the following courses; confidentiality and data protection, cyber security, emergency procedures awareness, fire safety, infection control, intermediate life support, introduction to health and safety, introduction to mental health, managing challenging behaviour, Mental Capacity Act, moving and handling, positive behaviour support, prevention management of violence and aggression (PMVA), safe handling of medicines, safeguarding vulnerable adults and the Mental Health Act.
- On Beech Ward, less than 75% of staff were up-to-date with their mandatory training in intermediate life support and prevention management of violence and aggression (PMVA). We were told that the format had changed for the Intermediate Life Support course and the prevention and management of violence and aggression training and that this was why a number of staff across both wards were out of date for this training.
- On Aspen Ward, 89% of staff were up-to-date with mandatory training as part of the Priory Academy training programme. All but one course compliance was above 75%, the lowest compliance was completion of Safeguarding Adults level 3 training at 50%.

Assessing and managing risk to patients and staff

- In the six months before inspection, Aspen Ward had 33 episodes of seclusion, Maple Ward had one incident of seclusion and there were no incidents of seclusion on Beech Ward. There were no episodes of long term seclusion on any of the wards. We reviewed seclusion records and found these in order. Records clearly showed seclusion was used as a last resort and reviews were documented in patient care records.
- In the six months before inspection there were 90 episodes of restraint on Aspen Ward that involved 23 different patients. This meant that staff restrained some patients more than once during their treatment. One episode of restraint on a patient was prone (face down) position. There were 23 episodes of restraint on Maple

Ward that involved 13 different patients. One of these restraints was prone position. There were 23 incidents of restraint on Beech Ward that involved 10 different patients. None of these restraints were prone.

- The provider trained staff in the prevention and management of violence and aggression, including de-escalation techniques. Staff told us they would attempt to verbally de-escalate a potentially violent situation to avoid resulting in restraint where possible.
- Staff used rapid tranquilisation where appropriate. Rapid tranquilisation is an injection given to calm a patient down. Staff offered oral medication first and where rapid tranquilisation was used, staff recorded this in patient's observation charts and medics monitored patients appropriately in line with National Institute for Health and Clinical Excellence guidance (NG10). The service did not monitor the numbers of rapid tranquilisations on patients; all episodes were recorded in individual patient's care records. The service had carried out an audit of rapid tranquilisation use on Aspen Ward in November 2016.
- We reviewed 12 care records across both Maple and Beech wards, which included detained and informal patients. Staff undertook a risk assessment of every patient on admission and updated these risk assessments regularly, including after an incident. Staff used the Priory's own risk assessment tool, which captured the individual's historical and current risk. We saw that all these risk assessments were up-to-date and regularly reviewed. However, on Beech Ward, we found in one risk assessment for a patient, staff recorded the patient's risk as 'high' in one section and 'medium' in another. This meant that the level of risk was unclear and would be confusing for staff in determining the patient's safety.
- We reviewed five patient care records on Aspen Ward, which were all for detained patients. All records contained a risk assessment on admission and staff had updated these regularly. However, the quality of the risk assessments varied. Three patient records contained comprehensive assessments of risk including historical risk and rationale. Two records reviewed contained indicators of risk and listed specific incidents, but did not contain a risk history or management plan.
- The occupational therapists also carried out daily risk assessments for the patients. Occupational therapists received a handover from nursing staff before one-to-one or group sessions and the multidisciplinary team assessed patients' suitability for group activities based on their current level of risk.
- Blanket restrictions were used only when justified. For example, we saw that on Maple Ward, smoking times were set to monitor the use of lighters on the ward. Staff stored the lighters in the nursing office and handed these out to patients at smoking times, before counting them in and storing these in the office. This was to ensure patients were kept safe. Staff told us that if a patient became agitated and requested a cigarette outside of the set smoking times, staff would facilitate this.
- On Beech Ward, staff supervised patients' access to the courtyard due to there being no CCTV cameras in the courtyard. This meant that patients had to ask staff to access the courtyard. However, we saw that this happened regularly and patients did not report this as an issue.
- There were banned items and restricted items listed on Aspen Ward which were in place to keep patients safe in line with the security of the psychiatric intensive care unit environment.
- On Maple and Beech wards informal patients could leave at their will and signs were displayed on the doors of the ward exits to remind informal patients of this. Staff told us that patients were required to ask the staff to open the door for them in order to keep other patients safe.
- Staff used observations to mitigate risks to patients. Staff assessed patients appropriately and recorded the reasons for levels of observations in care records. The provider set observation levels at four times per hour when a patient was first admitted. The ward doctor could then reduce when risk assessed to be safe and appropriate. We saw that observation charts recorded the actual time at which the patient was observed and what the patient was doing at that time. This was to ensure that patients could not predict their observation times in order to engage in risk-related behaviour, such as self-harm. This helped to keep patients safe. Two of the patients we spoke with on Beech Ward did not know why they were on their current level of observation.
- Staff searched patients in line with Priory's policy on Searching Service Users and Their Belongings in a

Treatment Environment. This occurred on admission to the wards, thereafter, staff only searched patients if individually risk assessed and care planned or on return from leave if risk assessment indicated a specific risk. Staff sought and recorded patients' consent to carry out these searches. However, three staff we spoke with on Beech Ward were unclear about this policy and said that all patients were searched every time they returned from leave. Care plans were not clear on what staff would do if the patient refused to be searched.

- Maple Ward had some concerns around patients bringing illegal substances on to the ward. The ward manager put measures in place to manage this, including supervised urine screening, personal searches and had made a request to the police for detection dogs to come to the ward. Staff also discussed this concern with patients in one-to-one meetings and morning meetings. We saw accurate and up-to-date care plans around random urine screening for a patient on Maple Ward with a history of substance misuse.
- Staff we spoke with on Aspen Ward were knowledgeable about the provider's safeguarding policy and procedures. All staff could name the safeguarding leads within the hospital and knew the process to escalate concerns. Staff compliance for safeguarding children training was 96%, safeguarding children and young people training was 83% and safeguarding vulnerable adults (level 2) training was 96%. However, only 50% of eligible staff had completed training in safeguarding adults (level 3).
- On Maple and Beech wards the provider had not kept staff up-to-date with training on safeguarding. On Beech Ward, staff compliance for safeguarding adults training (level 3) was 18% and safeguarding children and young people was 31%. On Maple Ward, staff compliance for safeguarding adults (level 3) training was 11%, safeguarding children training was 67%, safeguarding children and young people training was 22% and safeguarding vulnerable adults (level 2) training was 61%. However, staff we spoke with were aware of the safeguarding reporting procedures and we saw clear flow charts of the safeguarding process displayed within the nursing offices. Staff were also aware of who the designated safeguarding officers within the hospital were and said they felt confident to raise safeguarding concerns if necessary. The safeguarding leads across the hospital met on a weekly basis to discuss safeguarding referrals.
- Medicines were transported, stored, dispensed of and reconciled appropriately and in line with national guidance. We saw good systems of recording medication and reporting medication errors and learning lessons from these errors. Ward staff and the external pharmacists audited medication. A pharmacist visited the ward weekly to audit medication and medication charts. Medication was delivered from the pharmacy to hospital by courier and collected by designated nursing staff.
- The pharmacist produced weekly reports which staff accessed online. There were also links to updates on National Institute for Health and Clinical Excellence guidelines. The pharmacist also attended quarterly clinical governance meetings with the hospital to present a quarterly report and gave staff updates through a newsletter.
- Children were able to use a visitor's room to visit patients on the wards. There was a visitor's policy which contained guidance to the updated 2015 Mental Health Act Code of Practice. The policy stated that visits by children to parents, whether detained or not, were central to the maintenance of healthy relationships with parents or other relatives who are in hospital. Ward staff and the medical team carried out risk assessments to determine whether staff supervised these visits. On Aspen Ward, the visitor's room was accessed through an outside door leading directly into the room so children and other visitors did not have to walk through the ward area to meet with patients.

Track record on safety

- There had been no serious incidents on either Maple or Beech Ward reported in the last 12 months.
- There was one serious incident on Aspen Ward in the 12 months before inspection.
- The provider undertook an investigation following the incident. Staff followed hospital procedure, clearly documenting the incident. The director of clinical services had informed the CQC, the police, the local safeguarding team and the necessary professional bodies in a timely manner. Staff and patients received debrief following the incident.

- Following the investigation into the serious incident the provider produced an action plan with actions outlined to improve safety of the ward to ensure the incident did not reoccur. One significant change to the ward was to move from a mixed gender ward to a male only ward.
- On Maple and Beech wards, staff gave examples of recent adverse events that had led to improvements in safety, such as high numbers of self-harm incidents during the early evening, which led to additional activities being scheduled in for this time each day to engage patients in alternative activities. This had led to a reduction in the number of these incidents at this time of the day. Another example was given about a patient who had recently experienced pseudo-seizures. Pseudo-seizures are attacks that look like epileptic seizures, but are not caused by abnormal brain electrical discharges. They are often caused by psychological distress. Staff did not know what these were and therefore the ward manager provided some information about this to educate the staff in how to manage this event.

Reporting incidents and learning from when things go wrong

- Staff on Maple and Beech wards knew how to report incidents and most staff said that they received feedback and learning about incidents from senior staff in handovers or supervision. One staff member told us that they had never received any feedback about incidents. Staff told us that only the nurses reported incidents.
- All staff on Aspen Ward reported incidents. Staff we spoke with knew what to report and how to report incidents. Feedback was disseminated from senior managers to ward managers verbally during morning meetings and through emails. The ward manager fed back learning to staff in staff meetings, through the use of a communication folder and in emails. Changes were made following learning from incidents. For example, there was an incident where a patient had managed to breach the fence surrounding Aspen's enclosed courtyard. The service acted quickly to secure the fence, making it higher.
- Staff were supported with debriefs and supervision following incidents. The psychologist facilitated reflective practice sessions fortnightly. Reflective practice is the ability to reflect on one's actions to engage in a process of continuous learning.
- There was a risk management meeting and a clinical governance meeting held monthly. Staff shared learning between wards and produced a risk bulletin, which was then circulated to all staff. The Priory group shared learning from incidents across their services during governance meetings. The director of clinical services, conducted team incident reviews and determined lessons learned. Senior managers acted quickly to ensure incidents did not reoccur and supported ward managers to implement changes.
- The risk bulletin was displayed in the ward manager's office on Beech and in the nursing office on Maple. This outlined the main points discussed in the monthly risk meeting where staff reviewed incidents and shared lessons learned. We also saw a form in the Maple Ward nursing office called 'top risks for Maple'. This outlined the current risks specific to Maple Ward and this helped staff to identify areas of risk and supported them to be vigilant in these areas.
- On Maple Ward, daily mutual help meetings gave patients the opportunity to discuss recent incidents and reflect on their feelings about this. On Aspen and Beech wards, daily morning meetings were held for patients to outline their plans for the day and give feedback on the ward.
- Staff were open and transparent with patients and explained when something went wrong. This was in line with the provider's duty of candour policy. We saw this during our inspection of Aspen Ward where staff had explained to a patient and carer how a piece of their property had been lost and actions they had taken to locate it.

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

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

Assessment of needs and planning of care

- There were four main electronic care plans; keeping safe, keeping well, keeping healthy and keeping connected. Each care plan related to areas of a patient's recovery and included aspects of physical health, family and support network involvement, risk management and therapeutic activities.
- We looked at 12 patient care records across Maple and Beech wards. Staff completed comprehensive and timely assessments following each patient's admission. These assessments were person centred and holistic. For example, one assessment contained information about a patient's dog as part of their historical information. We also saw a care plan on Maple Ward that showed clear consideration of the needs of a patient with Autistic Spectrum Condition. However, on Beech Ward, we saw that there was no consideration of one patient's diagnosis of Autistic Spectrum Condition in their care plan and the admission assessments for this patient failed to record this diagnosis.
- We reviewed five patient care records on Aspen Ward. All records contained a comprehensive assessment of the patient on admission. Care plans considered least restrictive options around accessing fresh air; smoking; access to laptop; mobile phones and searches. Staff recorded patients' views on care and treatment in care plans. For example, concerns around weight gain as side effect of certain medication. Any use of seclusion was care planned with the patient.
- On all wards, care plans were up-to-date, personalised and included the patients' views. However, nine of the 17 records we looked at across the three wards contained language in some areas that suggested the care plan had not been developed with the patient and used jargon. For example, they used language such as 'concordant' and 'optimum levels of functioning'. We also saw one example of a care plan for a patient on Maple Ward where staff had used 'I' statements throughout the care plan, but the patient had been recorded as being 'unable to engage with staff in regard to a plan of care'.
- On Maple and Beech wards, staff completed physical health assessments on admission in 10 out of the 12 records we looked at. For those that were not completed, many of the responses to the physical health assessment questions were listed as 'uncertain'. We saw physical health care plans for all of the 12 records we looked at. We saw evidence of ongoing physical health monitoring, although the recording of this was difficult to find in some of the records we saw. For example, for two of the records we looked at on Beech Ward, information about patients' health conditions was repeated in different tabs on the electronic recording system.
- Evidence of ongoing physical health monitoring accessed externally to the hospital, for example, GP appointments, hospital appointments, was not always available on the electronic recording system. Although we found this information by speaking with the doctors on the ward (who had very good awareness of their patient's physical health history and needs), this could mean that nursing staff were unable to find important information about patient's physical health.
- On Aspen Ward, care notes showed evidence of routine physical health monitoring on admission and throughout ongoing care. Staff completed physical health monitoring scales National Early Warning Score (NEWS) weekly with patients. NEWS measures physiological factors in patients to monitor health during a hospital stay.
- Occupational therapists carried out initial assessments with patients following their admission to the wards. Nursing staff could refer patients to the occupational therapy team for functional skills assessments.
- All staff had access to care notes, which was the electronic recording system on a secure password protected system. Maple and Beech wards kept yellow folders that contained important current information for each patient, including their care plans. Green folders contained historical information about each of the

patients. We saw that these were filed appropriately and easily accessible to staff. On Aspen, folders were marked with room numbers instead of the patient's name to support confidentiality.

