The Priory Hospital North London

Quality Report

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

Ratings

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

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.

Summary of findings

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

Overall summary

We rated The Priory Hospital North London as requires improvement because:

- At the previous inspection in May 2016 we found that ligature risks were present across the wards. At this inspection there were still many ligature risks, including high risk ligatures in bedrooms on the child and adolescent wards. The pace of change following serious incidents on the child and adolescent wards was not rapid enough to ensure that ligature risks were removed or minimised. Serious incidents had included a child who had died. They had used a bedsheet and been found hanging from a ligature anchor point.
- There was a lack of clear leadership on the child and adolescent wards. At the time of the inspection neither ward had permanent ward managers available. Acting ward managers were in place, but they were unable to describe what actions were taken to ensure the safety of all young people on the wards.
- On the child and adolescent wards, the governance and risk management systems and processes in place had not been effective. Potential risks to young people were not proactively addressed and minimised in a timely manner. The systems and processes in place to monitor care were not effective on the child and adolescent wards. Audits were not effective in alerting staff or managers to areas where there were concerns and improvements were needed.
- At the previous inspection in May 2016 we found that there was not a full complement of nursing staff. At this inspection we found that staffing levels for nurses on the child and adolescent wards were not safe. There were numerous shifts when the number of registered nurses fell below the established level to one registered nurse on a shift. Young people did not always receive one to one nursing sessions and their escorted leave was sometimes cancelled due to staffing levels on the wards.
- Patients' risk assessments were not detailed and risk management plans did not always identify how staff could minimise risks effectively. On the child and adolescent wards, young peoples' risk assessments did not include information about all areas of potential risk, such as their physical health needs or history of severe self harm.
- Staff on the child and adolescent wards did not always understand what constituted restraint. Restraints of young people were not always recorded consistently on incident forms or within nursing notes. Care plans did not reflect how to support young people in the least restrictive way.
- On the child and adolescent wards emergency alarms and call buttons were not always responded to in a timely manner. The on-call doctor was on site, but did not carry an alarm or pager. Staff may not have been able to contact the doctor in an emergency.
- Physical health assessments of young people were not always fully completed on their admission to the hospital. Staff did not complete the paediatric early warning system correctly. This meant staff may not recognise a deterioration in a young person's physical health and report this to medical staff.
- Staff on the child and adolescent wards did not ensure that medicines were managed safely. Medicine administration records did not always show clearly which route 'as required' medicines should be or had been administered. Staff did not record in daily records why 'as required' medicines were required or how effective they had been.
- Clients having substance misuse treatment did not have early exit plans in case they left detoxification

Summary of findings

treatment early. Early exit plans would describe to clients how they could avoid such risks when leaving treatment early, such as alcohol withdrawal seizures or overdose.

- Clients having alcohol detoxification treatment were monitored using a validated withdrawal tool for two days. Serious complications from alcohol withdrawal treatment can occur after the first two days of alcohol detoxification.
- On all of the wards, patients and young peoples' care plans did not always reflect their needs. Care plans were not always personalised, holistic or recovery-orientated. On the child and adolescent wards, young people were not involved in producing their own care plans. Staff did not always understand the needs of the young people. Most patients on the adult ward did not have a copy of their care plan.
- Young people on the child and adolescent wards told us that some staff did not treat them with respect and dignity. They found some staff patronising and unsympathetic.
- On the child and adolescent wards, staff had not attended specialist training required to carry out their role effectively. They had not had training in epilepsy or autism, and did not have a good knowledge of the Mental Capacity Act 2005.
- On all of the wards, there was no clear record that informal patients were told that if they were informal, they had the right to leave at any time. On the child and adolescent wards this applied to informal young people over 16 years of age. This was not in accordance with the Mental Health Act code of practice.
- On the child and adolescent wards, information was not available in an 'easy read' format for young people with learning disabilities or difficulties.
- There was no system to indicate to staff when equipment needed replacing or recalibrating. Physical health equipment, such as blood glucose monitoring equipment, could become inaccurate if it was not maintained properly. Only an adult blood pressure cuff was available on one of the child and adolescent wards, and some equipment was not clean or within it's expiry date.
- The provider did not ensure that complaints were responded to within agreed time frames.

However, we also found the following areas of good practice:

- Chronotherapy was used to treat patients' depressive symptoms. Chronotherapy involves a variety of strategies to control exposure to environmental factors which may influence depressive symptoms. This treatment is not widely available in the United Kingdom, but has a strong international evidence base.
- On the adult ward, staffing levels had improved and the minimum staffing levels were consistently met or exceeded. Staff on the adult ward received regular one-to-one supervision, and had access to regular group supervision. This had improved since the last inspection.
- Patients, young people and carers had the opportunity to provide feedback to the service in various ways. This included community meetings and periodic surveys. Young people on the child and adolescent wards were involved in the recruitment of staff.
- Staff were supported following serious incidents. Staff were given the opportunity to reflect on incidents and identify changes that could be made to the service to prevent similar incidents re-occurring. Learning was identified following incidents and complaints, and was used to improve the service.
- Clients having substance misuse detoxification were monitored using validated withdrawal tools. Staff were knowledgeable regarding substance misuse and had received specific training.
- On the child and adolescent wards, the staff team provided a weekly programme consisting of education, therapy and activity-based groups.
- All patients and young people received a welcome pack when they were admitted to the hospital. Families of young people also received a welcome pack. This included information on how to make a complaint. Carers had access to a monthly carers group. They could meet other carers and discuss any issues or concerns that they may have.

Summary of findings

- Adult patients having acute mental health or substance misuse treatment reported that staff had positive attitudes and treated them with respect. Staff worked hard to meet the individual needs of patients, and supported them with areas such as religion and gender identity.
- On the child and adolescent wards, young people were expected to attend education that was provided on the ward. Staff supported young people to be reintegrated back into their local school or college provision.
- Staff supported young people to maintain contact with their families and carers. Families and carers were encouraged to attend ward rounds and care programme approach meetings. Where this was not possible staff gave other opportunities such as attending by conference call. Staff encouraged young people to maintain relationships with people that mattered to them.
- Staff found that the senior staff team were supportive and visible. Following a recent serious incident staff had received counselling and additional support.

During and following this inspection, we provided feedback to the provider regarding our concerns, and specifically our serious concerns regarding young peoples' safety on the child and adolescent wards. The provider immediately transferred an experienced child and adolescent service manager to provide leadership to the child and adolescent wards. The provider also developed a detailed action plan to address our concerns.

Summary of findings

Contents

Requires improvement

The Priory Hospital North London

Services we looked at
Acute wards for adults of working age and psychiatric intensive care units; Child and adolescent mental health wards; Substance misuse services

Summary of this inspection

Our inspection team

The Priory Hospital North London was inspected by a team including a CQC Inspection Manager, four CQC Inspectors, two CQC Assistant inspectors and four specialist advisors. Three of the specialist advisors were nurses and the other specialist advisor was a consultant psychiatrist in addictions. A student nurse also joined the inspection team.

Why we carried out this inspection

This was an unannounced comprehensive inspection. We undertook this inspection to check on the quality and safety of the services and to check on improvements made since our last inspection in May 2016.

At the inspection in May 2016, we rated Safe as requires improvement, and Effective, Caring, Responsive and Well-Led as good. The overall rating was good.

At the inspection in May 2016, we told the provider they needed to make the following improvements:

We found that the premises used by the service provider were not safe to use for their intended purpose. There were high risk ligature points in rooms designated as safer rooms. There were high risk ligature points in the laundry room that had not been identified.

This was a breach of Regulation 12(2)(a) of the HSCA (Regulated Activities) Regulations 2014.

We also recommended that the provider take the following action:

The provider should ensure that it has a full complement of permanent nursing staff.

The provider should ensure that staff are familiar with the principles of the Mental Health Act Code of Practice and the Mental Capacity Act.

The provider should ensure that the issuing and routine testing of personal alarms is recorded.

The provider should ensure that regular, individual supervision is available to all staff.

How we carried out this inspection

To understand the experience of people who use services, we ask the following five questions about every service:

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

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

During the inspection visit, the inspection team:

- visited the wards, looked at the quality of the physical environment, and observed how staff were caring for clients
- spoke with 21 clients, patients and young people
- spoke with the registered manager and the medical director
- spoke with the ward manager and acting ward managers of the wards
- spoke with 27 other staff members employed by the service provider, including nurses, doctors, occupational therapists, healthcare assistants, therapists and a dietitian
- spoke with two carers of young people

Summary of this inspection

- attended and observed a multi-disciplinary assessment of a young person
- attended and observed two handover meetings and two ward rounds
- attended and observed a young persons' community meeting
- looked at 21 care and treatment records, including medicines records, for clients. patients and young people
- looked at 11 exit interviews of young people
- carried out a specific check of medicines management on all of the wards
- looked at policies, procedures and other documents relating to the running of the services

Information about The Priory Hospital North London

The Priory Hospital North London is a 49 bed independent hospital in North London which provides care and treatment for people with mental health problems and substance misuse problems. The services provided at the hospital are:

Lower Court - A 27 bed ward for male and female adults with acute mental health problems, obsessional disorders and substance misuse problems.

Birch Ward - A 13 bed ward for children and young people up to 18 years of age. The ward provides care and treatment for males and females with acute mental health problems.