Best practice in treatment and care

- We looked at 22 prescription charts across Maple, Beech and Aspen wards. Records showed prescription charts had regular anti-psychotic medication and as needed (PRN) medication prescribed. We saw that staff followed The National Institute for Health and Care Excellence (NICE) guidance and prescribed anti-psychotic medication within British National Formulary limits. Patients are prescribed medication in varying doses and this was monitored through weekly audits by the pharmacist. There was a process in place should patients be prescribed anti-psychotic medication over limits recommended by the British National Formulary to be monitored more closely for side effects in line with guidance and this was recorded in care records.
- A psychologist worked on Maple and Beech wards for one day per week each and twice weekly on Aspen Ward. Their role was primarily to carry out assessments and recommendations and work with the multidisciplinary team to help support the patients. A psychologist facilitated reflective practice sessions on a monthly basis. Reflective practice is the ability to reflect on one's actions to engage in a process of continuous learning. Staff could refer patients to the psychologist for one-to-one time-limited sessions. Staff told us that many patients already had psychological input from their community teams and some patients had psychologists/therapists that visited them on the ward.
- Patients could complete Dialectical Behaviour Therapy (DBT), through a partnership trust associated with Forward Thinking Birmingham. Forward Thinking Birmingham was a partnership between five services to provide a mental health service for 0-25 year olds in Birmingham. All of Maple and Beech wards' inpatient beds were exclusively for this treatment pathway. Aspen Ward had five available beds for this pathway. Some patients had accessed the Dialectical Behaviour Therapy service prior to their discharge. The provider trained nursing and occupational therapy staff in Dialectical Behaviour Therapy and the plan was for Dialectical Behaviour Therapy skills groups to be run on the wards. Staff and patients we spoke with told us that the wards and patients would have benefited from more psychology provision.
- Patients had good access to physical healthcare, including access to specialists when needed. We saw that care plans noted individual physical health care needs, such as asthma, and included referrals for further investigations where necessary. Patients' nutrition and hydration needs were met and the wards had access to a dietician whom staff could refer patients to.
- Staff used recognised rating scales to assess and record severity and outcomes. The Health of The Nation Outcome Scale (HoNOS) was completed for all patients at the point of admission to the service and reviewed routinely by staff thereafter. This is a measure of the health and social functioning of people with severe mental illness and contains 12 items measuring behaviour, impairment, symptoms and social functioning.
- Clinical staff participated actively in clinical audits, such as care plan audits and medication audits. The provider issued a patient satisfaction audit every two months and this captured how patients felt about the service and the ward environment.

Skilled staff to deliver care

- The full range of mental health disciplines and workers provided input to the wards. This included nurses, healthcare assistants, occupational therapists, occupational therapy assistants, a psychologist, a consultant psychiatrist, a speciality doctor, a dietician, an art therapist, a discharge liaison nurse and a visiting pharmacist. District nurses from community teams could also support patients where appropriate. Patients accessed social work input through Birmingham City Council and some patients had social work support from their community teams. Social workers attended patients' section 117 discharge planning meetings.
- A pharmacist visited each ward weekly, reviewed all medication charts and checked for prescription writing errors and Mental Health Act paperwork for patients administered medication who were detained.

- There were no non-medical prescribers employed as part of the ward staffing at the time of our inspection. All qualified nursing staff were required to undertake yearly medication management training.
- All clinical staff received an induction at the start of their employment with Priory. Healthcare assistants also completed a 12 week programme of work which mapped on to the Care Certificate. Staff reported that they completed much of this training online on Priory Academy e-learning and sometimes access to computers to do this training had been an issue.
- Staff received an induction to the ward where they would be working and were orientated to the ward by regular staff members. Induction checklists were completed by all permanent and bank or agency staff. The induction checklist covered topics including safeguarding, observation levels, risk assessments and the location of emergency lifesaving equipment including emergency drugs, oxygen and the location of ligature cutters. All staff were required to sign once they had received an induction in each area and a countersign was required by senior staff from the ward. All nursing staff employed on a bank or agency basis were interviewed by either the ward manager or the director of clinical services to ensure they were suitable for the position.
- Staff had access to specialist training where there was an identified training need. For example, one staff member told us that they had received training in personality disorders, autistic spectrum conditions and Asperger's. This was in response to the ward admitting patients with these diagnoses. Staff said they could request additional specialised training if they felt they needed it.
- All staff had received an annual appraisal, which was mapped against the values of the organisation. On Aspen ward, staff completing regular clinical supervision was 63% at the time of inspection. The service manager and local ward manager acknowledged the need to improve on completion and recording of both clinical and managerial supervision. Staff on Beech Ward, 79% of staff on had received regular clinical supervision. On Maple Ward, 89% of staff had received regular clinical supervision. Staff told us they could access supervision more frequently if they requested this. Management supervision was carried out monthly by the ward managers. Staff accessed reflective practice with the psychologist fortnightly.
- Staff had access to fortnightly team meetings. These were attended by staff that were on shift at that time. The minutes were displayed in the nursing office on Maple and Beech wards and in a communication folder for staff on Aspen Ward.
- Ward managers addressed performance issues through management supervision. We saw examples of this process being managed to ensure patients received high quality care. Staff who required additional support to complete mandatory training were prompted through management supervision and a plan was put in place to ensure they had time to do this. The ward manager reviewed this weekly until it had been achieved. There were no instances of disciplinary action on the wards in the six months before inspection.

Multidisciplinary and inter-agency team work

- Multidisciplinary team meetings took place twice a week on all wards. On Maple and Beech wards the team reviewed half of the patients on each ward in each meeting. As Doctors were based on the wards, they were also able to review patients throughout the week if required. We saw a range of multidisciplinary professionals attended these meetings. We observed that staff gave clear information to patients about their medication and reviewed the patient's requests. We saw some discussion with the patient around planning for their discharge.
- On Aspen Ward, multidisciplinary meetings were attended by the consultant psychiatrist, junior doctor, occupational therapist, and nursing staff. We observed a meeting during our inspection. Staff showed an excellent knowledge of individual patients. Discussions about treatment plans, discharge plans and liaison with care co-ordinators all took place during meetings.
- Handovers took place between every shift and these were well-attended by nursing staff and members of the multidisciplinary team where possible. Maple Ward had introduced the 'what' handover tool, which includes an awareness of each patient's historic risks. Domestic staff were also given a daily handover which related to all wards within the hospital and they handed over to each other within their team. There were additional seven

day handovers that allowed staff to look at themes and trends during the course of the previous week. This was to ensure any non-regular or absent staff were also aware of previous handovers.

- Staff worked well with each other across the wards. All ward managers attended a morning meeting with the service manager. The ward managers had good links with the clinical services manager who visited the wards regularly. Staff liaised often with the safeguarding lead and Mental Health Act lead. If patients transferred between wards, staff carried out verbal and written handover and worked together to ensure the patient was in the most appropriate placement for their presentation.
- We saw effective working relationships between Maple and Beech wards and a partner agency who attended the ward weekly as part of the Forward Thinking Birmingham pathway. Staff reported that this working relationship was good and helped to bridge the gap between the acute wards and the community. We observed joined up working between the two teams and an in-depth and holistic awareness of the patients' needs and plans. Staff worked with partner agencies to support patient discharge planning. There were effective working relationships with the home treatment team, who visited the wards once a week.
- Partner agencies who worked closely with the hospital told us they had good communication with staff on Aspen ward. They told us staff were good at escalating concerns appropriately to partner agencies. We observed staff working collaboratively with visiting staff external to the hospital. The ward manager had good links with another psychiatric intensive care unit within the Priory. They shared best practice regularly, both verbally and through exchanging visits to their services.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The Mental Health Act administrator examined each patient's Mental Health Act (MHA) papers on admission (as authorised by the hospital managers Mental Health Act code of practice 35.19). The Mental Health Act administrator carried out scrutiny of detention paperwork and the medical director scrutinised medical recommendations. Staff knew who their Mental Health Act administrators were. Mental Health Act administrators offered support in making sure the Act was followed in relation to renewals, consent to treatment and appeals against detention. The administrator offered support to staff and visited ward daily to collect documentation and prompt staff of expiry dates.
- There were clear records regarding leave granted to patients and contingency plans and risk management; including terms and escort arrangements. Where only one kind of leave granted to a patient was included on the patient's records, the terms and conditions were clear. Where there was more than one type of leave granted to a patient, for example overnight leave, emergency medical leave or community leave, the terms and conditions were not separated and therefore unclear. Patients, staff and carers (where applicable) were aware of the what community leave they had and where to.
- All staff on Beech and Aspen wards had received training in the Mental Health Act. Seventy-eight percent of staff on Maple Ward had received training in the Mental Health Act. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- Consent to treatment and capacity requirements were followed. Copies of certificates of authorisation for medication were attached to medication charts where applicable. This meant that nurses were able to check medicines had been legally authorised before administering any medicines.
- Patients had their rights under the Mental Health Act explained to them on admission and routinely and regularly after, depending on the needs of the individual. In two of the 12 records we looked at, there were some minor omissions in the rights forms. On Beech Ward, we saw no record of how staff made sure that a patient with identified communication needs was supported to understand their rights. On Aspen ward, of the five care records we reviewed, two contained a partially completed rights form with no indication of when it would be completed or why it was not complete.
- A central team provided administrative support and legal advice on the implementation of the Mental Health Act and its Code of Practice.
- Detention paperwork was filled in correctly, up-to-date and stored appropriately.

- There were regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from these audits.
- Patients had access to the Independent Mental Health Advocate (IMHA), which was provided by Voice Ability. This service had been commissioned by the local authority, in accordance with the Mental Health Act Code of Practice 2015. The Independent Mental Health Advocate introduced themselves to patients following their admission. We saw that there was not much uptake of the Independent Mental Health Advocate and were told that patients preferred to access the advocacy service provided by the National Youth Advocacy Service.

Good practice in applying the Mental Capacity Act

- All staff on Beech and Aspen wards had completed training in the Mental Capacity Act and 78% of staff on Maple Ward.
- There was a policy on Mental Capacity Act, including Deprivation of Liberty Safeguards, which staff were aware of and could refer to. There were no Deprivation of Liberty Safeguards applications made in the last six months on any of the wards.
- Most of the staff we spoke with had a good understanding of the Mental Capacity Act and its guiding principles. Staff showed us examples where capacity assessments had been appropriately carried out and how patients had been supported to make their own decisions where possible. However, two staff were not aware of the statutory principles of the Act, in particular principle three, which outlines that people have the right to make decisions that others might regard as unwise or eccentric. When given examples, staff were not always able to understand that patients can make unwise decisions and maintain capacity. We found no record of discussion between the responsible clinician and the patient about treatment either at three months or at first administration of medication.
- We found that the Mental Capacity Act diagnostic test was not present on the capacity assessment form. This meant that capacity assessments did not cover all areas required. The form did not contain a space or prompt to record how staff supported patients to make decision for themselves. On Aspen Ward, in records where a capacity assessment was required, one record contained a capacity assessment form including diagnostic test and space to record the support given to patient to make their own decision. However, we saw that a capacity assessment for one patient was not decision specific.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation. The provider had recently (two weeks prior to our visit) put arrangements in place to monitor adherence to the Mental Capacity Act within the hospital.

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

Kindness, dignity, respect and support

- On both Maple and Beech wards we saw staff interacting with patients in a calm and pleasant manner. On Aspen Ward, we observed caring interactions between staff and patients. Staff gave patients the time to express themselves. Staff initiated conversations and engaged in appropriate humour with patients. We saw some particularly friendly and caring interactions between individual health care assistants and patients.
- Staff on all wards were responsive to patients' needs. On Aspen Ward we saw staff ensuring patients were hydrated in the hot weather by regularly offering them cold drinks. Staff gave patients sun protection cream to wear when they used the outdoor space. We saw staff engaged with a new patient to support him to settle in to the ward and enable him with his choice of activity. Staff responded to the moods of their patients and noticed when individual patients were acting out of character.
- Staff we spoke with showed a good knowledge and understanding of the patients on the ward and their individual needs. For example, on Aspen Ward, one member of staff showed an in depth knowledge and understanding of how to support a patient with a learning need. The staff member showed an understanding of particular personality traits which could have impacted on the patient and how staff had managed this in order to support the patient.

- Patients on Maple and Beech wards reported that on the whole, staff were caring, friendly and quick to respond to their needs. Patients felt that staff treated them well and communicated positively with them. Patients told us that staff respected their privacy and dignity by always knocking on their bedroom door before opening it. However, two patients on Maple Ward raised concerns about their privacy and dignity relating to the use of CCTV cameras around the ward, particularly in the female lounge and the courtyard.
- On Aspen Ward, we received nine comment cards and spoke with five patients. Patients told us the ward was safe and comfortable. Most patients who commented told us the food on the ward was good. One patient told us they would have liked bigger portion sizes. Another told us they liked the food, but felt cultural variety could improve. Patients told us they felt listened to by staff, but three raised some concerns about attitude and treatment by individual staff members. They told us the staff team as a whole were supportive and caring. All patients we spoke with told us they felt the environment was too restrictive in relation to items they could bring on the ward or allowed to use and where they were allowed to go unsupervised. One patient felt their rights were not fully explained to them; but felt staff responded well to them.

The involvement of people in the care they receive

- Staff orientated patients to the wards on admission. They gave them a welcome pack with information about the ward, and general information about how to access advocacy and how to feedback about the service. However, one patient on Maple Ward told us that they had not received any information about treatments on the ward and another patient said that they were not given any information about the ward and treatments until seven days after their admission.
- We spoke with 11 patients across the three wards. Patients we spoke with on Maple Ward said that they were involved in their care plans and staff listened to their views regarding their care and treatment. However, one patient on Maple Ward and patients we spoke with on Beech Ward were not aware of areas of their care plan and did not feel involved in decisions made about their care. For example, two patients on Beech Ward did not know why they were on their current level of observation and one patient did not know who their named nurse was.
- Patients on Aspen Ward told us they knew what was in their care plan and staff had involved them fully in the process. Patients also told us their family had been involved in care planning. We observed staff meeting with patients and their families to give feedback. One carer told us they had been fully informed through every step of their child's care both in person and through telephone calls.
- During multidisciplinary meetings on Aspen Ward, we observed staff had a good rapport with patients and gave them regular opportunity to input into discussions about their treatment. Carers were also included in the discussions and were able to express their opinions. Staff ensured patients and carers understood discussions by checking with them before the end of the meeting.
- On Maple Ward, we saw that patients had information displayed in their bedroom, which showed them who their named nurse was, who their doctor was and what day their ward review meeting would take place. This was in response to patients' concerns about not knowing this information.
- We saw that staff involved patients in their care in ward review meetings. For example, in the Maple Ward review meeting, we saw that medication and discharge planning were discussed together with the patient, as well as other areas of their care and treatment plans.
- National Youth Advocacy Services (NYAS) provided advocacy services throughout the hospital. Five of the patients we spoke with across all wards were not aware that they could access advocacy services.
- On Maple and Beech wards, one carer we spoke with told us they had been fully involved in their family member's care and treatment and had regularly attended meetings at the hospital. However, two out of three carers we spoke with across both wards did not feel involved in their family member's care and treatment. They told us they had not been given any information about the service, their family member's treatment or care plans and had not had regular updates about their family member's care. These two carers had not been given information about how to complain. None of the carers we spoke with knew how to give feedback on the service.

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

- Patients were able to give feedback about the service they received through patient satisfaction surveys, and daily mutual help meetings. These meetings took place on the wards and encouraged all of the patients to come together to discuss issues, concerns or requests on the ward. The hospital manager chaired regular 'voice' meetings in which patients and staff were given the opportunity to give their feedback on the service and areas for improvement.
- A patient satisfaction survey was conducted on Maple and Beech wards across a range of 22 questions relating to period January to March 2017. Of the 22 questions, nine received a positive response rate above 85% and all questions received a score over 75% with the exception of three. These questions related to satisfaction in experience with the junior doctor (70%), how they would rate their recent stay (71%) and how likely they would be to recommend the service to a friend or relative (31%). The highest scoring questions included: whether patients felt safe during their stay (100%), did a member of staff orientate the patient to the ward on admission (93%) and was the patient treated with respect and dignity (93%).
- On Aspen Ward, patients were asked 30 questions. Of these, 21 received a positive answer over 85%. The highest scoring questions were: choice of food (97%), staff communicated in a way the patient can understand (97%) and access to an advocate (96%). The lowest scoring questions were: the patient knows how to access their medical records (52%) and the patient is aware of the possible side effects of their medication (69%). We saw the clinical services manager had produced an action plan following the results of the patient survey to improve the experience of patients on the ward.
- Patients were able to get involved in decisions about their service. For example, on Beech Ward, one patient told us how some money had been donated to the ward and the ward held a meeting to ask patients how they would like this money to be spent. On Maple Ward, one patient reported they felt listened to and equal to staff in making decisions about the ward and their care. The ward manager on Aspen Ward produced a monthly 'you said' and 'we did' information leaflet regarding changes made on the ward resulting from patient feedback and suggestions made in community meetings.
- Staff actively involved patients who had previously used the service to make improvements and involved current patients, with the help of an identified staff member. The hospital director was involved in this and was recognised as someone who was proactive and would get things done.

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

Access and discharge

- The average bed occupancy in the six months before inspection on Aspen Ward was 86%, on Maple Ward was 96% and on Beech Ward was 79%. This number was lower for Beech Ward as the ward only opened in January 2017 and therefore the ward was gradually filled. The Royal College of Psychiatrists recommends an 85% bed occupancy rate for mental health wards therefore two of the three wards had a good level of occupancy.
- The hospital accepted patients from all areas. Five beds on Aspen Ward were allocated for patients eligible for treatment through Forward Thinking Birmingham, who lived in the Birmingham area. There were six patients placed on Aspen Ward who were from outside the Birmingham area in the six months before inspection. No patients on Beech and Maple wards were from out of area.
- Patients always had access to a bed on return to the ward following a period of leave.
- Staff told us they were not always able to refuse new admissions to the ward when they felt that the new admission may not be suitable for the current gender mix of patients on the ward. This meant that on Maple Ward, there were more male patients than female patients, despite this being a concern for the staff team. This resulted in female patients being asked to move bedrooms to ensure that the bedroom corridor was split into male and female zones, in accordance with the guidance in the Mental Health Code of Practice. However, the ward managers explained that they worked together to determine the most suitable ward

for new admissions where possible. For example, a patient was discharged from Maple Ward and was readmitted to Beech Ward due to concerns on Maple Ward during their previous admission.

- Patients were not moved between wards during an admission episode unless this was justified on clinical grounds and was in the interests of the patient. For example, there had been transfers between the acute and psychiatric intensive care unit (PICU) when patients had become acutely unwell or when patients were able to step down as they required less intensive support. We saw flow charts displayed in the nursing offices to show staff the process for referring a patient to the PICU.
- There had also been transfers between the two acute wards to manage safeguarding concerns between patients. This was appropriate as it did not affect the patient's level of acuity of care, but supported the patient during their admission.
- Patients were generally moved or discharged at an appropriate time of day. However, there had been occasions when patients had arrived at the hospital late at night. Staff told us that this was due to these patients travelling long distances from other services.
- Staff told us they worked closely with the Aspen Ward to make sure a bed was always available on the Psychiatric Intensive Care Unit if a male patient required more intensive care. All patients on Maple and Beech wards were part of the Forward Thinking Birmingham care pathway. If they needed to be moved to Aspen Ward PICU, there would need to be a bed available from the five allocated beds for Forward Thinking Birmingham patients. If there were no available beds, the service would need to get authority to purchase a private bed. Staff felt that this was a straightforward process. As the PICU was located on the same site as the acute wards, this remained sufficiently close for male patients to maintain contact with family and friends. No female patients had been sent to a PICU, but staff told us this would involve Forward Thinking Birmingham contacting other Priory locations, which may be out of area.
- In the six months before inspection, there had been two delayed discharges on Maple Ward and two delayed discharges on Beech Ward. The reasons for delayed discharge were often due to social issues such as lack of accommodation and appropriate placements. On Aspen Ward, there were 13 delayed discharges in the six months before inspection. Seven of the 13 were for non-clinical reasons.
- There was a discharge co-ordinator employed for patients accessing Forward Thinking Birmingham beds to support the transition and reduce instances of delayed discharge. The discharge coordinator reported good links with the home treatment teams and community care coordinators. The discharge coordinator met weekly with the acute ward managers, the medical team and a partner within Forward Thinking Birmingham, who supported coordination of patients care, to discuss progress, discharge planning and identify care needs for the patients upon their discharge.
- We observed that staff were considering discharge plans in multidisciplinary meetings and had discussed this with patients and carers in detail. However, in the care records we reviewed, staff had not recorded discharge plans or detailed discussions of discharge arrangements. For example, for one patient's ward review meeting minutes, discussions around discharge planning was recorded as 'assessment at [location]'. We did not find clear discharge plans in place in any of the care records we looked at. All but one of the patients on Maple and Beech wards we spoke with were unaware of their discharge plans.

The facilities promote recovery, comfort, dignity and confidentiality

- There was the full range of rooms and equipment to support treatment and care on all wards. On both Maple and Beech wards, there were fully equipped clinic rooms, a meeting room, space for therapeutic activities, a kitchen, a female-only and mixed lounge and access to a courtyard. On Maple Ward, there was a multi-faith/ respected space room that was shared between the two wards. Aspen Ward had enough rooms and equipment to support treatment and care. The ward had a clinic room, an activity room, a gym, a communal area and a quiet lounge. There were rooms available for patients to be seen for one-to-one sessions. All rooms were soundproof and confidentiality was maintained.
- There was access to quiet areas on both Beech and Maple wards and a room where patients could meet visitors. Patients were able to show visitors their bedrooms. Aspen ward had two separate rooms

patients used to see visitors. The rooms were accessible from the ward and also from the outside. This meant that visitors did not have to walk through the ward area when seeing patients. This also meant children could access the ward for visits without having to walk through the ward. The rooms were furnished comfortably and staff followed safety procedures when using these rooms to ensure detained patients could not leave the room through the external door.

- Patients had access to their own mobile phones. On Aspen Ward, each patient could have a mobile phone supplied by the ward while on the ward. They could use this with their own SIM card in order to keep in touch with friends and family. On Maple Ward, patients raised issues around the use of the phone. Patients told us that there should be a pay phone that they can use during the day time as they were discouraged from using the ward phone between 9am and 5pm so staff could use the line for clinical related calls. Staff told us that this was accurate and although patients were able to use the phone in this time, they were discouraged from making phone calls during these hours. There were no issues raised around the use of the phone on Beech Ward.
- Patients had access to outside space on all wards. On Beech Ward, this was supervised by staff due to there not being any CCTV cameras located in the courtyard. On Aspen Ward a staff member accompanied all patients while accessing outside space. There was a fenced courtyard with a seating area and access to some outdoor games.
- Patients on Maple and Beech wards gave mixed feedback on the quality of the food on the ward. Most patients told us that the food was good and they enjoyed having the option of takeaway nights. One patient told us the portion sizes were too small. Some patients told us they wished there was more choice. Patients we spoke with on Aspen Ward told us the food was of good quality and there was enough choice. Two patients told us that they would like bigger portion sizes and one patient told us they would like to access food from their own culture.
- Patients had access to food and drinks 24 hours a day with the support of staff. Patients could keep snack foods separately and staff supported them to have access to these. Patients also had access to take-away food once a week.
- We saw that patients were able to personalise their bedrooms and we saw many had chosen to do so.
- Patients had somewhere secure to store their possessions. On Maple Ward, this was currently within individual patient storage boxes within the staff room. On Beech Ward, patients' possessions were stored in individual storage boxes within the nurses' office and additional storage was available in locked compartments underneath patients' beds. On Aspen Ward, this was within a locked safe in lounge on the ward or in a safe in the ward manager's office.
- Activities took place on all wards and we saw activity planners displayed on the wards. Health care assistants ran these activities at the weekends. Activities included bingo, movie nights, relaxation, yoga, mindfulness, baking and art therapy.
- On Beech Ward, the ward had purchased five corporate passes for a local botanical gardens centre. These passes were used for staff, patients and their families during community leave. Most patients told us that activities took place a few times a week.
- On Maple Ward, we had mixed feedback about the frequency and suitability of activities. Two patients reported that activities did not take place daily and these activities were not varied to suit the needs of individuals. Other patients on Maple Ward, told us that activities led by the occupational therapy team always took place, whereas some of the ad-hoc sessions led by the nursing team were reliant on availability of staff. Two patients told us that activities and leave were cancelled due to staff shortages.
- On Aspen Ward, some patients told us they were bored. However, we saw staff gave patients the option to participate in structured daily activities and had a time table displayed in the main ward area. We saw patients participating in activities with occupational therapy staff. Patients were given a choice whether they wanted to participate and staff encouraged them in areas such as physical activity and exercise.
- We observed an occupational therapy session and an initial assessment. Staff engaged well with patients and listened to their views and opinions. We also observed an activity session and saw staff supporting patient-led activity.

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

Meeting the needs of all people who use the service

- Aspen Ward was accessed on one level. Patients who required wheelchair access could easily enter the ward through the front entrance. All bedrooms on the ward had been designed to accommodate wheelchair access. There were bedrooms on Maple and Beech wards that were wheelchair accessible with toilet and wash facilities. There was a working lift for patients or visitors who required disabled access to enter the ward. There were no patients requiring disabled access on the wards at the time of our inspection.
- Information leaflets were available in languages spoken by people who used the service. The service was able to access interpreters and/or signers through a local service that provided this support.
- Patients could request food which met their dietary and religious requirements, such as vegetarian, gluten free and halal.
- There was provision of accessible information on treatments, local services, and patients' rights and how to complain displayed on the wards. There was also an easy read version of the patient satisfaction survey. On Maple Ward, we also saw there was a noticeboard which showed which staff were allocated to each patient for different tasks/activities during that shift. This was introduced to support patients to know who their named nurse was and how to easily access support from staff.
- Patients had access to appropriate spiritual support. Ward managers told us that as these services were not contracted through Priory, they were able to contact local spiritual leaders if patients requested this. There was a multi-faith room on Maple Ward, which patients on Beech also used. This room contained religious and spiritual materials. Patients were able to request additional materials and we saw that one patient had requested a prayer mat and this was being sourced. On Aspen Ward, staff had purchased religious books for patients to access while on the ward. There was a quiet room on the ward patients could use for religious and spiritual needs.

Listening to and learning from concerns and complaints

- Aspen Ward received six complaints in the 12 months before inspection, one of which was upheld by the service following investigation. No complaints were referred to the Parliamentary and Health Service Ombudsman. The ward received 15 compliments in the 12 months before inspection.
- Maple Ward had received three complaints in the past 12 months. Two of these complaints were upheld and related to lost property, which had been replaced.
- Beech Ward had received two complaints in the past 12 months. One of these complaints was upheld and related to their discharge and care in the community. This resulted in staff now having NHS logins so they could access information regarding the patients' discharge plans. In addition, a standard discharge form had been produced to address the concerns raised in this complaint.
- Not all patients on Beech and Maple wards knew how to complain. Three out of seven patients we spoke with across the two wards did not know how to make a complaint. We saw that this information about how to complain was displayed on the noticeboard on Maple Ward. This information was not displayed on Beech Ward. Patients we spoke with on Aspen Ward knew how to complain if they wanted to and the process displayed on the ward.
- Staff we spoke with were aware of the complaints policy and how to escalate concerns raised by patients and carers. The service followed its own policy on handling complaints.
- Staff received feedback from managers about complaints through management supervision, by email and through governance meetings.

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

Vision and values

- Woodbourne Priory Hospital cited its's purpose as 'to make a real and lasting difference for everyone we support' and that it aimed to do so by adapting the behaviours of: putting people first, being a family, acting with integrity, being positive and striving for excellence.

- Staff on Maple and Beech wards were aware of the organisation's values and objectives and we saw these embedded into the values of the teams we saw. Staff also told us that the Priory values were addressed in the nurse development training programme. Staff we spoke with and observed on Aspen Ward demonstrated the values of the organisation, but were not able to describe specifically the values of the organisation despite these being part of the appraisal process. The organisation had undergone a merger and rapid expansion in the 12 months before inspection and the values of the organisation had not yet been embedded.
- All staff we spoke with knew who the senior managers in the organisation were and reported that they visited the ward regularly. Staff described the senior managers as approachable, accessible and interested in the well-being of the patients in their care. Most staff reported the senior leadership team were supportive. One staff member felt that higher management made decisions without liaising with ward staff.

Good governance

- There was a good clinical governance system in place throughout the hospital. The senior management team met monthly and there were daily morning managers meetings that reviewed any risk issues or fed back any learning. Senior managers knew what the main risks associated with the hospital were and were able to discuss them with good knowledge. There was wider scrutiny of governance by the Priory organisation.
- We saw that there were good governance structures in place for monitoring ward systems and processes. For example, supervision and appraisals were monitored. However, we found some issues relating to training compliance and it was unclear how the systems' alerts were actioned by ward managers.
- The hospital had recently gone through a period of rapid expansion. Since the previous inspection in November 2015, the bed capacity of the hospital had more than doubled and the number of wards had increased from three to six. They had introduced a psychiatric intensive care unit, a specialist eating disorders unit and two wards dedicated to patients eligible to access a new 0-25 service Forward Thinking Birmingham. There were governance systems and regular meetings in place through the senior management team and at ward level which fed into the Forward Thinking Birmingham partners.
- Changes to the staffing numbers on the wards was raised as a concern across the wards. Staff on Maple and Beech reported that they there were times when they were unable to facilitate escorted leave or activities due to the reduced number of staff on each shift. Patients we spoke with echoed this concern. Staff on Aspen Ward told us they managed, but on occasion at the detriment to their own breaks.
- We spoke with the director of clinical services regarding staffing. They told us that they had been given autonomy by senior management within the Priory over staffing levels if there was a clinical need to increase. They advised the staffing levels were appropriate to the acuity of the patients and the size of the wards when compared like for like to other services within the Priory group and externally.
- We found that there were good processes in place to support staff to learn from incidents and act on service user feedback. The introduction of the Mutual Help daily meetings on Maple Ward was an example of how staff gave patients opportunities to give their feedback on the daily running of the ward. The medical director chaired a monthly risk meeting for the hospital. Staff could submit items to the risk register through the ward managers.
- The provider used 'dashboards' to monitor key performance indicators such as training, supervision and appraisals and other indicators to gauge the performance of the team. These measures were in an accessible format and used by the staff team to identify areas of concern. Ward managers reported concerns with the recording system of these systems, particularly with regards to the recording of supervision.
- During inspection we found inconsistencies in how ward managers recorded and monitored completion of staff supervision. The dashboard used by the service was only able to capture recording of clinical supervision each month. This meant recording of managerial supervision was carried out by individual ward managers. The dash board did not record attendance at fortnightly reflective practice sessions. This also meant senior managers would have limited oversight of actual staff completion figures and relied on ward managers to keep up to date records.