Oak Ward - A 9 bed ward for children and young people up to 18 years of age. The ward provides care and treatment for males and females with acute mental health problems.

The NHS commissions beds for adults and children and adolescents at The Priory Hospital North London. Clients at the hospital also have their care and treatment funded by insurance companies, or are self funding.

The provider is registered to provide the following regulated activities:

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

Treatment of disease, disorder or injury

There was a registered manager in post.

What people who use the service say

Overall, patients and young people were positive regarding staff. They described staff as being respectful, supportive and knowledgeable. However, some young people described some staff on the child and adolescent wards as being patronising and unsympathetic. This related to staff who worked at night. The two patients in the adult ward being treated for obsessive compulsive disorder did not find staff knowledgeable about their specific needs.

Adult patients felt involved in their care and treatment. However, young people did not and had not worked with staff to develop their care plans.

Young people did not feel there was enough choice at mealtimes, and that the menu was not 'child friendly'. They also said that some food choices often ran out. Adult patients also spoke of food running out, but felt the food was good quality, although there were limited options for vegetarian and vegan patients.

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?

Inadequate 

We rated safe as inadequate because:

- At the previous inspection in May 2016 we found that ligature risks were present across the wards. At this inspection there were still many ligature risks. These were in communal areas and in clients' bedrooms. Some high risk ligatures were in young peoples' bedrooms on the child and adolescent wards. We highlighted the potential ligature risks on the child and adolescent wards with the provider during our inspection. The provider took immediate action to mitigate these risks.
- At the previous inspection in May 2016 we found that there was not a full complement of nursing staff. At this inspection we found that staffing levels for nurses on the child and adolescent wards were not safe. There were numerous shifts when the number of registered nurses fell below the established level to one registered nurse on a shift. Young people did not always receive one to one nursing sessions and their escorted leave was sometimes cancelled due to staffing levels on the wards.
- Patients' risk assessments were not detailed and risk management plans did not always identify how staff could minimise risk effectively. For clients having substance misuse treatment, the multidisciplinary team did not discuss potential risks effectively. On the child and adolescent wards, young peoples' risk assessments did not include information about all areas of young peoples' potential risk, such as their physical health needs or history of severe self harm
- Staff on the child and adolescent wards did not always understand what constituted restraint. Restraints of young people were not always recorded consistently on incident forms or within nursing notes. Care plans did not reflect how to support young people in the least restrictive way.
- On the child and adolescent wards emergency alarms and call buttons were not always responded to in a timely manner.
- On the child and adolescent wards staff had not completed paediatric early warning system records correctly. This meant that staff may not be alerted to a young person's physical health deteriorating. This also meant that deterioration in young peoples' physical health may not be escalated appropriately.
- The provider had an out of hours doctor on site. However, the doctor did not carry an alarm or pager so staff may not have been able contact the doctor immediately in an emergency.

Summary of this inspection

- Staff on the child and adolescent wards did not ensure that medicines were managed safely. Medicine administration records did not always show clearly which route 'as required' medicines should be or had been administered. Staff did not record in daily records why 'as required' medicines were required or how effective they had been.
- Clients having substance misuse treatment did not have early exit plans in case they left detoxification treatment early. There are specific risks to people if they leave alcohol or opiate detoxification treatment early, such as alcohol withdrawal seizures and overdose, which can be fatal. Early exit plans would describe to clients how they could avoid such risks.
- On all of the wards, informal patients were not consistently informed that they had the right to leave at any time. On the child and adolescent wards this applied to informal young people over 16 years of age.
- The provider did not have a system to alert staff working on the ward to the need to either replace or recalibrate physical health monitoring equipment. This presented a risk that physical health monitoring readings, such as blood glucose monitoring, could become inaccurate if equipment was not maintained appropriately. On the child and adolescent wards, only an adult blood pressure cuff was available on one ward and some equipment was not clean or within its expiry date.

However, we also found:

- During our inspection in May 2016 we identified a high number of staff vacancies and use of temporary staff. On the adult ward, this had improved and the minimum staffing establishment was consistently met or exceeded.
- Staff were supported following serious incidents. Staff were given the opportunity to reflect on incidents and identify changes that could be made to the service to prevent similar incidents re-occurring.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Physical health assessments of young people were not always fully completed on their admission to the hospital.
- On all of the wards, patients and young peoples' care plans did not always reflect their needs. Care plans were not always personalised, holistic or recovery-orientated.
- On the child and adolescent wards, staff had not attended specialist training required to carry out their role effectively. They had not had training in epilepsy or autism, and did not have a good knowledge of the Mental Capacity Act 2005.

Summary of this inspection

- Clients having alcohol detoxification treatment were monitored using a validated withdrawal tool for two days. Serious complications from alcohol withdrawal treatment can occur after the first two days of alcohol detoxification.

However, we also found:

- Staff on the adult ward received regular one-to-one supervision. They also had access to regular group supervision. This had improved since the last inspection.
- Clients having substance misuse detoxification were monitored using validated withdrawal tools. staff were knowledgeable regarding substance misuse and had received specific training.
- On the child and adolescent wards, the staff team provided a weekly programme consisting of education, therapy and activity-based groups.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

- On the child and adolescent wards, young people were not involved in producing their own care plans. Staff did not always understand the needs of the young people.
- Young people on the child and adolescent wards told us that some staff did not treat them with respect and dignity. They found some staff patronising and unsympathetic.
- Most patients on the adult ward did not have a copy of their care plan to refer to.

However, we also found the following areas of good practice:

- All patients and young people received a welcome pack when they were admitted to the hospital. Families of young people also received a welcome pack.
- Adult patients having acute mental health or substance misuse treatment reported that staff had positive attitudes and treated them with respect.
- Young people on the child and adolescent wards were involved in the recruitment of staff.
- Patients, young people and carers had the opportunity to provide feedback to the service in various ways. This included community meetings and periodic surveys.
- Carers had access to a monthly carers group. They could meet other carers and discuss any issues or concerns that they may have.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- On the child and adolescent wards, young people were expected to attend education that was provided on the ward. Staff supported young people to be reintegrated back into their local school or college provision.
- On the adult ward staff worked hard to meet the individual needs of patients. Staff supported patients with areas such as religion and gender identity.
- Staff supported young people to maintain contact with their families and carers. Families and carers were encouraged to attend ward rounds and care programme approach meetings. Where this was not possible staff gave other opportunities such as attending by conference call.
- Staff encouraged young people to maintain relationships with people that mattered to them.
- Patients, young people and carers were provided with information on how to make a complaint.

However, we also found the following areas for improvement:

- On the child and adolescent wards, information was not available in an 'easy read' format for young people with learning disabilities or difficulties.
- The provider did not ensure that complaints were responded to within the agreed time frames.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- There was a lack of clear leadership on the child and adolescent wards. At the time of the inspection neither ward had permanent ward managers available. Acting ward managers were in place, but they were unable to describe what actions were taken to ensure the safety of all young people on the wards.
- The pace of change following serious incidents on the child and adolescent wards was not rapid enough to ensure that areas of potential high risk were addressed.
- On the child and adolescent wards, the governance and risk management systems and processes in place had not been effective. Potential risks to young people were not proactively addressed and minimised in a timely manner.
- Systems and processes were not in place to ensure that there was effective monitoring of care and treatment on the child and adolescent wards. Audits were not effective in alerting staff or managers to areas where there were concerns.

However, we also found the following areas of good practice:

Summary of this inspection

- The recently appointed hospital director was very responsive to safety concerns. They ensured that a number of environmental safety concerns highlighted during our inspection were dealt with immediately.
- Following this inspection, the provider immediately transferred an experienced child and adolescent service manager to provide leadership to the child and adolescent wards. The provider also developed a detailed action plan to address our concerns.
- Staff found that the senior staff team were supportive and visible. Following a recent serious incident staff had received counselling and additional support.
- Learning was identified following incidents and complaints and was used to improve the service.

Detailed findings from this inspection

Mental Health Act responsibilities

At the time of the inspection, two young people on Oak Ward were detained under the Mental Health Act (MHA). Both of these young people were detained for treatment. The care and treatment records of these young people adhered to the MHA and the MHA Code of Practice.

Sixty four per cent of staff on the adult ward had received training in the MHA, and had a good understanding of the MHA. Information for the child and adolescent wards staff training was unavailable. Training for staff on the MHA was not mandatory training.

The hospital had a MHA administrator. They supported the staff with administrative and legal advice on the implementation of the MHA and its Code of Practice. Staff were able to contact the administrator when they needed advice.

The provider had relevant policies and procedures that reflected the most recent Code of Practice. Staff had access to local MHA policies and to the Code of Practice.

Young people received information regarding advocacy in their admission welcome pack. An independent mental health advocacy (IMHA) service was available to young people. The advocate visited the wards weekly and would meet with all new young people. Young people could contact the IMHA service directly if they wanted to.

Staff explained young peoples' rights under the MHA to them. Staff were explaining their rights to one young person on a daily basis. The young person was not able to understand their rights at the time, partially due to their learning difficulty. The service did not have information available in an accessible format such as 'Easy Read' for young people with learning disabilities or difficulties.

Staff ensured that Section 17 leave paperwork was completed and regularly reviewed. Staff ensured that young people were able to take section 17 leave when it had been granted.

Staff stored copies of young people's detention papers and associated records correctly and they were available to all staff that needed access to them.

Mental Capacity Act and Deprivation of Liberty Safeguards

- During our last inspection in May 2016 we identified that staff were not familiar with the Mental Capacity Act (MCA). During this inspection, 79% of staff on Lower Court adult ward had received training in the MCA. Staff were clear about the principles relating to the MCA including when a capacity assessment would be necessary. However, they told us that doctors took full responsibility for completing capacity assessments.
- Training information was unavailable for the child and adolescent wards at the time of the inspection. Following the inspection, the provider told us that MCA training for staff was mandatory. However, staff did not have a good understanding of the MCA. Following the inspection, the provider informed us that MCA training for staff was mandatory. The MCA applies to young people over 16 years of age. Nursing staff told us that the doctors assessed the capacity of young people on admission; this was regarding the young person's capacity to consent to care and treatment. Staff did not understand that capacity was decision specific and not just regarding capacity to consent to care and treatment. During the inspection we did not identify any other decision-specific capacity assessments.
- There had been no Deprivation of Liberty Safeguards (DoLS) applications made for patients during the 12 months before our inspection.
- Policies on the use of the MCA and DoLS were available for staff to access. The Mental Health Act administrator supported staff with queries about the MCA.
- Where a young person was under 16 years of age doctors assessed and recorded if they met Gillick competence or not. Gillick competence is a term in medical law to decide whether a young person under 16 is able to consent to their care and treatment, without the need for parental permission of knowledge.

Detailed findings from this inspection

- Care records included information about who had parental responsibility for the young person and who should be consulted about their care and treatment. The staff reviewed the young person's capacity to consent to their care and treatment at the weekly ward rounds.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute wards for adults of working age and psychiatric intensive care units	Requires improvement	Good	Good	Good	Good	Good
Child and adolescent mental health wards	Inadequate	Requires improvement	Requires improvement	Good	Inadequate	Inadequate
Substance misuse services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Inadequate	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement

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

Good

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

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

Requires improvement

Safe and clean environment

- A comprehensive risk assessment of the care environment took place in January 2018. Monthly quality walk arounds were also completed by staff. This included an assessment of the safety and suitability of the premises and equipment.
- During our last inspection in May 2016 we identified that the premises were not safe for their intended use. This was because there were a significant number of high-risk ligature points across the ward, some of which had not been identified by staff. During this inspection, work was still needed to ensure the premises were safe for their intended use.
- The provider had devised a programme of works to remove most of the ligatures and install mirrors to help staff observe blind spots more easily. There was no target date for completion of these works at the time of our inspection.
- Staff regularly observed each patient to help mitigate the risks posed by ligature points and blind spots. If patients' risk levels increased, staff observed them more frequently. A thorough and up to date ligature risk assessment was now in place which identified the environmental works needed to improve the safety of the ward environment. However, there was a lack of additional information about how staff should mitigate each identified ligature risk whilst these works were pending, aside from altering the frequency of patient observations.
- Blind spots were present throughout the ward. Staff stationed themselves at two nursing stations so they could observe the communal areas of the ward at all times.
- Two bedrooms located near one of the nursing stations, and had viewing panels in the doors to enable staff to observe patients more easily. However, we identified significant ligature risks including curtain rails and telephones with cords were present in these bedrooms.
- The ward complied with guidance on eliminating mixed-sex accommodation. Although the ward was mixed sex, all bedrooms had en-suite facilities and a female only corridor and female only lounge.
- During our last inspection in May 2016 the issuing and routine testing of personal alarms was not recorded. During this inspection staff members had easy access to alarms to call for assistance in an emergency. Alarms were tested and recorded on a daily basis.
- All ward areas were clean, had good furnishings and were well-maintained. Cleaning records were maintained for the general ward environment, and showed that all areas were cleaned regularly.
- Staff adhered to infection control principles, including handwashing. Infection, prevention and control (IPC) and hand hygiene audits were completed regularly. Action plans were developed following these audits to ensure that the ward complied with IPC principles.

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

Good

- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs. Resuscitation equipment and emergency drugs were checked each week. However, a weekly check to ensure equipment in the clinic room was in working order had only been in place since March 2018 and these checks had often since been missed.
- There was no system in place to alert staff on the ward to the dates by which physical health monitoring equipment needed to be either replaced or calibrated. Staff recorded they were not aware as to whether equipment had been tested and serviced as necessary during the March 2018 quality walk-round.
- Although clinical equipment appeared to be visibly clean, staff did not keep a record to show when items were last cleaned. A new clinic room cleaning record was implemented during our inspection visit.

Safe staffing

- Minimum staffing establishment levels outlined that two registered nurses and one nursing assistant should be present on the ward at all times, and that this should be increased to two registered nurses and two nursing assistants when 23 or more patients were present on the ward. Staffing levels met these establishment levels and in most cases exceeded them.
- During our last inspection in May 2016 we identified a number of nursing staff vacancies on the ward and staff turnover was high. We found during this inspection that staff retention had improved. Staff turnover was 11.6% and had improved since the last inspection. The staff vacancy rate had also decreased to 7.8%. The provider had offered long term agency staff additional training and offered them positions as permanent staff members if appropriate.
- During the 12 months before our inspection, 1,300 shifts were covered by bank or agency staff. 3,143 shifts were not covered by bank or agency staff. However, these uncovered planned shifts were usually in addition to the minimum staffing establishment. Therefore, safe staffing levels were maintained.
- During the 12 months before our inspection, staff sickness was 6.4%. This was a slight increase from our last inspection in May 2016.
- The ward manager could adjust staffing levels according to case mix. For example, additional staff were rostered when patients required enhanced observations.
- Bank and agency staff received a comprehensive induction to the ward. This included environmental hazards including ligature points that had been identified, as well as an introduction to the patients.
- Plans were being developed to ensure a senior nurse was scheduled to work across the hospital each weekend.
- Patients reported that they knew who their named nurse was and could approach them at any time if they had queries about their care and treatment. However, one to one time between patients and their named nurse was not routinely organised.
- We did not identify any examples of activities or escorted leave being cancelled due to short staffing.
- A doctor was available 24-hours a day. However, there was a risk that the duty doctor could not attend an emergency situation promptly. In an emergency, staff were instructed to telephone the on-call room. The duty doctor did not carry a pager or mobile telephone, so could not be located easily if they left the on-call room.
- Staff were mostly up to date with their mandatory training. Overall training compliance for the ward was 83% at the time of the inspection.
- The training courses with compliance rates that were lower than 75% were rapid tranquilisation, maintaining professional boundaries, IT security, the Mental Health Act, Deprivation of Liberty Safeguards, cyber security, clinical risk assessment and anaphylaxis.

Assessing and managing risk to patients and staff

- All seven of the patient care and treatment records we examined had comprehensive risk assessments in place. These were completed promptly on the day of admission and updated regularly and after any incidents.
- The risk assessment template prompted staff to include details of risks to the patient, risks the patient presented to other people and a history of risk related incidents. Staff were able to access historic risk assessments that had been completed during previous admissions to hospitals in The Priory Group.

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

Good

- Details about how staff should manage the risks identified in risk assessments were lacking. For example, we identified one patient whose risks of suicide, self-harm, self-neglect and non-adherence to medication had recently increased. The frequency of their routine observations was increased to mitigate the risk of suicide and self-harm. However, other risk management strategies to mitigate the risks of self-neglect and non-adherence to medication were absent. This in turn presented a risk that the identified areas on the patient risk assessment may not be managed and minimised.
- The main way in which staff managed identified risks was through observation. Patients whose overall risk levels increased were subject to increased observations.
- One patient had a risk traffic light system in place to identify their level of risk. When they identified changes in their own risks, they communicated this with staff using red, amber and green. This system helped staff identify how frequently the patient's observations needed to be completed.
- Staff searched patient bedrooms only when there was a risk that the patient might bring drugs or alcohol onto the ward, or if staff had reason to believe that other items that could be used to self-harm were present on the ward. Searches of patients returning from leave were not routine for those on the general mental health and obsessive compulsive disorders treatment programmes.
- Staff did not apply unnecessary blanket restrictions on patients' freedom. Items that could be used by patients to self-harm were banned. Personal items such as mobile telephones and access to the internet were unrestricted unless there was a specific risk that these items presented to an individual patient. However, patients reported that they were asked not to bring sweets, snacks or toast onto the ward. Other foodstuffs were permitted.
- Staff implemented the provider's smoking policy. All cigarettes and electronic cigarettes were banned in all hospital buildings. Patients were asked to smoke in allocated smoking zones within the hospital grounds. The provider also ensured that all e-cigarettes had a Portable Appliance Test to ensure they were safe to use.
- Informal patients' right to leave the ward at any time was not always clear to them. Patients reported that they were strongly dissuaded from leaving the hospital during their first few weeks or if their individual risks were heightened. A sign was displayed to request that informal patients should notify staff if they were leaving. However, this was not sufficiently clear about patients' right to leave. Staff understood that they could not legally prevent informal patients from leaving and would need to consider using the MHA if they had concerns about the safety of a patient intending to leave. However, staff did not do all they could to make this clear to patients. In some cases, informal patients were placed on enhanced observations. However, staff assured us that if they had safety concerns about informal patients choosing to leave, they would take urgent action in accordance with Section 5 of the Mental Health Act 1983. This would allow a registered nurse or the duty doctor to prevent the patient from leaving the hospital.
- Staff did not seclude patients on the ward. There was no seclusion room at the hospital. Staff aimed to use the least restrictive intervention when responding to incidents of violence or aggression, by using verbal de-escalation as a first course of intervention.
- Thirty episodes of restraint were recorded on the adult ward in the 12 months leading up to our inspection. Staff avoided restraining patients in the prone position if possible, and there were no recorded incidents of prone restraint during the 12 month time period. Episodes of restraint were recorded in detail on incident reporting forms. Details included the type of restraint, which staff members were present at the time and what their role in the intervention was and the total duration of the restraint episode.
- Seven incidents of intramuscular rapid tranquilisation had taken place during the 12 months before our inspection. Staff had followed professional guidance when using rapid tranquilisation, completing the necessary physical observations in all but one case.
- Staff understood how to report safeguarding concerns and could give examples about the type of incident they would report as safeguarding. Staff from the adult ward made 28 safeguarding referrals to the local authority during the 12 months before our inspection. The ward manager met with the local authority safeguarding adults team each quarter to discuss progress with safeguarding investigations and safeguarding themes in the local area.
- Seventy nine per cent of staff had received training in safeguarding adults, and 93% of staff had received training in safeguarding children at the time of our inspection.