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

- Mandatory training rates overall were good across all wards. However, compliance rates for safeguarding adults and children training were very low on Maple and Beech Wards, and in one instance on Aspen Ward.
- There were two quality improvement leads, which were due to expand to four, who were responsible for supporting wards with improvements. Senior managers walked the wards regularly with patients to identify areas for improvement and highlighted issues or concerns that needed addressing. These were then acted upon without delay. The service also monitored the quality of care plans and care notes and this data was held centrally within the hospital.
- Ward managers held sufficient authority and administration support to do their roles effectively. A ward clerk provided administrative support. There were times when the ward manager supported staff on the ward, but were still able to carry out their own duties.
- Staff took a proactive approach to safeguarding, there was a good process in place to recognise and respond to safeguarding concerns. Staff knew who the safeguarding leads were within the organisation.
- There was good provision in place for reviewing the Mental Health Act through the Mental Health Act administrator. However, there had been no one in place to monitor adherence to the Mental Capacity Act until two weeks before the inspection took place. The Mental Capacity Act diagnostic test was not present in the standard Priory Mental Capacity Act assessment form.
- Staff were able to submit items to the service's risk register. There was good monitoring of this risk register at ward level and the staff had ward-level risk registers to highlight key areas on concern relating to individual wards.

Leadership, morale and staff engagement

- Staff working on all wards had low levels of sickness and reported no bullying or harassment cases.
- Staff knew know to use the whistle-blowing process and felt able to raise concerns without fear of victimisation. Staff reported feeling well supported by their managers and described the ward managers and senior leadership team as approachable.
- Morale and job satisfaction was high across all wards. Staff told us they enjoyed their role and felt that the teams worked well together. On Maple Ward, the provider had introduced a 'staff member of the month' scheme and patients and staff were encouraged to vote. On Aspen Ward, staff told us they loved their job. Staff told us they felt they could discuss issues with their team in an open and non-judgemental way.
- Staff were given opportunities for leadership development. Nurse development training was offered to qualified nurses to support them with career progression. Health care assistants completed the care certificate as part of their induction in to the role. Staff reported there was progression within the service. On Maple Ward, staff told us that health care assistants were encouraged to support patients with specific tasks such as reviewing their care plans. The ward manager told us that this had been well received by the health care assistants and helped to empower these staff members. On Aspen Ward, a health care assistant had been recruited to a trainer position in addition to their role.
- We saw good team working and staff told us they felt supported by the team around them. Ward managers were well supported by the senior leadership team. The manager of Beech Ward told us they had been well supported during the opening and transitionary phase of Beech Ward.
- Senior managers had the skills and passion to carry out their roles effectively. Senior managers, including the hospital director, medical director, director of clinical services and support services manager had excellent knowledge of individual wards and patients. This was evident in their daily visits and visibility on wards across the hospital.
- Staff were given the opportunity to feedback on services and input into the service development through staff forums and clinical governance meetings. Senior staff invited all staff to a monthly staff forum where they were able to give feedback on the running of the service. Staff reported they felt valued and listened to within these meetings. Clinical governance meetings took place once a month and ward managers fed back the learning from these meetings to the rest of the ward staff through clinical risk bulletins. There was also a staff representative on each ward that met with the senior leadership team and fed back to the team any updates or changes.

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

Commitment to quality improvement and innovation

- All of the wards had begun to introduce the Safewards model. Safewards is a model that aims to keep psychiatric wards as safe as possible by reducing patient behaviours that can result in harm. We saw the implementation of this by staff providing consistent messages, good team working and being attentive to patients' needs.
- Aspen Ward was part of the national associate of psychiatric intensive care units (napicu).
- All nursing staff were registered to receive alerts by email about changes to medication and national guidance.

Child and adolescent mental health wards

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are child and adolescent mental health wards safe?

Safe and clean environment

- Rowan Ward had moved to a purpose built ward in January 2017 and the furniture on the ward and decoration was relatively new. There was a large communal area that could be observed from the nursing station with two corridors leading off it. On Mulberry Ward there was a smaller communal area. There was always one member of staff in the communal areas and lines of sight was good on both wards. Mulberry Ward was an older ward and the furniture and decoration was well maintained, but in need of redecoration. Staff told us Mulberry Ward was scheduled for refurbishment. Both wards looked visibly clean, there were domestic staff who cleaned the wards daily, and the staff expected the patients to clean and tidy their bedrooms.
- Staff completed up-to-date environmental risk assessments, including ligature risk assessments. A ligature is something used for tying or binding something tightly and can be used to self-harm. A ligature point is a place where patient who want to self-harm might use to tie something to strangle themselves. All fixtures and fittings on Rowan Ward were anti-ligature. On Mulberry Ward, there were ligature points identified, but staff had reduced the risks using observation and individual risk assessment of patient.
- Patients on both wards had their own bedrooms with en suite bathroom and toilet. On Rowan Ward, male and female bedrooms were allocated at different ends of the ward. On Mulberry Ward, there were male and female bedrooms next to each other. Privacy and dignity was not compromised as it was not possible to see into rooms when walking past and staff used observations to reduce any risk. This complied with the Code of Practice and department of health same sex guidance, as no members of one sex had to walk through an area occupied by the other sex to reach toilets or bathrooms.
- Both wards had fully equipped clinic rooms with accessible resuscitation equipment and emergency drugs. Rowan Ward had a couch for physical examination in the clinic room and on Mulberry Ward there was a separate room for physical examinations.
- Records showed both wards checked their emergency bags daily, however on Rowan Ward, we found four out of five 5ml syringes were out of date since April 2017. The checks showed staff had ticked to say the syringes were present. We raised this with ward staff and the syringes were replaced immediately. The deputy manager told us staff would be reminded checks needed to include ensuring equipment was in date rather than just ensuring equipment was present.
- At the time of inspection, Rowan Ward did not have a thermometer to record the clinic room temperature and the room felt very warm. Staff told us this was because the thermometer batteries had run out two weeks previously and there was a delay in replacing them. When we raised this with the deputy manager, the batteries were replaced the following day and a fan installed. The next day the thermometer read 27C which was higher than recommended storage temperatures for most medications. We contacted the pharmacist who advised the efficacy of the medication would not be compromised, as it had not been exposed to high temperatures for a prolonged length of time.
- There were hand gel dispensers at the entrance of each ward and we observed staff using them correctly in line with infection control principles. We saw members of staff with long painted nails. This was not in line with the Priory's policy on Standards of Dress, Uniform and Personal Appearance that stated nails should be short and unpolished.

Child and adolescent mental health wards

- All equipment was well maintained and safety stickers were visible and in date.
- All staff on the ward carried alarms that could be used to attract the attention of staff in the event of an emergency or as a nurse call system. Staff were able to respond quickly in the event of an incident and staff from other wards could also respond to emergency alarms. There were nurse call systems in every bedroom for patients to use.
- The wards did not have seclusion rooms. If a patient required seclusion, they would be secluded on an adult ward.

Safe staffing

- At the time of inspection, there were no staff vacancies on either ward. The annual staff turnover rate for Mulberry Ward during the period June 2016 to May 2017 was 21%. Staff turnover for Rowan Ward in the same period was 11%.
- The sickness rate for the 12 months up to March 2017 was 2% on Mulberry Ward and 3% on Rowan Ward, this was low.
- The ward managers were able to increase the staffing to reflect the acuity of the patients. The ward managers said they use bank nurses in the first instance and then agency staff. Where possible they try to block book staff and use staff that were familiar with the ward. The number of shifts that were covered by bank or agency staff on Rowan Ward between March 2017 and May 2017 was 12% and on Mulberry Ward, it was 14%.
- Rotas showed there were enough staff on each shift. A member of staff was present in communal areas at all times on both wards. Staff and patients told us there was enough staff for each patient to have one-to-one time and leave or activities were rarely cancelled due to staffing issues.
- The wards had adequate medical cover 24 hours a day. A consultant psychiatrist provided medical input Monday to Friday between the hours of 9-5. Out of hours on call medical cover was provided through a rota system and details were held in the staff office of the on call arrangements and contact details. Staff and patients reported no concerns about accessing a doctor and stated that the system worked well. Staff told us there was adequate medical cover day and night and a doctor could attend the ward quickly in an emergency.
- At the time of inspection, 85% of Mulberry Ward staff had completed their mandatory training and 75% of Rowan Ward staff. The target for mandatory training for the service was 90%.

Assessing and managing risk to patients and staff

- There was one occasion of seclusion of a patient from Rowan Ward between September 2016 and February 2017. The seclusion lasted 120 minutes and child and adolescent mental health staff were present throughout.
- There were 18 incidents of restraint involving six patients during the six months before inspection on Rowan Ward and 36 incidents of restraint involving 12 patients on Mulberry Ward. The hospital did not routinely collect data on how long the restraints were held for. There were no incidents of prone restraint as Priory hospitals management of violence and aggression training does not include it. Records showed following restraint staff monitor the physical health of the patient.
- The management of violence and aggression training staff received ensured the emphasis was on de-escalation techniques and this made up 50% of the training. All of the staff we spoke to were able to explain how they would respond to violence and aggression and showed they had a good understanding of de-escalation. We saw a staff training video made by an ex patient who spoke in her own words about her experience of restraint and how best to communicate with the patient prior, during and after restraint. The Priory group had a steering group for reducing restrictive practice where they shared learning across all hospitals.
- There was good medicines management practice; both wards had a hatch in the clinic room door they dispensed from and patient came up one at a time to ensure their privacy was maintained. If required then staff would take the medication to the patient. There was some medication in the medication cupboard labelled as waiting to be destroyed. The delay was because policy states a pharmacist should be present.
- A pharmacist visited the ward weekly to audit medication and medication charts. Medication was delivered from the pharmacy to hospital by courier and collected by designated nursing staff. The pharmacist visited the wards weekly but did not always need to speak with staff.

Child and adolescent mental health wards

- There were no non-medical prescribers employed as part of the ward staffing at the time of our inspection and all qualified nursing staff were required to undertake yearly medication management training.
- Staff told us they used intra muscular rapid tranquillisation if oral medication had been refused. Records showed physical health monitoring was completed following a patient receiving rapid tranquillisation.
- We looked at every patient record and saw staff had completed an up-to-date risk assessment using a recognised tool. We observed staff updated the risk assessment at every multidisciplinary meeting and after every incident. Risk assessments we looked at corresponded to the patient's risk care plan.
- There was a list of restricted items on each ward and each patient was individually risk assessed to determine what they were allowed in their room and what access to the kitchen and the grounds they had.
- Staff searched patients randomly following leave from the ward or if they had reason to suspect the patient may have a restricted item. Staff also conducted random room searches. Staff said they always seek the patient's consent before carrying out a search and staff recorded this in the patient's electronic care record. This was in line with Priory's policy on Searching Service Users and Their Belongings in a Treatment Environment.
- There were signs on both wards informing informal patients if they wanted to leave, they needed to speak to the nurse in charge. However, both ward managers explained that as they are children's wards an informal patient would not be able to leave the ward unaccompanied by staff.
- On Mulberry Ward, 95% of staff were up-to-date with level 3 children's safeguarding training and on Rowan Ward 76% of staff were up-to-date. Staff on both wards could give examples of how they would recognise abuse and take action. There was clear guidance to ensure safety of any children that visited the ward.

Track record on safety

- There were no reported serious incidents for child and adolescent mental health wards during the 12 months before inspection. Ward managers told us if there was any learning from any serious incidents throughout the hospital or Priory group then it would be communicated through the governance group and staff handovers.

Reporting incidents and learning from when things go wrong

- The staff we spoke with knew what an incident was and how to report it. Mulberry Ward gave an example of how they developed a detailed handover sheet following an incident of an agency staff letting a patient access their bedroom alone. Other wards had since adopted the handover sheets.
- There was a risk management meeting and a clinical governance meeting held monthly. Staff shared learning between wards and produced a risk bulletin, which was then circulated to staff. The Priory group shared learning from incidents across their services during governance meetings. The director of clinical services, conducted team incident reviews and determined lessons learned.
- Staff and patients told us they had debriefs following any incidents. Staff occasionally held reflection groups together with patients so everyone could reflect together and be assured they were all well. This practice began following a community meeting called by a patient because she was worried about the staffs' well-being.

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- We looked at all of the patient's care records. All records showed a doctor and a nurse had completed a comprehensive and timely assessment soon after admission whether the admission was within hours or out-of-hours.
- Records showed a doctor completed a physical examination and there was ongoing monitoring of physical health problems. One of the patients on Rowan Ward had type 1 diabetes and we observed a multidisciplinary discussion around how best to support them in managing their diabetes. We saw staff completing regular blood monitoring checks to monitor the patient's blood sugar levels, and explaining to them what the results mean and what action they would need to take.
- The wards used an electronic care notes system to record the patient's risk, care plans and progress. There were four main electronic care plans; keeping safe, keeping well, keeping heathy and keeping connected.

Each care plan related to areas of a patient's recovery and included aspects of physical health, family and support network involvement, risk management and therapeutic activities. One of the preceptorship nurses had developed prompts in order to support the nurse and patient in completing their care plans. The care plans across both wards were recovery focused and reflected the patient's views. Records showed staff offered each patient a copy of their care plans. There were also two sets of paper files for each patient. One file contained relevant contact details and Mental Health Act paperwork and the other one contained historic care plans and multidisciplinary meeting notes. These were stored securely in the nursing offices.