- Information about how to raise a safeguarding referral with the local authority was displayed for staff. Two designated safeguarding leads worked on the ward. Both the safeguarding lead and hospital social worker could be contacted by staff for advice on safeguarding.
- Staff followed safe procedures for children visiting patients. Rooms were booked outside the ward for patients to meet privately with young relatives.
- Patient care records were stored on an electronic system. Existing patient records were accessible to staff if patients were re-admitted to the service at a future date.
- Medicine administration records and physical health monitoring records were completed on paper. Staff were not expected to record information on more than one system, minimising the risk of information being recorded in the wrong place and becoming difficult to locate. All staff, including agency staff, could access both electronic and paper records.
- Staff followed good practice in medicines management in line with national professional guidance. Medicines reconciliation took place on admission. Medicines were stored securely and in well-organised cabinets and a medicines fridge, and were disposed of safely.
- Controlled drugs were safely stored in a controlled drugs cabinet according to professional guidance. Volumes of controlled drugs administered or destroyed were clearly recorded in the controlled drugs register.
- Staff recorded ambient room and fridge temperatures each day. Staff knew what action they should take to ensure the efficacy of medicines if their storage temperatures fell outside of the normal range.
- Staff reviewed the effects of medication on patients' physical health regularly and in line with professional guidance, especially when the patient was prescribed a high dose of antipsychotic medication. Physical health monitoring took place each day for patients on antipsychotic medications.

Track record on safety

- Staff reported 15 serious incidents on the ward during the 12 months before our inspection. Serious incidents were immediately reviewed by the organisation's board of directors. Many of these serious incidents reported by staff were subsequently reviewed by the provider's board and downgraded to standard incidents.
- Three serious incidents had occurred on the ward since January 2018. These incidents were subject to ongoing investigations at the time of our inspection. However, staff had reflected on these incidents and discussed initial changes that could be made to the service to prevent similar incidents re-occurring in the meantime.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them using an electronic incident reporting system. Staff could flag incidents as having safeguarding implications using the electronic form if necessary. The hospital senior management team reviewed all incidents each morning.
- Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong. For example, following a near-miss where a patient was almost administered the incorrect medicine, the patient received an apology and was kept updated about actions such as increasing training and medicines competency checks to prevent similar incidents re-occurring.
- Incidents that had recently taken place both on the ward and at other locations operated by the provider were discussed by staff at monthly clinical governance meetings. They identified what they could learn from recent incidents and how to implement feedback from recent incident investigations. For example, the medicines trolley was relocated within the clinic room following an incident where a patient told staff they were able to take medicine by reaching across the stable-door between the corridor and clinic room.
- Staff received appropriate support following serious incidents. Three serious incidents had taken place on the ward in recent months, along with other incidents elsewhere in the hospital that had a direct effect on staff. Immediate debriefs took place following these incidents, as well as ongoing reflection during staff meetings over the following weeks. Sessions with counsellors and other necessary adjustments were made for staff who needed time to reflect following serious incidents.

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

Good

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We examined seven care and treatment records relating to patients on the general mental health and obsessive compulsive disorder treatment programmes.
- Mental state examinations of patients were thorough and were completed promptly on the day of admission during the doctor's assessment.
- Patients' initial nursing assessments were generally completed in a timely manner. These assessments identified information about how patients managed long term physical health conditions. They also helped staff to understand each patients' personal background and important relationships.
- Patients' physical health needs were assessed on admission and were summarised in a 'keeping me healthy' care plan. This also included information about managing patients' long term physical health conditions. Initial physical health assessments included patients' weight, height, body mass index, blood pressure, a summary of existing physical health conditions and consideration of appropriate health screening.
- Patients' care plans included the different aspects of patients' care and treatment and were completed soon after admission and updated regularly. Each patient had four separate care plans in place entitled 'keeping me safe, keeping me connected, keeping me well and keeping me healthy'.
- Patients contributed and offered their views about their care. However, some of the content, including recovery goals, was generic and lacked the necessary level of detail to ensure they were person-specific.

Best practice in treatment and care

- Patients were prescribed medicines appropriately for their specific mental health problem. Medicines were prescribed following National Institute for Health and Care Excellence best practice guidance.
- Patients were assessed by a therapist on admission and a programme of therapies specific to their needs was put in place. These therapies were delivered in line with best practice guidance. Therapeutic programmes included cognitive and dialectical behavioural therapies, psychotherapy, drama and art therapy. Other groups including managing emotions, anger management and women's and men's discussion groups were also part of the therapy programme.
- Chronotherapy was used to treat patients' depressive symptoms. Chronotherapy involves a variety of strategies that control exposure to environmental factors that may influence depressive symptoms. For example, bright light was used to simulate daylight and a specific sleep programme was used. Staff used depression scales to monitor the effectiveness of chronotherapy.
- Patients overwhelmingly reported that there were not enough activities available to them outside of the therapies programmes. There was a lack of activities particularly during evenings and at weekends, when the only routine session was a reflection on the previous week.
- Staff were aware that work was needed to improve provision of activities outside of the therapy programme. Patients had raised this issue both informally and during community meetings. Staff had started to act on this feedback by implementing an enhanced activity timetable during a recent bank holiday weekend.
- Although patients knew who their named nurse was, they reported that one to one time between them and their named nurse was not routinely arranged. This meant there were gaps in monitoring any changes in patient risk and other specific care needs. This then led to patients' care records not being up to date for other staff to follow.
- Staff referred patients to physical healthcare specialists if needed and supported patients to attend physical health appointments. A physical health lead nurse worked with patients' named nurses to ensure that

needs relating to physical health conditions were included in sufficient detail in patient care plans. Another nurse was trained to take blood samples to support the ongoing monitoring of patients' physical health conditions, such as diabetes.

- A dietitian worked half a day across the hospital. Patients were referred to the dietician if they required individualised eating/dietary plans.
- Staff supported patients to lead a healthier lifestyle. The ward doctor was trained in smoking cessation, and assisted patients who wished to stop or reduce their smoking to access nicotine replacement therapies. Some patients were encouraged to join a local gym. Exercise classes and a healthy living group, where patients discussed diet and exercise, featured on patients' activity programmes.
- Staff used Health of the Nation Outcome Scales (HoNOS) to measure improvements in the health and social functioning of all patients on admission and at the point of discharge. Staff also used the Yale Brown Obsessive Compulsive Scale to assess changes in the symptoms of patients with Obsessive Compulsive Disorders.
- The service did not participate in national clinical audits, but local audits to assess the quality of care and treatment delivery were in place. Staff audited medicines, patient care records, completion of physical health monitoring charts and completed clinic room checks.

Skilled staff to deliver care

- The core ward team consisted of nursing staff, doctors and specialist therapists. Other professionals also contributed to patients' care and treatment programmes as needed. These included occupational therapists, a dietitian, and a speech and language therapist. A social worker also worked across the hospital. A pharmacist visited the ward once a week to provide advice to patients about their medicines.
- Staff were experienced and qualified and had access to professional development opportunities to build on their experience. The provider supported some staff to complete formal nursing training.
- Managers provided staff with appropriate inductions. This included immediate training in how to operate systems such as telephones, alarms and patient care records. A structured programme ensured the new staff member completed their mandatory training within the first few weeks of employment. During the first few weeks in post staff worked alongside experienced colleagues to familiarise themselves with the policies, procedures and protocols of the ward.
- Agency staff received a local induction. This included familiarising themselves with the identified ligatures and blind spots on the ward so they could complete routine observations safely.
- During our last inspection in May 2016 not all staff received regular one-to-one supervision. During this inspection we identified that staff received monthly one-to-one supervision. Supervision compliance during the 12 months before our inspection was 74%. This figure also accounted for staff on long-term sickness or long periods of annual leave, meaning that they missed scheduled supervision sessions. Group supervision also took place every three months. Staff discussed clinical issues and updates to clinical guidance during these sessions. Staff discussed queries about how best to manage and support individual patients as well as compliance with training and completion of audits during one to one supervision.
- Ninety nine per cent of staff had received an annual appraisal during the 12 months before our inspection. In-depth discussions about individual performance, development needs and career aspirations took place during appraisals.
- Managers ensured that staff could access the necessary specialist training for their roles. For example, staff had received training in undertaking observations, administering medicines by rapid tranquilisation, report writing and conducting searches. Staff championed specific subjects and could access enhanced training in these areas, for example, safeguarding, physical health monitoring and phlebotomy.
- Managers supported staff through periods of poor performance. Staff were monitored constructively during supervision sessions and accessed additional training and competency checks following incidents.
- The service did not use volunteers at the time of our inspection and had no immediate plans to do so.