Best practice in treatment and care

- Prescription records showed doctors prescribed rapid tranquilisation medication outside of National Institute of Health and Care Excellence guidelines. The guidelines state that Lorazepam should be used but the hospital prescribed Promethazine. Staff told us Promethazine was used when Lorazepam was contra indicated, this means when it cannot be used for a number of reasons, including allergy or if the patient had certain medical conditions. However, we did not see written evidence of this clinical reasoning within care records.
- The hospital followed the National Institute of Health and Care Excellence guidance with regard to psychological therapies; they offered a range of therapies including, occupational therapy, cognitive behavioural therapy, family therapy and drama therapy. In addition, a personal trainer and yoga teacher visited the wards weekly.
- If the patients required intervention from physical healthcare specialists then staff would refer them and would support the patient in accessing the treatment.
- We saw staff on both wards used recognised rating scales to assess and monitor the patients' acuity and progress. The wards mostly used Health of the Nation Outcome Scales for Child and Adolescent Mental Health and the Children's Global Assessment Scale. They completed these on admission, midway and discharge.
- Records showed nursing staff participated in weekly clinical audits including record keeping and risk assessments. There were also regular quality walk rounds completed with a patient from each ward. These walk rounds checked for things like the tidiness of the ward and whether each staff member was wearing a name badge, as well as asking the patient about their experience as a patient.

Skilled staff to deliver care

- There was a good range of mental health disciplines needed for a child and adolescent mental health ward; mental health nurses, learning disability nurses, paediatric nurse, nursing assistants, social workers, occupational therapists, psychologists, family therapist and doctors. The staff were all sufficiently qualified, some were very experienced and others were newly qualified. It was mandatory for all nursing assistants to complete the Care Certificate or be trained to NVQ level 3.
- All new staff to the ward received an appropriate induction from a senior member of staff and were orientated to the ward by regular staff members. Induction checklists were required for all permanent and bank or agency staff. The induction checklist covered topics including safeguarding, observation levels, risk assessments and the location of emergency lifesaving equipment including emergency drugs, oxygen and the location of ligature cutters.
- All staff received clinical and managerial supervision on a regular basis and records showed all staff had received an appraisal. Staff meetings were held monthly.
- Ward managers told us that there were no current staff performance issues at the time of inspection.

Multidisciplinary and inter-agency team work

- Both wards held weekly multidisciplinary team meetings led by the psychiatrist. Members of the team, including education, reported on the patients' progress and reviewed any risks before a discussing the best way forward for that patient. The patient was then invited into the meeting in order to hear what decisions had been made and was given an opportunity to express their views. The doctor acknowledged that the multidisciplinary meeting was not an appropriate environment in which to do this as there were up to 10 professionals in the room. The doctor explained they would see the patient on a one-to-one basis to hear their views if they did not feel comfortable raising them in front of everyone. We observed one patient ask for

her bathroom privacy status to be reviewed and the members of the multidisciplinary team listened to her, discussed the risks with her and came up with an action plan that was agreed by all.
- Handovers were between night and day ward staff and included observation levels, any incidents that had taken place in the past 24 hours and a summary of the previous week. A more detailed printed out handover sheet was also given to staff so they could see at a glance the relevant information regarding the patient they were observing.
- Records showed there was joint working with community teams, schools and the local authority. We observed a community team visiting a patient at the time of inspection and they discussed the patient's care with the ward staff.
- The occupational therapy team and the education team had agreed a timetable of sessions so the patient did not have to choose between occupational therapy and education and sometimes they ran groups together, for example, arts and crafts.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- The staff we spoke with demonstrated a good understanding of the Mental Health Act and its Code of Practice. On Rowan Ward, 91% of staff had up-to-date training and 96% on Mulberry Ward. All of the staff knew how to access the Mental Health Act administrator if they needed advice.
- The Mental Health Act administrator created and monitored a spreadsheet system to manage patient information relating to detention including, expiries, consent to treatment and appeals against detention. The administrator offered support to staff and visited ward daily to collect documentation and prompt staff of expiry dates.
- We looked at all of the detained patients' files and found all of the Mental Health Act paperwork was in order and there were approved mental health practitioners reports in the files.
- Consent to treatment forms were in place where required.
- Records showed patients had their rights read to them when necessary.
- There was access to an Independent Mental Health Advocacy service; their contact details were visible to patients on the wards.

Good practice in applying the Mental Capacity Act

- All staff had up-to-date training in the Mental Capacity Act and Gillick competence guidelines. The staff we spoke with demonstrated their understanding of the Mental Capacity Act and Gillick competence by giving examples of when they had considered it. We observed a discussion around whether a patient had capacity or not concerning managing their type 1diabetes and the food choices they were making.
- Staff knew where to get advice regarding the Mental Capacity Act within the organisation. The provider had recently (two weeks prior to our visit) put arrangements in place to monitor adherence to the Mental Capacity Act within the hospital. Staff did not carry out routine audits of paperwork relating to the use of the Mental Capacity Act at the time of our inspection.
- The Mental Capacity Act diagnostic test was not present in the standard Priory Mental Capacity Act assessment form. This meant that capacity assessments did not cover all areas required. There was no space on the form or prompt to record how staff supported patients to make decision for themselves and no record of discussion between the psychiatrist and patient about treatment either at three months or at first administration of medication.
- There was a policy on Mental Capacity Act, including Deprivation of Liberty Safeguards, which staff were aware of and could refer to. There were no Deprivation of Liberty Safeguards applications made in the last six months on any of the wards.

Are child and adolescent mental health wards caring?

Kindness, dignity, respect and support

- We observed staff interacting with patients in a number of settings during the inspection, including, on the ward during observations, during a multidisciplinary meeting and in an occupational therapy group. We observed staff show warmth, compassion and respect. Staff used appropriate humour when communicating with the patient. We saw staff showed a good understanding of the patient's needs and they listened to their points of view.
- We observed staff supporting the parent of a patient who was ready to be discharged. The parent was due to travel by taxi to collect their child from the hospital and

we saw staff supporting the parent with their own anxiety over the long journey. Staff had supported the parent to arrange a taxi and offered verbal support to help ease anxiety. In order to support this further, and negate the need for the patient and parent to stop on the way home, staff prepared a packed lunch for the pair. This was an example of staff going above and beyond their duties to support both patients and carers.

- All of the patients we spoke with felt the staff were kind and caring. We received 13 comment cards and eight had positive comments on about the staff, there were no negative comments about the staff. One of the patient said it was hard to get time to talk to staff after 4pm and they often had to wait until the night shift was on duty.

The involvement of people in the care they receive

- Staff told us upon admission the patient was introduced to their named nurse, or told when they would be able to meet them if they were not available. They were given an information booklet to help them familiarise themselves with the ward and if appropriate another patient would show them around the ward and introduce them to the others.
- Within 48 hours of admission, the named nurse completed the care plans with the patient. All of the patients we spoke with felt involved in their care and knew they could have copies of their care plans if they wished.
- There was access to advocacy and they visited the ward on a weekly basis. Their contact details were on display in the wards.
- Patients were able to give feedback about their care and the service in a number of ways. There were regular community meetings, frequency depended on the ward. Mulberry Ward held them every morning and patients chaired them and took the minutes. Ward managers would respond to the suggestions made. There were also hospital wide Voice meetings every month that were attended by the hospital director and patient representatives from each ward. Patients also participated in the Quality walk rounds. There was an ex patient who gathered feedback from the patient on the child and adolescent mental health wards and attended the monthly clinical governance meetings.
- A patient satisfaction survey was conducted on Mulberry and Rowan wards across a range of 24 questions relating to period January to March 2017 . Of the 24 questions, the most positive response rate was in relation to the service received (100%) and effectiveness of the service in helping the relationships between the patient and their family (100%). The lowest scoring questions were in relation to the kinds of services offered (64%), advice the patient was given about what to do between appointments (58%) and the length of time before a first appointment was arranged (58%). We saw the clinical services manager had produced an action plan following the results of the patient survey to improve the experience of patients on the ward.

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

Access and discharge

- At the time of our inspection, the average bed occupancy for Rowan Ward during the period December 2016 to May 2017 was 94% and for Mulberry Ward was 92%. The average length of stay, in days, for patients discharged between June 2016 and May 2017 was 63 for Rowan Ward and 70 for Mulberry Ward.
- During the period December 2016 to May 2017, there were no reported delayed discharges from Rowan Ward and there were five delayed discharges on Mulberry Ward.
- The ward managers told us there were often delayed discharges, particularly on Mulberry Ward, that were not due to clinical reasons but often due to a delay in an appropriate placement being found. At the time of inspection on Mulberry Ward, there were two patients well enough to be discharged since April 2017, but both were awaiting external placements. The hospital were chasing the relevant agencies in order to resolve this issue as soon as possible.
- Discharge plans were clearly documented in the keeping connected care plans and discussed in multidisciplinary meetings, the notes of which were recorded in the patient's care records.
- Patients were referred by their GP, community child and adolescent mental health team, or other health professional. Ward managers reviewed the referrals received on the same day and once the hospital had accepted the referral then admission was generally on the same day and could be out-of-hours if the patient

had a long way to travel. Local referrals were given priority. Occasionally, the ward managers told us they visited the patient first, but usually there was not enough time.
- Patients were not moved unnecessarily between wards. Some patients were discharged from Rowan to Mulberry Ward as part of their recovery.

The facilities promote recovery, comfort, dignity and confidentiality

- Both Mulberry and Rowan wards had enough rooms and equipment to support treatment and care. There were several rooms that were used for group or individual therapy sessions. Patients on Mulberry Ward told us they did not think there were enough rooms or outdoor space. They told us they were told they could access Rowan Ward's garden, but in practice this rarely happened. Patients also told us Mulberry Ward's environment was too dark, did not have enough natural light and there was not enough space. The ward manager told us Mulberry was scheduled for a refurbishment and this would include a garden.
- Staff told us the room in Mulberry ward used for drama therapy was next door to the staff room and the wall separating the two was not soundproof. If patient wanted to express him or herself in a therapeutic, confidential environment, there was a chance this would be overheard by staff next door. This would not be resolved until the refurbishment had taken place.
- Both wards had a range of games, books and art and craft materials that the patient could access. Patients could access the classroom out of school hours to use the computers.
- There were quiet areas on the wards and patients could have visitors on the wards or there was a visiting room off the ward. Patients could use the cordless ward phone to make calls from their bedroom.
- We saw that patients could make their own drinks and snacks. Drinks and fruit were always accessible in the communal areas of the wards.
- We saw patients could bring their own bed covers and pictures from home to personalise their bedroom. Patients had a risk assessment in order to determine what they were allowed in their rooms and this was reviewed weekly.
- Staff supported patients to do their own laundry. Patients could store their possessions securely if they were not allowed in their rooms.
- During the week, the patients' attended school and therapy sessions. On Mulberry Ward, every Thursday there was a ward outing to the cinema or bowling, the patients decided where to go in their community meetings. All of the patients we spoke with told us they felt there were not enough things to do at the weekends. The wards used to have an activity coordinator that worked weekends, but this was no longer in place. The management team were aware of this but there were no plans to replace the post.

Meeting the needs of all people who use the service

- The local education authority provided education across both wards. There was a head teacher, deputy and two teachers. Each student met weekly with their named teacher and reviewed their progress.
- Both wards had lift access, but in order to access the children's wards, patients would have to pass through an adult ward to gain entry. There was access to disabled toilet facilities. One bedroom on Rowan Ward was designed to accommodate wheelchair access.
- Information leaflets about local services, treatment and the complaints procedure were available on the wards. Staff told us they were available in other languages upon request and staff had easy access interpreters and signers.
- We saw menus offered a range of food and patients could request food that met dietary and religious requirements such as vegetarian, gluten free and halal.
- Neither ward had a multi-faith room but the staff told us they could access religious books or prayer mats for patients if required. Staff gave examples of when they had supported patients off the ward in order to attend their place of worship.

Listening to and learning from concerns and complaints

- The patients we spoke with knew how to raise a complaint and the ward information booklets explained the complaints procedure. The staff we spoke with knew how to support a patient in making a complaint and could describe the complaints process.
- In the 12 months before inspection, there had been seven complaints on Mulberry Ward, three were upheld. On Rowan Ward there had been three complaints and

two were upheld. None had been referred to the Parliamentary and Health Service Ombudsman. The themes of the complaints were about building work around the hospital and missing items of clothes.
- Staff received feedback from managers about complaints through management supervision, by email and through governance meetings.

Are child and adolescent mental health wards well-led?

Vision and values

- Woodbourne Priory Hospital cited its purpose as 'to make a real and lasting difference for everyone we support' and that it aimed to do so by adapting the behaviours of: putting people first, being a family, acting with integrity, being positive and striving for excellence.
- The staff we spoke with were unaware of the organisations specific visions and values and the wards did not have their own values or objectives. The organisation had undergone a merger and rapid expansion in the 12 months before inspection and the values of the organisation had not yet been embedded.
- All of the staff and the patients we spoke with knew who the senior managers were within the hospital and told us they frequently visited the wards. They described them as approachable.

Good governance

- There was good governance from the ward to the board; there were morning flash meetings that reviewed any risk issues or fed back any learning. Ward community meetings fed into the hospital wide Voice meetings and there was an ex patient who gathered feedback from the patient and took it to the clinical governance meeting. Managers passed any learning or actions from those meetings back to the ward.
- There was a monthly risk meeting, which produced a risk bulletin for all staff, and staff could submit items to the risk register through the ward managers. The Quality walk rounds was another way the ward managers were made aware of any issues or concerns that needed addressing. Senior managers knew what the main risks associated with the hospital were.
- There was mostly sufficient staffing on the wards to provide care and one-to-one time for the patient. Mandatory training rates were good and all staff had received and an appraisal and regular supervision. However, the system for recording supervision did not take into account completion of clinical, managerial and reflective practice supervisions. Managers recorded only clinical supervision on the Priory wide dashboard and recorded other supervisions separately. This also meant senior managers would have limited oversight of actual staff completion figures and relied on ward managers to keep up to date records.
- The ward managers had targets to reach around recruitment and retention and neither ward had vacancies at the time of inspection.
- The ward managers both felt they had enough authority to do their role and a ward clerk provided administrative support to them both. There were times when they supported the staff on the ward during busy times and if an activity was going on but they were able to balance this with their ward manager duties.
- There was a proactive approach to safeguarding and a good process in place to recognise and respond to safeguarding concerns. Staff knew who safeguarding leads were within the organisation.
- There was good provision in place for reviewing Mental Health Act through the Mental Health Act administrator. However, there had been no one in place to monitor adherence to the Mental Capacity Act until two weeks before the inspection took place. The Mental Capacity Act diagnostic test was not present in the standard Priory Mental Capacity Act assessment form.

Leadership, morale and staff engagement

- The ward staff we spoke with were very positive about the leadership of the wards and the wider hospital. They felt the morale was good and they were part of a good team.
- Senior managers had the skills and passion to carry out their roles effectively. Senior managers, including the Hospital Director, Medical Director, Director of Clinical Services and Support Services Manager had excellent knowledge of individual wards and patients. This was evident in their daily visits and visibly on wards across the hospital.
- Some of the sessional workers said they did not always feel listened to by the ward managers or the senior management team. They told us the hospital had made changes that affected their therapy without informing them. They were hopeful the recent appointment of a therapy manager would improve communication and coordination of their sessions.