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

Good

Multidisciplinary and interagency team work

- Staff attended a monthly clinical governance meeting and a monthly ward staff meeting. The business meeting had a flexible agenda and its aim was to enable staff to discuss the way the ward operated and to reflect on new clinical guidance.
- Effective multidisciplinary handovers took place between each shift, which helped to promote continuity of care. Discharge summaries were sent to patients GPs or community mental health teams if necessary. When patients were aiming to be discharged to a community mental health team, staff worked hard to involve them in discussions about ongoing support for patients once they had been discharged.
- The ward team had developed effective working relationships with other agencies. For example, a staff member periodically attended a meeting with NHS England to discuss learning from incidents and best practice that was being implemented by other providers of mental health inpatient services. Staff had also developed a working relationship with the team at the local London Underground station. They had an agreement in place that they would alert them if ever a patient who they were particularly concerned about was unable to be located.

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

- During our last inspection in May 2016 we identified that staff were not familiar with the principles of the Mental Health Act code of practice. During this inspection, 64% of staff had received training in the Mental Health Act (MHA). Staff had a good understanding of the MHA and could describe the purpose of the MHA.
- A MHA administrator worked on-site. Staff could access support and advice with the MHA from the MHA administrator at any time, including the providers MHA policy and procedure.
- During our inspection, there were no patients detained under the MHA. However, on previous occasions when patients had been detained under the MHA, the MHA administrator had completed audits of MHA documentation and ensuring patients' were informed of their rights.

Good practice in applying the Mental Capacity Act

- During our last inspection in May 2016 we identified that staff were not familiar with the Mental Capacity Act (MCA). During this inspection, we found 79% of staff had received training in the MCA. Staff were clear about the principles relating to the MCA including when a capacity assessment would be necessary. However, they told us that doctors took full responsibility for completing capacity assessments.
- We did not identify any examples of capacity assessments or best interest decisions being required for patients on the general mental health or obsessive compulsive disorder treatment programmes.
- There had been no Deprivation of Liberty Safeguards (DoLS) applications made for patients during the 12 months before our inspection.
- Policies on the use of the MCA and DoLS were available for staff to access. The Mental Health Act administrator supported staff with queries about the MCA.

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

Good

Kindness, privacy, dignity, respect, compassion and support

- Staff developed positive, therapeutic relationships with patients. During the inspection we observed positive staff interactions and patients told us that staff supported them with their emotional and practical needs.
- Patient feedback about the support staff gave them to understand and manage their care and treatment was mixed. Two patients told us that staff did not have a detailed enough understanding of the specific needs relating to their diagnosis of Obsessive Compulsive Disorder. The remaining patients reported that staff supported them with specific queries about their medicines or their condition.

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

Good

- Patients told us that staff respected them and always behaved appropriately towards them. For example, by knocking and waiting for a response before entering bedrooms.
- However, three patients reported that they were not comfortable with staff opening their bedroom doors at night to complete their routine observations. Most bedroom doors did not have viewing panels for staff to use, so doors needed to be opened so that these observations could be completed.
- Staff directed patients to other services when appropriate and could support them to access local support groups and appointments at local hospitals.
- Staff carefully identified the individual needs of patients. Cultural, religious and social needs were discussed on admission and documented in patient care records. Staff then supported patients with these identified needs. For example, by supporting patients to attend worship.
- Staff said they were confident in raising concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences, and that there was an open culture.
- Staff maintained the confidentiality of information about patients. All records relating to patients were securely stored. Key information about patients care and treatment was displayed in a locked nursing office and hidden from view. Staff conducted all conversations about patient care in private.

The involvement of people in the care they receive

- Each patient received a welcome pack on admission which contained key information about the way the ward operated such as visiting times and meal arrangements, and an introduction to staff members.
- Staff communicated with patients so they understood their care and treatment. The pharmacist ran a drop-in session for patients every two weeks. Patients were invited to attend to ask questions about their medications.
- Feedback surveys were offered to patients during their stay and on discharge from the service. Routine feedback was welcomed by staff at any time, and patients were able to feed back about the service during community meetings.
- At the time of the inspection, a feedback survey was undertaken of recently discharged and current patients, clients and young people. The survey consisted of fourteen positive statements about peoples' care and treatment. For ten statements, over 70% of people agreed or strongly agreed. However, for statements regarding staff listening and understanding them, and there always being plenty of things to do, just over half (54%) of people agreed or strongly agreed. The feedback survey was completed by 13 patients. The number of people completing the feedback was small, and did not identify which wards the feedback related to.
- Attendance at community meetings varied. Three separate weekly community meetings were held on the adult ward, one each for the mental health, addictions treatment and Obsessive Compulsive disorders treatment cohorts. For patients on the Obsessive Compulsive disorders and addictions treatment programmes, community meetings formed part of their structured treatment programmes, so attendance was compulsory. Staff struggled to engage patients receiving general mental health care and treatment with community meetings, and attendance was very low.
- Plans to involve patients in the staff induction process in the near future were being discussed during staff meetings.
- Five of the seven patients we spoke with did not have their own copy of their care plan. This meant that patients could not easily reflect on their progress against their recovery goals outside of arranged consultations with staff. However, patients did discuss their views about their care plan when they met with staff and contributed to discussions during ward rounds.
- Staff ensured that patients could access advocacy. Patients told us they knew how to contact the advocate. A poster containing information about how to contact the advocate was displayed in the main lounge.

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

Good

- Families and carers were supported by staff. A monthly relatives group took place at the hospital. Relatives and carers were encouraged to provide feedback about the service at these groups and could meet others to share their experiences and obtain emotional support from other carers.
- With patients' consent, relatives and carers were invited to join meetings about the patient's care and treatment. They were also provided with welcome information when their loved one was admitted to the hospital to help orient them and provide useful information such as visiting times.

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

Good

Access and discharge

- Average bed occupancy during the 12 months before our inspection was 88%.
- Most of the patients on the ward were self-funding. Patients on the obsessive compulsive disorders programme and those with body dysmorphic disorders were generally funded by NHS organisations. Two patients were on these programmes during the time of our inspection. Most patients were self-funding and waiting lists were rare, with most admissions planned in advance. On rare occasions when beds were not available for new admissions, patients were offered a bed on a similar ward at another hospital within the Priory Group.
- Beds were always kept available for patients who went on overnight leave and patients were not expected to move beds during an admission unless justified on clinical grounds.
- Beds on a psychiatric intensive care unit were obtainable at the local NHS trust or at a private provider a short distance away.
- In the last 12 months there was one delayed discharge from the adult ward. This was due to a delay in finding suitable accommodation by the patient's local authority.
- Some patients agreed to attend hospital for a set programme of treatment. Other patients' discharges were planned by staff from an early stage, sometimes involving stakeholders including community mental health teams.
- However, patients did not have documented discharge plans in place in their care records. Discharge plans help to ensure the smooth coordination of services and care after a patient leaves hospital. This includes resolving potential barriers to a timely discharge.
- Staff supported patients during transfer between services. For example, staff always accompanied patients if they needed treatment at the local general hospital.

The facilities promote recovery, comfort, dignity and confidentiality

- All patients had their own bedrooms and were not expected to sleep in bed bays or dormitories. Bedrooms were personalised, and patients were able to bring their own possessions and electrical equipment with them.
- Each patient could keep their possessions securely. Although patients did not possess a key to their bedrooms, these could be locked if they asked a staff member. Patients could also keep their valuable possessions in a safe, if they wished.
- A full range of rooms and equipment was available to patients. However, there was a shortage of bookable rooms for activities and therapies on the ward. Staff told us that they used rooms elsewhere in the hospital building and always booked rooms in advance.
- Three patients reported that the ward was often too cold and that it took a long time for staff to turn the heating up. Staff told us about a recent boiler issue that had since been resolved.
- Patients could either meet visitors in quiet areas of the ward, or, if appropriate, could access separate rooms elsewhere in the hospital, especially if children visited.

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

Good

- Each patient was able to use their own mobile telephone during their stay, unless there were specific risks identified with patients being in possession of their mobile telephones. Each bedroom also had a landline telephone for patients to use.
- The hospital had large grounds. Patients could generally freely access this space. Patients whose risks were perceived to be higher were escorted by staff when they accessed the hospital grounds.
- Patients reported that the food was of good quality. We observed patients and staff accessing the same food that was prepared on-site.
- A kitchen area was available on the ward for patients to freely access. They could store and prepare snacks and hot drinks in this area.
- Staff encouraged patients to develop and maintain relationships with people that mattered to them. One patient had been supported to visit family elsewhere in the country during a weekend when they were well enough to take overnight leave. Other patients were encouraged to keep in contact with and involve family members in updates about their care.
- Family therapists supported patients and their families to gain the skills needed to support each other following discharge from the service.