Child and adolescent mental health wards

- Sickness rates were low and there were no bullying or harassment cases at the time of inspection. All of the staff felt able to raise concerns without fear of victimisation.
- Staff had the opportunity for leadership, training and development roles. They told us they could input into service development.

Commitment to quality improvement and innovation

- Both wards were part of the Quality Network for inpatient child and adolescent mental health wards peer review process and one of the ward managers was a peer reviewer.

Specialist eating disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are specialist eating disorder services safe?

Safe and clean environment

- A ligature risk assessment was carried out annually by staff. A ligature is something used for tying or binding something tightly and can be used to self-harm. A ligature point is a place where patients who want to self-harm might use to tie something to strangle themselves. The most recent ligature risk assessment for Oak Ward was recorded as May 2017. Bedroom areas were fitted with anti-barricade doors and anti-ligature fixtures and fittings. Ligature risks in communal areas were mitigated by increased staff presence, therapeutic observations and risk assessments for each patient. Offices that contained ligature risks, for example the staff office, were locked to prevent access by patients. Ligature cutters and wire cutters were available for staff use in emergency and were stored in staff offices, clinic rooms and an office used for care planning. All staff had keys to enable them to access these areas.
- An external area ligature point audit was completed in May 2017 which covered the main hospital, the car park and entrance area. The service's car park and driveway area were both covered by CCTV with signage in place to inform patients and visitors of its use.
- Oak Ward admitted only female patients and was compliant with guidance on same sex accommodation as a result.
- The ward had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. An emergency grab bag, a defibrillator and a suction machine were present and were checked daily. Emergency medications were also checked and were found to be in date. Fridge and clinic temperatures were measured daily and recorded for audit purposes. We found that all temperatures recorded were within recommended guidelines for the safe storage of medication.
- All areas of Oak Ward were visibly clean, furnished to a high standard and were cleaned routinely by the domestic staff employed by the hospital. We reviewed cleaning records for the six weeks before our inspection and found them to be complete and up to date. Records of the checking of fridge and freezer temperatures were also documented daily in kitchens used by patients to practice food preparation as part of their therapeutic activities timetable. We reviewed the records of the temperature checks and also found them to be complete and in date.
- Soap and hand gel dispensers were in place on the entrance to Oak Ward and in communal areas throughout the hospital. We observed staff to be practicing the principles of infection control and using the hand gel when leaving and entering the ward environment.
- Equipment for the monitoring of physical health was present and included weighing scales, blood pressure machines and a couch for electrocardiograms to be completed. Equipment for the use of nasogastric feeding was also available. Nasogastric feeding is an intervention used in eating disorder services where a narrow feeding tube is placed through a patients nose and down into their stomach. The tube can be used to give a patient fluids, medications and liquid food complete with nutrients. All equipment used for physical health monitoring had been maintained in line with manufacturers' recommendations and records to evidence this were in place and reviewed by our inspection team.

- Environmental risk assessments had been completed and records to evidence this were reviewed as part of our inspection activity. A fire risk assessment was completed annually with a recent date of May 2017, fire contingency checks were completed weekly and a weekly test of the fire alarm system also took place. Portable appliance checks were completed and had been reviewed in October 2016 as part of an annual schedule.
- All staff were provided with an alarm whilst working on the ward. Alarms could be activated either to summon assistance, or in an emergency. Alarm call panels were available on each floor of Oak Ward and provided guidance to staff as to where assistance was required. Each shift had a designated member of staff working in a responder role and who carried a portable radio to liaise with other wards in case of emergency. The responder member of staff was also provided with ligature cutters and wire cutters and carried this with them at all times.

Safe staffing

- As of March 2017, Oak Ward had a total of 20 substantive staff. Establishment levels for whole time equivalent nurses were six and there were two vacancies. Establishment levels for non-qualified staff were nine and there was one vacancy which was in the process of being recruited to.
- During the period June 2016 to May 2017 staff turnover on Oak Ward, was 9% of the staffing establishment. In the 12 months up to March 2017, staff sickness rates were low at 1.6%.
- The number of shifts filled by bank and agency staff in the three months before our inspection was 182 (28%), there were no shifts left unfilled during the same period. The ward manager informed us that due to the specialised nature of the ward, they endeavoured to use staff that were familiar with the ward and the patient group wherever possible and that this worked well.
- During our inspection we observed there to a be a qualified member of staff in the communal areas of the ward at all times. Patients that we spoke with reported staff to be visible and accessible and gave no examples of where escorted leave or planned activities had not taken place due to staff shortages.
- All patients that we spoke with reported that there were sufficient staff to enable them to have regular one-to-one times with their named nurse and specialist clinicians including the dietician, occupational therapist and psychologist. Patients reported that they had scheduled sessions on a weekly basis with allied health professionals as part of their therapeutic programme and that this worked well.
- All staff that worked on the ward were required to be trained in the prevention and management of violence and aggression. This ensured that when staff were required to utilise verbal or physical interventions to ensure patient safety they were suitably trained to do so. Staff and patients that we spoke with told us that physical interventions were rarely used and only as a last resort when all other interventions had been unsuccessful.
- A specialist eating disorder consultant psychiatrist was in post on Oak Ward and provided medical input for three days per week. Medical cover for the service on remaining days was provided by a second doctor based at the hospital and who also covered neighbouring wards. On call medical cover was provided through a rota system and details were held in the staff office of the on call arrangements and contact details. Staff and patients reported no concerns about accessing a doctor and stated that the system worked well.
- Staff that worked at the service were able to access a range of mandatory training opportunities including equality and diversity, health and safety and infection control. The average attendance rate at mandatory training by staff was 86% and this was monitored by the registered manager through the electronic e-learning system and monthly audits. There was one area of training with an attendance rate below 75% which was confidentiality and data protection training. The providers target for mandatory training was 90%.

Assessing and managing risk to patients and staff

- There were no seclusion facilities in use on Oak Ward and there had been no recorded use of long term segregation during the period September 2016 to March 2017.
- There were 41 incidents of the use of restraint during the period September 2016 to March 2017, involving 26 individual patients. None of the restraints were reported

as being in the prone position and the hospital did not support the use of prone restraint with patients, in line with national guidance from the Department of Health. All incidents of the use of restraint required an incident form to be completed following its use.

- A restraint care plan was in place where needed to administer nasogastric feeding and included the clinical teams consideration of least restrictive options. Nasogastric feeding is an intervention that can be used to deliver liquid nutrients through a tube passing through a patient's nose and into their stomach. If restraint was required, the care plan advised staff that an incident report should be completed. There were two recorded uses of nasogastric feeding restraints in the six months before our inspection and staff reported that it would only ever be used when all other interventions had failed.
- We reviewed six records relating to the care and treatment of patients admitted to Oak Ward during our inspection, this equated to 75% of the overall patient caseload. We found that detailed risk assessments were present in all care records reviewed. Risk assessments were reviewed weekly as part of the clinical multidisciplinary meeting between the ward medic, staff and patient. However, in practice we found that risk assessments were reviewed more frequently and after any incident that took place.
- There were no blanket restrictions in place at the service at the time of our inspection. Where restrictions were in place, staff and patients told us they were individually care planned and reviewed regularly by the multidisciplinary team and the patient the restriction applied to. Staff that we spoke with could discuss the definition of blanket restrictions as set out by the Mental Health Act Code of Practice 2015 and identify actions they would take to ensure they were not in place at the service.
- At the time of our inspection, three of the eight patients admitted to Oak Ward were detained subject to the Mental Health Act. We saw signage on external doors on the unit advising patients that were not detained to speak to a member of ward staff if they wished to leave. Patients that we spoke with told us that staff practiced an approach of positive risk taking and that they were not dissuaded unduly from leaving the service. During our inspection we were given examples of where the clinical team had convened a meeting out of hours to work proactively with a patient who wished to leave the unit. A range of options were provided rather than detaining the patient and a least restrictive approach was taken to managing their risk.
- Oak Ward had a policy on the use of therapeutic observations to minimise the risk of potential suicidal, violent or vulnerable patients harming themselves or others and to reduce risk behaviours. The policy had been issued in June 2017 and had a review date of 2020. All staff that we spoke with were aware of the policy, the steps required to increase patient observations and when it might be required, and the guidance that observations could only be decreased following a discussion with the consultant psychiatrist or doctor responsible for the ward.
- Oak Ward had a visitors policy in place for staff regarding arrangements for visitors to the ward, including visits by children. The visitors policy had a review date of 2020 and contained guidance to the updated 2015 Mental Health Act Code of Practice. The policy stated that visits by children to parents, whether detained or not, were central to the maintenance of healthy relationships with parents or other relatives who are in hospital. During our inspection we spoke with patients who had been visited on Oak Ward by their children, they reported that staff had gone over and above in their efforts to promote a safe and welcoming environment for their dependent to visit them.
- A policy was in place to provide guidance for staff on searching patients and their belongings in a treatment environment. The policy had a review date of 2018 and set out guidance for staff that all searches should be reasonable and proportionate and that the privacy and dignity of each and every person to be searched should remain paramount at all times. Routine searches of patients or their bedrooms were not in place at the time of our inspection.
- Their had been no use of rapid tranquilisation on Oak ward in the twelve months prior to our inspection. Rapid tranquilisation is when medicines are given to a patient who is very agitated or displaying aggressive behaviour to help quickly calm them. This is to reduce any risk to themselves or others, and allow them to receive the medical care that they need.

Specialist eating disorder services

- Staff that we spoke with demonstrated a good understanding of how to identify and act on safeguarding concerns and information was available for staff in communal areas of the ward, including contact details for local safeguarding leads for the ward and hospital.
- Staff were able to access safeguarding training as part of the mandatory training package for all staff employed by the priory hospital. At the time of our inspection 82% of staff on Oak Ward had undertaken training in safeguarding adults and 88% had undertaken training in safeguarding children level two.
- A pharmacist visited the ward weekly, reviewed all medication charts and checked for prescription writing errors, administration errors and Mental Health Act paperwork for patients administered medication who were detained. There were no non-medical prescribers employed as part of the ward staffing at the time of our inspection and all qualified nursing staff were required to undertake yearly medication management training.
- Staff were aware of patients at risk of falls and pressure ulcers due to low body mass index. All patient records contained an adapted Waterlow pressure area risk assessment chart to assess the likelihood of skin tissue breakdown and pressure mattresses were available for patient use.

Track record on safety

- There had been no reported incidents that met the criteria of a serious incident in the 12 months before our inspection of Oak Ward.
- Staff were able to give us examples of where improvements to safety had taken place, including the updating of door key pad codes following an incident where the previous codes had been learnt by a patient observing staff leaving the ward.

Reporting incidents and learning from when things go wrong

- All staff that we spoke with were aware of their responsibility to report incidents using the hospital's electronic incident reporting system and could explain how to do so if needed.
- All incidents and near misses were required to be recorded within 48 hours of taking place, incidents were electronically escalated to the ward manager and director of clinical services. The ward manager was responsible for reviewing all incidents as they were received and weekly incident audits were required by the director of clinical services to identify emerging trends or areas for concern.
- Patients that we spoke with told us that staff were open and transparent with them and explained if and when things went wrong. Staff met frequently as part of scheduled team meetings and reflective sessions and took the opportunity to review feedback from investigations of incidents both internal and external to the service.
- Staff were able to provide examples of when debriefs had been held following incidents and learning had been implemented. This included reviews of the ward security following a patient absconding. Staff reported that the ward manager offered them support following incidents and went out of their way to check on their wellbeing.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

- We reviewed six records relating to the care and treatment of patients admitted to Oak Ward during our inspection, this equated to 75% of the overall patient caseload. We found that comprehensive and timely assessment of all patients had been completed following admission and updated regularly thereafter.
- Physical examinations of all patients were completed at the point of admission to the hospital and used recognised rating scales including a modified early warning system adapted for patients diagnosed with an eating disorder which recorded respiratory rate, temperature, heart rate and blood pressure. Weight recording was completed for all patients a minimum of weekly and body mass index and bone density scans were requested when necessary. All care plans reviewed demonstrated that physical health monitoring was increased or reduced according to patient need and could be increased to hourly if required.

- Care plans were divided into four specific areas; keeping safe, keeping healthy, keeping well and keeping connected. Each care plan related to areas of a patients recovery and included aspects of physical health, family and support network involvement, risk management and therapeutic activities. We found that all care plans had been completed to a high standard, were up to date and recovery oriented. Care plans reviewed all demonstrated evidence of personalisation by patients, included their views and in some instances included patient quotes.
- All patients had a completed personal emergency evacuation plan. This recorded an individualised plan for patients needing to evacuate the ward in an emergency such as fire or requiring medical treatment.
- All information needed to deliver care was stored securely and available to staff when required. Oak Ward recorded the majority of information relating to patient care using an electronic care records system and each patient had a file for the storage of assessments and correspondence in a paper format. Each patient also had a grab file stored in the ward office to be used in case of an emergency or a breakdown in the electronic records system. The patient grab file contained a copy of patients Mental Health Act paperwork and recent leave forms, a copy of their care plans and risk assessment and details for next of kin or support networks involved in their care.

Best practice in treatment and recovery

- Medication was prescribed in line with guidance from the National Institute for Health and Care Excellence; NG69 Eating disorders, recognition and treatment and national guidance from the Royal College of Psychiatrists CR189 Management of Really Sick Patients with Anorexia Nervosa. Interventions offered alongside medication regimes included psycho-education about eating disorders and monitoring of weight, mental and physical health.
- Patients on Oak Ward were able to access psychological therapies recommended by the National Institute for Health and Care Excellence, including cognitive behavioural therapy and dialectical behavioural therapy. Psychological therapies were available either on a one-to-one basis or as part of the therapeutic activities timetable via mindfulness groups and relapse prevention workshops.
- An advanced eating disorders dietician was in post and provided access for patients to specialist physical health care and monitoring of nutritional and hydration needs. An adult nutritional screening tool was used on Oak Ward and included an assessment and recommendation by the dietician following a review of patients height, weight and body mass index. Nutritional requirements were divided into energy, protein and fluid intake and food and fluid charts were used to record and measure changes in physical health.
- The dietician had completed a pathway to assist staff working out of hours with patients at risk of re-feeding syndrome. Re-feeding syndrome is a group of clinical symptoms that can occur in a malnourished or starved individual upon the reintroduction of nutrition and can lead to risk of cardiac arrhythmias, respiratory insufficiency and fatality. The re-feeding pathway provided guidance on the assessment of re-feeding risk, electrolyte replacement therapy and clinical monitoring in the early stages of re-feeding.
- A therapeutic activities programme was in place and specialist interventions including daily and personal activities of daily living assessments and skill acquisition groups were led by an occupational therapist. Group based interventions included drama therapy, yoga, art therapy and a cinema club. The occupational therapist also provided one-to-one interventions including goal setting, meal planning and weekly scheduled meetings with each patient to review their progress and plan for future interventions.
- We attended a body image group as part of our scheduled inspection activity. The group was facilitated by the ward manger and encouraged patients to reflect on anxiety management strategies and the different coping techniques used. The group also encouraged patients to work collaboratively and to speak openly about their experiences.
- A range of outcome measures and rating scales were in use and were completed by nursing staff, psychologists and the occupational therapists. The Model Of Human Occupation Screening Tool had been completed for all

patients to assess their functioning in cognitive and motor skills domains and the Eating and Meal Preparation Skills assessment had also been completed with patients by the occupational therapist on Oak Ward.