Meeting the needs of all people who use the service

- The service made adjustments for disabled patients. There was one fully accessible bedroom and wet room available on the ward, and a second bedroom was planned to be made fully accessible in the near future.
- Leaflets about medicines, treatment programmes and how to complain were available to patients. These leaflets and the patient welcome pack could be sent for full translation into any language by the hospital admissions team.
- Staff could access an interpreting service. Interpreting needs were assessed on admission. Interpreters were then booked for each assessment and clinical consultations with the patient and their family.
- Dietary requirements were met for different religious and ethnic groups. We identified examples where specific dietary requirements, such as the need for kosher food, were identified an admission and successfully managed by the on-site catering staff.
- A group was recently used to facilitate a discussion between patients about sexuality and homophobia.
- In the past year, staff had worked hard to protect the dignity of a transgender patient. Staff prepared ahead of the admission by learning about gender pronouns and sharing information relating to the patient's gender identity only on a need-to-know basis.
- Staff accessed different ministers of religion on behalf of patients and facilitated prayer in quiet spaces when necessary. Staff also told us they occasionally escorted patients to the local church.

Listening to and learning from concerns and complaints

- During the 12 months before our inspection, eight formal complaints were made about the adult ward. One of these was upheld, five were partially upheld, and two were not upheld.
- Complaints were acknowledged and responded to appropriately. However, in cases where responses to complaints were delayed, it was not always apparent that holding letters had been sent to the complainant to inform them of the delay. Out of the ten complaints we reviewed, across the hospital, six were responded to outside of the provider's 20 day response timeframe.
- Patients knew about the formal complaints process and how to make a complaint. Staff were able to support patients to make a complaint in the most appropriate format. Information about how to complain was provided in the patient welcome pack.
- Complaints featured as a standard item on the agenda for the monthly clinical governance meeting.

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

Good

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

Good

Vision and values

- The provider had set out a list of behaviours which underpinned the service. These were; putting people first, being supportive, acting with integrity, striving for excellence and being positive. Staff demonstrated the providers values in their day to day work.
- All staff had completed 'putting people first' training, which was aligned to the providers values. Staff were appraised each year against the providers values.
- Staff contributed to discussions about the vision and strategy for the service during team away days, which took place every six months.

Good Governance

- Good systems were in place to ensure that incidents were reported and discussed. Lessons from incidents were shared and actions implemented, and safe staffing levels were always in place.
- Although staff proactively prepared for patients' discharge, recorded discharge plans were absent from patient care records.
- Staff had identified ligatures and a programme of works was planned to help staff manage ligatures and blind spots in the long term. However, there was a lack of information available to staff about how to manage these identified risks whilst these works were pending.
- Although physical health monitoring equipment appeared to be clean and in working order, the service did not have a robust system in place to alert staff on the ward to the need for equipment to be calibrated or disposed of. A record to show how frequently the clinic room and its equipment was cleaned was implemented during our inspection.
- Audits were in place to monitor the safety and quality of care and treatment. However, the audit did not review the quality of patient care records in detail.
- A monthly clinical governance meeting was in place for staff working on the ward. Standing agenda items included learning from complaints and incidents.
- Staff implemented recommendations from reviews of incidents. Although the final investigation reports relating to the recent serious incidents were ongoing, initial actions had been identified by staff and changes made.
- Despite the fact that many patients were self-funding and referred themselves to the service, staff worked hard to keep in touch with their GPs and community mental health teams, if they had them.
- Staff maintained and had access to the hospital risk register. Senior staff reviewed items on the risk register and could escalate issues to the provider's risk register if needed, which was reviewed by the executive board of directors.
- The service had a business continuity plan in place. This meant that the delivery of care and treatment could still continue in an adverse event.
- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well. However, staff and patients reported that the internet connection was often poor. This sometimes led to delays when accessing the patient care records system.
- Staff made notifications to the relevant external bodies as needed.
- Staff, patients and carers had access to up-to-date information about the work of the provider. This information could be accessed online and staff received regular bulletins.
- Patients and carers could feedback about the service informally, by using the formal complaints process, or in routine satisfaction surveys.
- Managers had access to feedback relating to their ward and discussed it with staff at clinical governance meetings and considered ways to improve the service.

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

Good

Leadership, morale and staff engagement

- The ward manager had been in post for a number of years. The organisation supported them to gain the necessary skills required for the job, by giving them the opportunity to initially act up to ward manager level, and by supporting them to access additional specialist training. They felt that leadership development opportunities in the organisation had recently improved and management training was available for new managers.
- Staff and patients reported that leaders within the hospital were visible and approachable at all times. Leaders demonstrated a thorough understanding of the services they managed.
- Staff reported that they felt respected, supported and valued. We received consistently positive feedback about working for the provider and the culture of the staff team.
- Although staff felt able to raise concerns with their managers without fear of retribution, some staff were unclear about the whistleblowing process.
- Some staff members were elected by their peers to sit on the providers 'you say' forum. Forum members raised issues from the wider staff group with the hospital's senior management team each month. The forum included the providers executive team every three months.
- We identified positive examples where managers had supported staff through periods of poor performance, by implementing individual goals and access to additional training.
- Staff specifically reported that people from diverse backgrounds were represented at all levels of the staff structure and that there were equal opportunities for career development. Individual development needs were discussed during annual appraisals.
- The dietitian supported staff to maintain a healthy lifestyle. They coached staff about how to maintain healthy eating habits when working long shifts.
- Sickness rates at the time of the inspection had increased slightly to 6.4%. We were told this increase was generally because of staff on long term sick leave.
- An occupational health service was available to all staff working for the provider. Staff were reminded of this service following the serious incidents that had recently occurred in the hospital. In addition to the occupational health service, leaders had organised for therapists to run supportive sessions for staff immediately following serious incidents.
- The organisation recognised positive staff success. Every two months staff voted for a colleague to receive a £50 prize for outstanding achievement. Teams across the organisation also competed for an annual outstanding achievement prize to attend a black tie dinner at a hotel.

Commitment to quality improvement and innovation

- We did not identify any examples of quality improvement initiatives taking place.
- Staff took time to reflect on research that was taking place in their fields to improve the treatments available. For example, staff had reviewed research into chronotherapy and collated a strong evidence base, which led to chronotherapy being offered as treatment at the service.

Inadequate

Child and adolescent mental health wards

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

Are child and adolescent mental health wards safe?

Inadequate

Safe and clean environment

- During our last inspection in May 2016 we found that the premises were not safe for their intended use. This was because there were a significant number of high risk ligature points across the ward, some of which had not been identified by staff. During this inspection we found that work was still needed to ensure the premises were safe for their intended use.
- Staff did not complete regular risk assessments of the ward environment every day. This was the frequency required by the hospital management team.
- Ligature risks were present across the ward environments. Although an up to date ligature risk assessment identified these risks, actions to help mitigate these risks had not been completed. Non-collapsible curtain rails were in place in the majority of the bedrooms. This meant that staff could not ensure that the environment was safe for young people. The service had recently replaced all the en-suite bathroom doors with collapsible doors, which were attached with velcro. The service was in the process of upgrading all the bedrooms to rooms with minimal ligature points. During the inspection we highlighted the potential ligature risks with the provider who took immediate action to mitigate these risks.
- The layout of the wards did not allow staff to observe all parts of the ward. Closed circuit television cameras captured images from the communal areas and were operated from the nursing office. However, staff were unable to observe young people in their bedrooms without opening the doors. Staff managed these risks by reviewing the frequency of individual young peoples' observations, particularly for those at risk of self-harm. Staff told us that there was always a staff member in the main corridor.
- Staff had access to alarms. Each member of staff carried an alarm. When staff activated their alarm, a panel in the nurses' office showed the location of the activated alarm.
- Young people had access to nurse call buttons in their bedrooms. However, one young person and one staff member informed us of recent occasions where they had called for help using alarms or call buttons and there had been a delayed response. This meant that both staff and young people could not be assured that alarms were always responded to in a timely manner.
- The most recent fire risk assessment and action plan was completed in January 2015. This had recommended that all young people had personal emergency evacuation plans in place. Following the inspection, the provider sent their updated fire safety policy. This described personal emergency evacuation plans only being required when a young person needed assistance during a fire evacuation.
- The wards were visibly clean and tidy with adequate furniture. The domestic staff had a cleaning rota to ensure that all areas of the ward were cleaned regularly. Maintenance work was completed when requested. However, some maintenance work was not always

made safe and introduced additional ligature points. This had occurred when closed-circuit television cameras and an air conditioning unit had been installed.

- Handwashing prompts were on display in the clinic rooms and the staff toilet. These ensured staff were reminded of the importance of infection prevention.
- Young peoples' physical observations did not take place in the clinic rooms because there was not enough space for an examination couch. Physical observations were completed in young peoples' bedrooms. This ensured young people's privacy. Young people who required an electrocardiogram occasionally had to access the clinic room on the adult ward.
- The wards kept anaphylaxis medicine, emergency eye wash and oxygen in the clinic rooms. These were all in date and the oxygen cylinders were full. Emergency grab bags and a defibrillator, for when a person's heart has stopped, were kept in the nursing offices. Staff checked the emergency bag regularly to ensure all equipment was in place and suitable for children and young people. Ligature cutters were available for staff, if required. However, there was out of date equipment in the grab bag on Oak Ward. Birch Ward only had the adult size of blood pressure monitoring cuffs. This meant that young people who were underweight or small may not have had accurate blood pressure readings taken. Staff ordered these during our inspection visit and replaced out of date equipment in the grab bag.
- There was no system in place to alert staff on the ward to the dates by which physical health monitoring equipment needed to be either replaced or calibrated.
- The clinical waste bin and general bin in the clinic room on Oak Ward were broken. This meant that staff had to open them with their hands rather than using the foot pedal. This was an infection control risk. Neither of the clinic rooms had separate hand washing facilities. Birch Ward did not have non-touch taps fitted which was an infection control risk.
- Domestic staff told us that they cleaned the clinic rooms daily. However, staff did not keep a record of this. The wards had no cleaning records for medical equipment or fridges that contained medicines. Staff told us that they cleaned equipment before and after using it. On Birch Ward the fridge in the clinic room and an oxygen mask were visibly dirty. Staff could not ensure that either the medical equipment or environment was clean, presenting an infection control risk. A new clinic room cleaning record was implemented during our inspection visit.