- The Health of The Nation Outcome Scale was completed for all patients at the point of admission to the ward and reviewed routinely by staff thereafter. This is a measure of the health and social functioning of people with severe mental illness and contains 12 items measuring behaviour, impairment, symptoms and social functioning.
- Senior managers at the hospital completed weekly care plan audits, reviewing the completeness of risk assessments, discharge checklists, consent and care plan detail. Oak ward received a score for the last week of June 2016 of 97% following the most recent audit.

Skilled staff to deliver care

- A range of mental health disciplines and workers provided clinical input to Oak Ward and included qualified nurses, health care assistants, a cognitive behavioural therapist, a psychologist, occupational therapist and an advanced eating disorders dietician
- The Priory Group had a safer recruitment and selection including prevention of illegal working policy with a review date of October 2019.
- Qualified staff were required to maintain current professional registration with regulatory bodies, including the Nursing and Midwifery Council and the Health Care and Professions Council for occupational therapists and psychologists. Professional registration with regulatory bodies was checked by the Priory Group at the point of employment and monitored yearly following this.
- All staff that required an annual appraisal in the 12 months before our inspection had received one. Appraisals of staff performance incorporated feedback from colleagues and patients and this was used to identify areas for staff development.
- Management supervision was provided for staff by the Oak Ward manager and we reviewed evidence that this happened routinely and reviewed as part of the annual appraisal process. Clinical staff were able to access profession specific supervision and peer support groups and we reviewed meetings of scheduled allied health professional therapy meetings which had recently taken place.
- Regular peer supervision meetings took place on Oak Ward with an external facilitator. Staff reported that the peer supervision meetings gave them the opportunity to reflect on the ward environment and dynamics and to discuss any areas that may be of concern. Oak ward staff also participated in monthly team reflective practice and were facilitated by the ward manager.
- All staff commencing employment on Oak Ward received an appropriate induction to the service. Staff employed on a permanent contract received a local induction pack which allocated three weeks for them to work in a supernumerary capacity and become familiar with the hospitals policies and procedures. During the induction period new workers were allocated a buddy and were also required to work a shift on each ward across the hospital site.
- Induction checklists were required for all permanent and bank or agency staff. The induction checklist covered topics including safeguarding, observation levels, risk assessments and the location of emergency lifesaving equipment including emergency drugs, oxygen and the location of ligature cutters. All staff were required to sign once they had received an induction in each area and a countersign was required by senior staff from the ward.
- Staff and patients on Oak Ward had identified that bank or agency staff unfamiliar with the specialist nature of the eating disorder service sometimes struggled with the complexities of the conditions that patients presented with. As a result, a series of twelve flash cards had been produced, with the title "eating disorders, the very least you need to know" and included guidance for new staff on maintaining professional boundaries, physical contact, social networking and gifts. The flash cards had been laminated and illustrated by the occupational therapist working at the service in collaboration with patients on the ward.
- Healthcare assistants were supported to undertake the care certificate standards as part of their induction and development pathway and we observed this being completed by the ward manager at the time of our

inspection. All staff also received a six month probationary period with a continual assessment of their performance and regular reviews with the ward manager. During our inspection we reviewed the notes of a completed probationary review and found detailed feedback from the ward manager and a review of time keeping, absence records, reliability and a cross check that the induction pack had been satisfactorily completed.

- We found that staff received the necessary specialist training to undertake their role. A nasogastric training competency pack was available for all staff and covered two levels; level one - theoretical knowledge and nasogastric tray preparation and level two - insertion of a nasogastric tube and feeding via a nasogastric tube. All staff were required to complete level one training but level two training could only be undertaken by qualified staff or the services dietician. All staff that undertook nasogastric feeding were also required to have undertaken a nursing competency assessment and to have been signed off as competent to do so by senior colleagues.
- A certificate in eating disorders had been designed by the ward manager for Oak Ward and accredited by Brighton University. The national training course to complete the certificate had been created following feedback from patients, carers, occupational therapists, dieticians and psychologists, with the aim of enabling multi-disciplinary team members to extend their knowledge and skill base in order to improve their practice and service provision. The course required that participants attended five one day workshops per year, comprising diagnostic criteria and clinical risks, therapeutic use of self, application of therapeutic interventions, interventions with food and group work and body image.
- A food for thought educational training programme had been designed by the advanced eating disorders dietician and was available for all staff across the Woodbourne Priory Hospital. The training programme covered the psychological, physiological and social aspects of dietary intake and was aimed at helping all staff develop their specialist knowledge and ability to recognise unhealthy eating habits.
- There had not been any permanent staff on Oak Ward subject to performance management in the six months before our inspection. The ward manager was able to give examples of where staff had received regular performance reviews throughout their probationary period and management supervision following their permanent appointment in post.

Multidisciplinary and inter-agency work

- The team on Oak Ward held weekly multidisciplinary review meetings for all patients and we attended one of these as part of our inspection activity. The weekly review meeting was attended by the patient and key members of the team including the dietician, occupational therapist, psychologist and a member of the nursing team. Areas covered as part of the review meeting included physical health, risk management plans, relapse prevention plans and discharge planning. Patient views and feedback were sought throughout the meeting and they had also been supported by staff from the ward to prepare pre meeting questions and discussion points.
- A format for the weekly multidisciplinary meetings was in place and available as guidance for staff. Aims for the meeting had been agreed in accordance with the accreditation for inpatient mental health services: Standards for adult inpatient services. Goals had also been documented to outline what a multidisciplinary review should sound and feel like, this included the use of appropriate language for patients and carers, collaborative, patient and carer centred and a place where patients and carers were encouraged to ask questions and to raise concerns.
- Patients on Oak ward had been involved in deciding the format of the weekly multi-disciplinary meeting and feedback had been sought from them by staff about its effectiveness through a multidisciplinary meeting evaluation form, this was used to shape the structure, format and content and to ensure that patients had a voice in how the meetings were organised and to ensure their needs were met during the weekly reviews by the staff team and consultant.
- Weekly staff meetings took place and alternated between a ward business meeting and a safe space meeting. A daily flash meeting also took place on the

ward and included a review of all patients progress in the preceding 24 hours, any changes to patient risk, significant incidents and a review of patients therapeutic observation levels.

- Handovers were held between the morning and night time shifts on a daily basis. A further handover could be convened in the case of an afternoon shift being used due to increased patient observation levels or further staff being required on shift to facilitate one-to-one's or scheduled activities and section 17 leave for patients detained subject to the Mental Health Act.
- We found that effective working relationships were maintained with teams and organisations external to Oak Ward and the Woodbourne Priory Hospital. The occupational therapist routinely held discharge planning meetings with community teams and patients care co-ordinators and we received feedback that this worked well helping patients to make the transition back into the community following their admission to the ward.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- Mental Health Act paperwork was reviewed by the Mental Health Act administrator employed at the Woodbourne Priory Hospital where Oak Ward was based, and medical recommendations were scrutinised by the medical director for the hospital.
- All staff that we spoke with were aware of the Mental Health Act administrators role and we were informed that she visited the wards each morning to collect Mental Heath Act paperwork and inform staff of deadlines relating to paperwork completion.
- Records of section 17 leave granted to patients on Oak Ward were clear and we found that outcomes of leave were monitored and used to inform future care planning, we also found that terms and conditions relating to leave granted were clear and well documented within the Mental Health Act paperwork on the ward.
- At the time of our inspection, 82% of staff had received training on the Mental Health Act and the 2015 Mental Health Act Code of Practice.
- Staff we spoke with were aware of the main principles of the Mental Health Act and the Code of Practice guiding principles, including least restrictive practice and the implications of blanket restrictions on patients' rights.
- We found evidence that patients had their rights under section 132 of the Mental Health Act explained to them on admission and routinely thereafter. We also found evidence that patients had been actively supported by the responsible clinician on Oak Ward to appeal to a Mental Health Act tribunal where they had been unhappy about their detention in hospital.
- We found that where patients had refused to have information shared with their nearest relative, this had been documented clearly. The nearest relative is a designated relationship defined in the legislation of England and Wales through the Mental Health Act 1983, as amended by the Mental Health Act 2007 and relates to an individual who should be consulted as part of the assessment, admission and treatment of a patient detained subject to the Mental Health Act.
- A Mental Health Act administrator was employed by the hospital and provided oversight and guidance for staff on the application and use of the Mental Health Act. The Mental Health Act administrator had responsibility for ensuring that all paperwork was complete and also ensured that Mental Health Act tribunals and managers meetings were arranged for patients detained under the Act and who wished to lodge an appeal.
- We found that in one instance, the responsible clinician on Oak Ward had unnecessarily completed a T2 form within three months of medication first being administered to a patient. A T2 form is part of the Mental Health Act 1983 paperwork used to record a patients consent to the administration of medication, this is not required within three months of medication treatment commencing and it was not clear why the T2 form had been completed early.
- The Mental Health Act administrator for the hospital had created a spreadsheet system to manage patient information relating to detention, including consent to treatment completion, Mental Health Act section expiries and planned tribunal appeals and hospital managers hearings. However, routine audits of Mental Health Act paperwork did not take place at the hospital.

- Patients were able to access independent mental health advocacy services and these had been commissioned by the local authority in accordance with the 2015 Mental Health Act Code of Practice.

Good practice in applying the Mental Capacity Act

- At the time of our inspection,100% of staff had received training in the 2005 Mental Capacity Act. Staff that we spoke with during our inspection had a good understanding of the Mental Capacity Act, it's five statutory principles and the definition of restraint including the restriction of a patients freedom of movement.
- The service had a policy in place to provide guidance for staff on the use of the Mental Capacity Act, with a planned review date of February 2018. A policy was also available for staff on the Deprivation of Liberty Safeguards, with a review date of March 2018 and 88% of staff had received training on the application and use of Deprivation of Liberty safeguards.
- At the time of our inspection, three patients admitted to Oak Ward were detained under the Mental Health Act. There had been no Deprivation of Liberty Safeguards referrals made by the service in the twelve months before inspection.
- Capacity to consent to treatment was not always recorded correctly. At the time of our inspection we found that two patients had been assessed as lacking capacity to consent in clinical notes, but recorded as consenting to treatment on the Mental Health Act consent to treatment T2 form. This was raised with the responsible clinician and hospital manager at the time of our inspection and assessments repeated and correctly documented.
- There had been no best interest assessments in the six months prior to our inspection, although staff were able to identify when a best interest assessment would be appropriate in the event a patient had been assessed as lacking capacity, and the role of a best interest assessment in promoting a patients wishes, feelings, culture and personal history.
- Staff that we spoke with told us that they would be able to gain support and advice on the application of the Mental Capacity Act from the Mental Health Act administrator based at the service or the consultant psychiatrist.
- We did not find that routine audits of paperwork relating to the use of the Mental Capacity Act were carried out at the time of our inspection.

Are specialist eating disorder services caring?

Kindness, dignity, respect and support

- Throughout our inspection we observed staff attitudes and behaviours that were responsive, discreet, respectful and provided a balance between practical and emotional support for the patients on Oak Ward.
- All feedback we received from patients that we spoke with on Oak Ward was without exception outstanding. The ward manager and the team were described as phenomenal by many of the patients we spoke with. Patients that we spoke with told us that the clinical team never gave up on them and that the levels of dedication, compassion, consultation and consideration of patient needs by the staff team was incredible. One patient that we spoke with said that the Oak Ward staff team had given them their life back, and a life that they had never thought would be possible.
- We received nine comments cards by previous patients on Oak Ward including feedback from carers and families. One carer fed back to our team that the depth of commitment by staff on Oak Ward was beyond belief, and the more they saw, the more they were amazed. Another feedback comment card received from a carer cited the ward as providing a constant service, over and above what could be expected, in all aspects of the care provided.
- All patients that we spoke with said that staff understood their individual needs. We were told that staff were sensitive and supportive, communicated effectively and took their time to develop a broad knowledge of patients, their support networks and the way they could support them. One patient told us that it was the little things that the staff group did which let

them know that had listened to them, this included inspirational quotes hidden under objects to be found by patients when they were having a difficult time during their recovery.

The involvement of people in the care they receive

- Staff and patients had developed a patient guideline booklet to orientate and welcome new admissions to the ward and we reviewed this during our inspection of the service. We found that the guideline booklet contained details on the ethos and philosophy of the ward. the approach to graded meal supervision by staff, coping strategies and advocacy services.
- We were given examples of when previous patients on Oak Ward had written letters and left them in bed spaces for new admissions after their discharge. Letters contained best wishes for the future, reassurance and handy tips about getting to know the ward environment and staff group.
- All patients we spoke with told us that they had been fully involved in care planning and the management of their care as soon as practicably possible in their recovery. We were provided with feedback that the ward team were always patient focussed and one patient that we spoke with told us that although they were supported by the ward team, they felt their care had been led by their wishes and goals.
- Patients were able to access independent mental health advocacy services and these had been commissioned by the local authority in accordance with the 2015 Mental Health Act Code of Practice.
- We found examples of patients engaging collaboratively with staff to engage in community based initiatives and support a local charity for eating disorders. The year before our inspection, patients had been supported to attend a local Chinese restaurant with karaoke facilities and subsequently formed a band, hired a recording studio and produced a charity single which was sold and profits donated.
- Patients were encouraged to decorate the walls of Oak Ward and to display their art work. An art exhibition had been held by patients with the support of staff to develop creativity and build self-esteem, and t shirts had been created with the ward motto of "make every day worth it" printed on them, these had also been sold to support donations to charity. During our inspection we were also shown examples of calendars that had been created with dates documented for carers meetings and we were given examples of mugs that had been produced with the ward motto on and pictures of the clinical team in fancy dress and were sold to promote awareness of eating disorders and to promote the patient and ward motto.
- The consultant psychiatrist and staff on the ward gave examples of annual traditional events held for patients including a kings speech held during the Christmas period. The format involved staff, led by the consultant dressed in costume as King Richard, addressing the patients and reflecting on their achievements either reached collaboratively with staff, as a peer group or independently as part of their recovery. The annual speech culminated by echoing the philosophy of every patient being worth it, and a thank you from the staff team for the privilege of being able to be involved in their recovery.
- A family and carers eating disorder service self-assessment booklet had been designed by staff and patients on Oak Ward and illustrated by the wards occupational therapist. The booklet provided information for care givers on understanding the concept of eating disorders, helpful communication strategies and help and support networks. The booklet contained poems written by patients on Oak Ward and theories on coping strategies that had been conceptualised by the ward manager and formed part of a national eating disorder training programme for multidisciplinary teams.
- Staff on Oak Ward had successfully piloted a caring for carers programme and had received positive feedback by the people they had supported, this was in the process of being rolled out to the rest of the hospital site at the time of our inspection. Oak Ward also held regular carer and sibling support groups facilitated jointly by staff and a family member of a patient who had previously received care on the ward. A caregivers/ significant others pathway had been also been developed to provide guidance for staff working with patients carers and support networks.
- A patient satisfaction survey had been commissioned by the hospital and we reviewed the latest results for Oak Ward which related to the year 2015 to 2016. A total of 22

questions were asked, ranging from whether patients had been treated with respect and dignity, whether they felt safe on the ward and whether they had been involved in decisions about their care and treatment. Oak Ward had scored 100% in the satisfaction ratings for 21 out of the 22 possible questions. The domain that they scored less than 100% for was the quality of food served at the hospital and in this area the hospital had scored a 50% satisfaction rating.