Safe staffing

- Nursing staff turnover during the 12 months prior to our inspection was 23.3% on Birch Ward and 31% on Oak Ward. Staffing vacancies were 31.3% on Birch Ward and 15.5% on Oak Ward.
- The staff sicknesses rates on Birch Ward was 3.3% and on Oak Ward 2.5%.
- Staffing levels on the wards were not safe. The minimum requirement on both wards was two registered nurses and one healthcare assistant during the day and one registered nurse with two healthcare assistants at night. Staff told us that there were not always two registered nurses on duty during the day. This was particularly an issue on Oak Ward. This had been discussed in team meetings and during staff supervision. Staff rotas showed that there were shifts where there had only been one registered nurse working during the day. On Oak Ward this had occurred for 14 shifts in March 2018 and for seven shifts in April 2018. On Birch Ward there were two shifts with one registered nurse in April 2018. This meant that the wards were often working below the established staffing levels which did not provide a safe environment for young people.
- When necessary, managers deployed agency and bank nursing staff. Over the past 12 months 1,197 shifts were filled by bank or agency staff on Birch Ward and 1,000 shifts on Oak Ward. Wherever possible the service tried to use regular bank and agency staff. These staff were offered short term contracts on occasions to maintain consistent staffing.
- The ward manager or nurse in charge could adjust the healthcare assistant staffing levels daily to take account of young peoples' needs and the level of observation they required. For example, they booked additional staff to meet the needs of young people who were continuously observed by staff.
- Bank and agency staff received an induction to the wards. Bank and agency staff had to complete an

induction checklist to ensure that they understood the way the ward operated and the needs of the young people. This included patient and staff boundaries and safeguarding.

- A staff member was present in the communal area of the ward at all times.
- Young people told us that they did not always receive regular one to one sessions with their named nurse. Staff were putting in measures to ensure that this was rectified.
- During weekdays a doctor could attend the wards quickly in an emergency. Three consultant psychiatrists covered the wards full time and co-ordinated medical treatment and care. Medical support to the wards was also provided by two junior doctors.
- During the evenings, nights and weekends the hospital had one on-call doctor who was on site. However, the on-call doctor did not carry a pager or have a mobile phone so if they were not in their office they had to be located. This meant that they may not be able to attend the wards quickly in an emergency.
- Overall, staff across the hospital had completed 93 % of their mandatory training. The breakdown for staff that had completed mandatory training on each of the child and adolescent wards was unavailable.

Assessing and managing risk to patients and staff

- We reviewed nine risk assessments for young people, five from Birch Ward and four from Oak Ward. Staff had completed a risk assessment for all of these young people on admission. Staff used the standard risk assessment tool on the provider's electronic records system. However, we found that risk assessments were not detailed and did not include information about all areas of potential risk. One young person had physical health needs and a history of seizures. Staff had not included the physical health needs or risk of seizures within the young person's risk assessment. Another young person had been admitted following a serious attempt to harm themselves. Staff had not included any details within the risk assessment of how to manage this potential risk except by observation. Young people did not have risk management plans in place to ensure staff knew how to manage all of the identified potential risks.
- Staff responded to changing risks to, or posed by young people, by altering the level of observation of young people. At young people's weekly ward round, the multi-disciplinary team decided what level of observation was required for each young person to ensure their safety and the safety of others. Observation levels were frequently changed as the needs of young people changed. Staff recorded these changes. However, the young people's updated risk assessments did not detail the reasons why the level of risk had changed or any incidents which may have led to this change.
- Staff were not aware of all of the specific issues on the ward. Specific ligature risks had not been identified and mitigated. A staff member was always available on the main corridor to observe young people and mitigate the risk from ligature points in the corridor. Closed circuit television cameras were also remotely monitored. If an incident occurred, staff would be contacted on a dedicated mobile phone. However, there was not a clear line of view to all areas of the corridor by staff and the closed circuit television cameras. Staff kept communal rooms such as the activity rooms locked except when staff were available to be in the rooms with young people.
- Staff searched all young people and their belongings on return from unescorted leave. Staff searched young peoples' bedrooms if needed.
- Staff applied blanket restrictions on young people's freedom only when justified. The ward placed some restrictions on young people to ensure that they attended school and therapeutic activities and so that staff could ensure young peoples' safety. Young people were able to move between the two wards until eight thirty in the evening when they had to return to their own ward. Young people had access to their bedrooms. On some occasions young peoples' bedrooms were locked and needed to be opened by staff. This was when young people were continuously observed by staff.
- Staff adhered to best practice in implementing a smoke free policy. Young people were not able to smoke on the hospital grounds or when on escorted leave.

Inadequate

Child and adolescent mental health wards

- Young people under 16 years of age who were informal patients were not able to leave the ward without an adult accompanying them. If they wished to be discharged they would have to ask staff or contact their parents or carers.
- The service did not have a seclusion room. If staff could not manage young people safely on the ward, staff made a referral to a psychiatric intensive care unit.
- The wards had 57 incidents of restraint in the 12 month period prior to our inspection. Three of these restraints had been in the prone position.
- Staff were not consistently recording when restraints took place or the details of the restraint. On Birch Ward staff were not clear what constituted a restraint. The descriptions provided by staff indicated that they had restrained young people and had not recorded this as restraint.
- Staff informed us that they only used restraint occasionally and would only use it if de-escalation techniques failed. However young peoples' care plans did not reflect how staff should use de-escalation techniques. One young person was refusing to take physical health medicines, which were essential for their health and well-being. The care plan did not outline how staff should be encouraging them and what techniques they should use.
- We reviewed two incidents where patients had been restrained by staff. During one incident six members of staff had taken part in the restraint. However, staff had not recorded any detail about which position the young person was restrained in or where the six staff were situated. In the other incident the incident report stated that restraint had been used but there were no details of the restraint and there was no recording of restraint in the young person's records.
- The wards in this service were not participating in any restrictive interventions reduction programme.
- Staff received mandatory training on the prevention and management of violence and aggression.
- Staff were trained in safeguarding, knew how to make a safeguarding alert and made these when appropriate. All staff received mandatory training in safeguarding children.
- The wards had a safeguarding lead that ensured that safeguarding referrals were made when appropriate and tracked all safeguarding referrals. The safeguarding lead ensured that the relevant local authority was informed if a young person was on the ward for a period of three months or more. Staff made referrals to the Prevent programme, which aims to stop individuals from getting involved in or supporting terrorism or extremist activity.
- Staff knew how to identify children and young people at risk of, or who were suffering significant harm. The staff team across the wards had made 36 safeguarding referrals in the 12 months prior to our inspection. Staff worked in partnership with other agencies such as social workers, teachers and GP's.
- Staff followed safe procedures for other children and young people visiting the ward. No visitors under the age of 18 were allowed onto the ward. Any visitors under 18 had to be accompanied by an adult and a room elsewhere in the hospital was booked for the visit.
- Staff used a combination of paper and electronic records. The electronic record contained the majority of care and treatment information, including daily progress notes on the young people, assessments and care plans. Paper records contained details of Mental Health Act assessments, Mental Capacity Act assessments and signed care plans.
- All staff had access to both electronic and paper records including bank and agency staff.
- Staff did not always follow good practice in medicines management. The recording of 'as required' medicine was not clear and did not alert staff to the reasons why medicines had been administered, or whether they had been effective. We reviewed two medicine administration charts that did not state clearly if the medicine had been given orally or by intramuscular injection. On one occasion a young person had complained of feeling dizzy and unsteady following the administration of their prescribed 'as required' medicine. However, the additional medicine was not recorded in their care and treatment records or reviewed during a subsequent doctor's examination.
- We checked the arrangements for the storage of medicines. In both wards medicines were stored securely in a cupboard or a locked fridge within a locked clinic room.

- There were no young people on high doses of antipsychotics at the time of the inspection. One young person was on olanzapine which had recently been increased. Staff were monitoring their weight regularly in line with National Institute for Health and Care Excellence (NICE) guidelines.
- A pharmacist visited the wards weekly. The pharmacist audited the medicine processes weekly and sent the findings of the audit to all of the registered nurses, doctors, the clinical director and the hospital director. The audit showed staff any concerns that had been highlighted by the pharmacist and the significance of the concerns. Once the concern has been rectified staff updated the system to say it has been actioned.
- Staff were not completing paediatric early warning systems correctly. Therefore, if young people were prescribed medicines that could have an impact on their physical health, staff may not pick these up in a timely manner. This meant concerns may not be escalated to the doctor.