- Patients were able to attend regular community meetings and we reviewed the minutes of these as part of our inspection activity. We found that patients were able to provide feedback about the ward and offer suggestions for how things could be improved. All patients that we spoke with fed back that the community meetings worked well, were effective and brought about change. We were also told that when changes were not possible, this was communicated clearly to them in a respectful manner and explanations were provided by the staff team.
- Patients were able to become involved in decisions about the service and took an active role in the recruitment process of new staff as part of a service user directed team recruitment and team performance programme. The initiative had been developed by staff and patients on Oak Ward with the aim of giving patients a voice throughout the process of building a staff team. The occupational therapist for Oak Ward who had joined the team five months before our inspection had been interviewed by a panel of service users during the recruitment process.
- Patients were supported to give feedback about staff as part of a "turning the tables, service user appraisal and probation feedback" initiative. Patients provided feedback on a variety of staff performance areas including approachability, professional demeanour and how they facilitated leave with patients away from the hospital environment. We found evidence of patient feedback within staff probationary records made available to us during our inspection activity.
- Patients had completed advance statements as part of their relapse prevention work completed with the occupational therapist on Oak Ward. An advance statement is a way for patients to say how they would like to be treated in the future if they are unable to decide for themself and can include details on preferred management of bills, looking after dependants and management of daily affairs.

Are specialist eating disorder services responsive to people's needs?
(for example, to feedback?)

Access and discharge

- At the time of our inspection, there were 8 patients receiving care and treatment on Oak Ward. The average bed occupancy during the period March 2016 to March 2017 was 97% and the average length of stay, in days, for patients discharged between March 2016 and March 2017 was 183 days.
- During the period March 2016 to March 2017, there were no reported delayed discharges from Oak Ward and there were no re-admissions to the ward within 90 days during the same period.
- There was always a bed available on Oak Ward following a period of leave. When patients were discharged from Oak Ward this was following a period of planning and preparation for patients in collaboration with the clinical ward team and was always scheduled for an appropriate time of day.
- We found evidence in all care records reviewed of the consideration of section 117 aftercare services for patients admitted to the ward and detained subject to the Mental Health Act. Section 117 aftercare is the provision of free after-care for people who have been in hospital subject to certain sections of the Mental Health Act. We also found evidence in all care records of robust discharge planning for all patients and details of contact being maintained with clinical teams where a patient had been admitted away from their geographical home.
- All feedback we received from carers and families of patients admitted to Oak Ward was that the treatment provided had been recovery focussed from the point of admission. Patients that we spoke with gave us multiple examples of staff helping them to prepare for discharge including discharge preparation groups and home visits facilitated by the occupational therapist for the ward.

The facilities promote recovery, comfort and dignity and confidentiality

- There were a range of rooms and facilities available to support treatment and care on Oak Ward, including a patient lounge, art therapy and craft room, and a patient kitchen with seating facilities. The patient lounge contained comfortable sofas, a television, books and games and a patient activity timetable. We also found that inspirational quotes had been placed around the lounge area by the ward manager for patients to read.
- All areas were decorated to a high standard and most of the ward area had evidence of decoration and personalisation by patients using the service. We found that inspirational quotes were updated daily by patients and included a thought for the day and thought for the night. Patients and staff had created a ward identity and motto as being "the mighty Oak" and "make every day worth it" and we found that motif's and Oak tree's had been painted around the ward to signify this. Patient and staff artwork had been used to decorate the ward walls and to promote an therapeutic atmosphere and ownership of the environment by people who used the service.
- There were designated quiet areas on the ward and on the first floor which had been decorated by a previous staff member. The quiet area had been named the purple patch and had comfortable seating available. Staff and patients that we spoke with told us that the location worked well, and enabled patients to have some space and quiet time whilst not isolating themselves or returning to their bedroom.
- A visitors room was available and patients reported that visitors were made welcome by staff. Patients had access to their own mobile phone to make calls in private and their was also a ward cordless phone which was available for patient use.
- Oak Ward had access to its own designated garden space, this included a smoking area, garden benches and deckchairs. The garden area was grassed throughout and the patients and staff had recently undertaken a garden project and were in the process of redeveloping the area with raised planters and vegetable patches. The aims of the gardening group had been decided collaboratively by the staff and patients to help with anxiety about food, bring about a sense of satisfaction from watching something grow and nurturing it, and to offer the opportunity to produce food that could be used for patient meal clubs.
- Patients were able to access a kitchen area to make drinks and snacks independently or with support from staff. Patients were also supported by staff on Oak Ward to shop for meal ingredients and prepare their own meals as part of skill acquisition one-to-one sessions and meal clubs. Patient feedback regarding the food provided by the Woodbourne Priory hospital was that it was generally of good quality but could lack vegetarian options and choice, particularly on Sundays.
- Bedrooms and personal areas were personalised by patients and they were supported to do so by staff. We found that patients had decorated their bedroom doors with artwork bearing their name and inspirational quotes. Bedroom areas were accessible during the day unless it was individually care planned by the multidisciplinary team due to risk. All bedroom areas also had lockable storage for patient belongings.
- A varied programme of therapeutic activities was available for all patients and included skill acquisition groups, psycho-educational workshops, meal clubs and community based outings. During the evenings and weekends, the activity programme was less structured and was based around feel good and sociable activities. All patients that we spoke to provided positive feedback about the therapeutic activity programme and reflected that the less scheduled times were as a result of having so many opportunities during the day, that they had requested evenings and weekends as more relaxed time without feeling the need to attend groups.

Meeting the needs of all people who use the service

- Adjustments were in place for patients with reduced mobility including a patient lift and accessible bathroom facilities for people who may be using mobility aids or wheelchairs.
- A notice board was in place in the main ward area and contained details of the local advocacy service and the name and contact details for the ward advocate, details of local safeguarding structures and the safeguarding lead for the hospital. Details were also available on how

to make a complaint, a carer involvement strategy and consent form and copies of the family and carers self-assessment booklet designed by the ward staff and patients.

- Patients were able to request a choice of food to meet their specific dietary, religious and ethnicity requirements, this could include halal meat, gluten free and vegetarian options.

Listening to and learning from concerns and complaints

- Guidance for patients on the process of making a complaint was in place and displayed on a notice board within the communal area of the ward.
- All staff that we spoke with were able to discuss the systems in place for processing and responding to complaints. A complaints policy was available for staff to ensure that all patients had access to an effective complaints procedure. This provided guidance for staff in managing a complaint and gave details on third party organisations that patients could contact if they wished to pursue complaints further.
- During the 12 months before our inspection, there were no complaints received by the provider relating to the care and treatment of patients on Oak Ward.
- During the 12 months before our inspection, there were five compliments received relating to the care and treatment of patients on Oak Ward. Staff received thanks from patients for being respectful and supportive during their recovery and for providing support, guidance, kindness and clinical expertise.

Are specialist eating disorder services well-led?

Vision and values

- Woodbourne Priory Hospital cited it's purpose as 'to make a real and lasting difference for everyone we support' and that it aimed to do so by adapting the behaviours of; putting people first, being a family, acting with integrity, being positive and striving for excellence.
- Patients and staff on Oak ward had developed a ward based philosophy incorporating; We treat everyone with dignity and respect, we never stop learning, we want to work here, we love and are passionate about what we do, and we listen, we change and we reflect.
- Staff that we spoke with during our inspection of the service were aware of the organisations vision and values and were able to give examples of how they were demonstrated in their clinical practice, including striving for excellence and being a family.
- Staff on Oak Ward knew who the senior managers were within the organisation and fed back that they were visible and accessible. The Hospitals registered manager visited the ward frequently and was responsive to feedback and requests made by staff on the ward

Good governance

- There were effective and well structured governance procedures in place on Oak Ward and within the Woodbourne Priory Hospital. Staff were supported to access training and development and the attendance rates at mandatory training was 86%. Staff were also supported to access specialist training to support them in their role and the ward manager had developed a national training package for eating disorder services, accredited by the university of Brighton.
- Shifts were covered by sufficient staff of the right grade and experience. Where bank or agency staff were used, the ward manager sought to ensure they were familiar with the service and the patient's needs. A training and information package had also been designed collaboratively by staff and patients to assist temporary staff who were new to the ward and had limited experience working in the eating disorder clinical specialty. Appraisal rates for permanent staff were high and there were arrangements in place for managerial and clinical supervision, including profession specific supervision for allied health professionals.
- The ward manager was able to monitor the performance of the ward using a range of key performance indicators including staff absence and turnover, reported incidents and medication management. There was evidence that staff had met and discussed incidents and that learning lessons and changes had taken place as result.

- Patients were fully engaged in the development of the service, the decoration of the ward environment and the recruitment, development and appraisal process of permanent staff. Therapeutic activity programmes and community meetings were embedded as part of the ward activity and feedback was sought from patients routinely about the care and treatment provided.
- The ward manager fed back that they were able to make changes to the eating disorder service and were given sufficient authority and support from senior managers at the Woodbourne Priory to do so. A risk register was in place enabling the hospitals senior management and national provider to have oversight of any areas of concern and the manager of Oak Ward had used the risk register to highlight the potential of patient risk increasing as a result of the recent move from the ward where the eating disorder service had been located in previous years.

Leadership, morale and staff engagement

- Staffing turnover and sickness rates during the period March 2016 to March 2017 were low at 5% and 1.6% respectively.
- At the time of our inspection there were no grievance procedures being pursued by staff on Oak Ward and there had been no previous allegations of bullying or harassment.
- All staff that we spoke with were aware of the whistleblowing process and said they would feel able to raise concerns without fear of victimisation if needed.
- Morale amongst all staff that we spoke with was excellent. Staff reported that they felt valued and respected by the ward manager and that a culture of mutual support, learning and reflection underpinned the approach of the clinical team. Several patients and staff gave examples of where the ward manager had gone over and above to provide a quality service and to be available for patients. One staff member said that the ward manager was the last person you would see in the evening, and the first person you would see the next morning, another cited them as a role model for both staff and patients and they felt privileged to work alongside them as part of the clinical team.
- All staff that we spoke with said they enjoyed high levels of job satisfaction and felt empowered to deliver a high quality and effective service. The staff team and patients had worked collaboratively to develop the identity of the ward as "the mighty Oak" with a ward motto of "#worth it" and a goal to make every day worth it. The ward identity, goals and aims were promoted throughout the service and were visible on patient art work, clinical documentation and decorated in communal areas. Staff and patients used a reflective model to develop the culture of the ward and to guide their clinical work, treatment and professional approach and the processes of this had been decorated on a wall in the main ward.
- There were opportunities for staff development, the care certificate standard was in place for health care assistants and a range of training was provided for staff across the Woodbourne priory by the ward manager and dietician.
- The culture of the ward was openness and transparency. All patients that we spoke with said that staff communicated effectively with them and offered explanations if and when things went wrong and changes were made as a result.
- Staff were well engaged in the development of the service. Staff that we spoke with reported that the team culture was open and they were encouraged to bring forward ideas for improving care. We saw multiple examples of where staff and patient initiatives had been supported by the ward manager and embedded as part of clinical practice.

Commitment to quality and innovation

- Oak Ward was accredited with the Quality Network for eating disorders, valid from 2015 to 2018 and had been awarded a rating of excellent, one of only five eating disorder services in the country to obtain an excellent rating.

Outstanding practice and areas for improvement

Outstanding practice

Oak Ward was accredited with the Quality Network for eating disorders, valid from 2015 to 2018 and had been awarded a rating of excellent, one of only five eating disorder services in the country to obtain an excellent rating.

Patients on Oak Ward were fully involved in the development, maintenance and evaluation of the ward philosophy and its recovery based approach to care. Patients were routinely involved the recruitment and appraisal of staff and were supported to participate in a range of community activities to showcase their talents, raise money for a local charity and raise the public awareness of eating disorders.

Areas for improvement

Action the provider MUST take to improve

- The provider must mitigate risks by ensuring ward security checks are carried out and signed as complete by a responsible individual.
- The provider must ensure staff on Maple, Beech and Aspen wards are adequately trained in safeguarding adults and children to enable them to carry out the duties they are employed to perform and keep patients safe from harm.

Action the provider SHOULD take to improve

- The provider should ensure risk assessments are reflective of patients current and historical risk. They should detail risk in a clear way order, so that staff accessing records can find accurate information without confusion or delay.
- The provider should ensure care plans do not use jargon and reflect the language used by the patient where possible.
- The provider should record complete and contemporaneous patient records including a record of decisions taken in relation to the discharge planning.
- The provider should enable and support patients to understand their plans for discharge.
- The provider should have a system in place to audit the use of rapid tranquilisation.
- The provider should ensure when checking items in emergency bags that they are both present and in date.
- The provider should ensure clinic room temperature is monitored and recorded daily and equipment used to monitor temperature is in working order.
- The provider should ensure rationale for prescribing outside National Institute of Health and Care Excellence guidelines is clearly documented in care records.
- The provider should ensure Mental Capacity Act assessments include a diagnostic assessment and there are processes in place to audit the Mental Capacity Act.
- The provider should ensure the accurate recording of staff supervision.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure staff were adequately trained to carry out the duties they are employed to perform. Compliance with mandatory safeguarding training for both child and adult level 2 and 3 was low on Maple and Beech wards, and in one instance on Aspen Ward. This was a breach of regulation 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The service did not do all that is reasonably practicable to mitigate risks by ensuring ward security checks are carried out and signed as complete by a responsible individual. We found a significant number of security checks on Beech Ward had not been completed between March 2017- June 2017. We found a room on Beech Ward, which patients were not risk assessed to access, to be unlocked. This was a breach of regulation 12(2)(b)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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