Track record on safety

- The service had 37 serious incidents in the 12 months prior to our inspection.
- Serious incidents included an incident where a young person repeatedly self-harmed on the ward. Another incident occurred where a young person was able to obtain a four inch screw from their bedroom which they threatened to self-harm with. Police assistance was required to maintain the young person's safety.
- One serious incident resulted in the death of a young person. This young person was found hanging by a bed sheet from a bathroom door. This incident was still being investigated.
- Following these incidents, the provider had taken a number of actions to reduce risks to the safety of young people on the unit. This included the replacement of bathroom doors with collapsible doors. Some fixtures in bedrooms had been changed. However, there remained a number of environmental risks in most bedrooms including non-collapsible curtain rails. This meant that the actions taken were not completed with the speed and impact required to minimise high risks to the safety of young people.

Reporting incidents and learning from when things go wrong

- Staff we spoke with knew what incidents to report and how to report them. There was a good example of where staff had completed an incident form and a put a follow up action plan in place.
- Staff could record incidents as having safeguarding implications using the electronic form if necessary. The hospital senior management team reviewed all incidents each morning.
- Staff we spoke with understood the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide reasonable support to that person. Staff were able to give an example of when they had been open and transparent with a young person and their family after an incident on the ward.
- Staff received feedback from the investigation of incidents within the wards and other services operated by the provider. Lessons learnt from incidents were discussed at the weekly ward managers meeting and sent round on a bulletin for staff. This was displayed on the wall in both nursing offices. Learning from incidents was discussed at team meetings.
- There was some evidence that staff made changes as a result of feedback from incidents. For example, young people were no longer able to bring unsealed plastic bottles onto the wards. This was following an incident where alcohol had been bought to the ward using a plastic bottle. The service had made improvements to safety following a serious incident by replacing all the bathroom doors with anti-ligature collapsible doors. However, there continued to be ligature points on the wards including non-collapsible curtain rails.
- Staff told us that they received the necessary support following incidents, including a recent serious incident resulting in the death of a young person. Immediate debriefs took place following this incident. In addition, there was ongoing reflection during staff meetings over the following weeks. Sessions with counsellors and other necessary adjustments were made for staff that needed time to reflect following serious incidents.

Inadequate

Child and adolescent mental health wards

Are child and adolescent mental health wards effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- A mental health assessment of the young person was completed at, or soon after, admission. We reviewed nine care and treatment records across both wards. A doctor had reviewed and assessed the mental health of young people on the day of admission to the ward. However, for two young people this assessment had been undertaken on the following day. This meant that a full assessment of the young persons' mental health risks had not been undertaken.
- Staff assessed patients' physical health needs in a timely manner after admission. However, in four of the young peoples' care and treatment records the assessment by the doctor admitting the young person to the ward was incomplete. Young peoples' height and weight, medicines for physical health care needs, and their cardiovascular status were not always recorded. Following the inspection the management team informed us that they had put actions in place to ensure that all physical health assessments were completed correctly.
- Staff did not always develop care plans that reflected the needs of the young people, which had been identified during the assessment. Some young people had specific needs identified including physical health needs, attention deficit hyperactivity disorder and learning difficulties. These specific needs did not feature in the young peoples' care plans. During and following the inspection, the management team put in place an action plan to ensure that young peoples' care plans reflected their specific needs.
- Young peoples' care plans were not personalised, holistic or recovery focused. Staff had not ensured that the young person's voice was heard through their care plan.
- Staff did not always update young peoples' care plans where necessary. An example of this was when staff told us that a young person had been diagnosed with an autistic spectrum disorder. Their care plan had not been updated to reflect this.

Best practice in treatment and care

- Staff provided a range of care and treatment interventions suitable for young people. The interventions were those recommended by, and were delivered in line with, guidance from NICE.
- The staff team provided a weekly programme which comprised of education, therapy and activity based groups. Patients were assessed by a therapist on admission and a programme of therapies specific to their needs was put in place. Therapy sessions that the young people were offered included individual therapy, dialectical behaviour therapy, drama therapy and family therapy. Young people informed us that the therapy programme was beneficial to their recovery.
- Activity co-ordinators facilitated activities during the evenings and weekends. This included activities both on and off the wards. There was a weekly group community outing. The activity was decided by young people at the weekly community meeting.
- Staff ensured that young people had access to physical health care services. Staff referred young people to acute general hospitals when needed, and also liaised with specialist children's hospitals. For example, one young person had been admitted to an acute hospital during the time of our inspection, due to their physical health deteriorating.
- Staff assessed and met young peoples' needs for food and drink. The service had a dietitian who visited once a week to support young people with eating disorders or who had other dietary needs. Staff had implemented a good care plan for a young person with an eating disorder. Another young persons' care plan identified that they needed to drink two litres of water a day. This was to be recorded on a fluid chart. However, staff had not consistently completed the fluid chart.
- Staff supported young people to live healthier lives through participation in smoking cessation schemes. Young people who needed support with issues relating

to substance misuse were referred to a drug and alcohol treatment programme. This operated on the adult ward. When this was not appropriate, they were referred to community drug and alcohol services.

- Staff used recognised rating scales to assess and record treatment outcomes. All young people had Health of the Nation Outcome Scales for Children and Adolescents completed. Staff also completed the Children's Global Assessment Scale.
- Staff participated in clinical audit. An audit calendar showed when regular audits, such as for ligatures and infection control, should take place. The ward managers received regular updates on audits of the care records. However, the audits were not effectively alerting staff or managers to areas where there were concerns. For example, the care records audit showed whether the records had been completed, not the quality of the records. The infection control audit had not identified the absence of cleaning records for the clinic rooms or that that there was no record when medical equipment was cleaned.

Skilled staff to deliver care

- The team comprised of a full range of specialists to meet the needs of the young people. The multi-disciplinary team included nurses, doctors, occupational therapists, family therapists, a dietitian, clinical psychologists, activity co-ordinators and teachers. The hospital was recruiting to fill a full time social worker position.
- The therapy and teaching staff were experienced, qualified and had the right skills and knowledge to meet the needs of the young people. New staff had recently been recruited to the nursing team. However, both wards still used a large number of bank and agency staff. The service was actively looking at employing bank and agency staff on short term contracts to ensure consistency of staffing.
- Managers provided new staff with an induction. New staff completed an induction process which included competency assessments for the administration of medication and the use of observations. Bank and agency staff also received an induction and had to complete an induction checklist. The young people were producing an induction video for new staff to be able to watch to introduce them to the ward.
- Nursing staff received regular supervision. The percentage of staff that had received regular supervision was 80 % on Birch Ward and 84 % on Oak Ward. However, the supervision records were brief, young people's needs were not discussed during supervision. Staff had the opportunity to attend monthly reflective practice sessions and a staff dialectic behaviour therapy group session.
- Staff received an annual appraisal. The compliance rate was 99 % across both wards. In-depth discussions about individual performance, development needs and career aspirations took place during appraisals.
- Managers ensured that staff had access to regular team meetings. These took place monthly on both wards.
- Staff received specialist training for working with young people. However, staff did not always receive the necessary specialist training to meet young peoples' specific needs. Some staff had been requesting training to support their work with young people who had obsessive compulsive disorder. Staff told us that they had not received training in areas such as epilepsy and seizure management, autistic spectrum disorders, eating disorders or personality disorders.

Multi-disciplinary and inter-agency team work

- Staff held regular multidisciplinary meetings. These were held daily in the morning for nursing, therapy and educational staff to attend. Staff discussed all of the young people at this meeting and any changes that had occurred since the previous morning.
- Nursing handovers took place at the beginning and end of each shift. Information regarding young people such as changes in risk and updates about incidents were shared at these handovers.
- A contract was in place between the service and two local NHS mental health trusts, whose patients routinely used nine of the beds on the unit. The service was following the new models of care approach that had been launched by these trusts. The aim of this approach was to ensure that young people were admitted close to home and to reduce the length of admissions. Staff had a weekly meeting with a coordinator for the trusts to discuss the progress of each young person. Staff reported that this had cut length of stay and delayed discharges dramatically for young people.

Inadequate

Child and adolescent mental health wards

- Staff worked closely with local child and adolescent community mental health teams, adult mental health teams and drug and alcohol teams. Staff worked closely with the local authority regarding safeguarding concerns or when children who were ordinarily cared for by local authority services were admitted.

Adherence to the MHA and the MHA Code of Practice

- At the time of the inspection, two young people on Oak ward were detained under the Mental Health Act (MHA). Both of these young people were detained for treatment. The care and treatment records of these young people adhered to the MHA and the MHA code of Practice.
- Staff received mandatory training in understanding of the MHA, and were supported by a MHA administrator. Staff were able to contact the administrator when they needed advice.
- The provider had relevant policies and procedures that reflected the most recent guidance. Staff had easy access to local MHA policies and to the Code of Practice.
- Young people received information regarding advocacy in their admission welcome pack. An independent mental health advocacy (IMHA) service was available to young people. The advocate visited the wards weekly and would meet with all new young people. Young people could contact the IMHA service directly if they wanted to.
- Staff explained young people's rights under the MHA to them. Staff were explaining their rights to one young person on a daily basis. The young person was not able to understand their rights at the time, partially due to their learning difficulty. The service did not have information available in an accessible format such as 'easy read' for young people with learning disabilities or difficulties.
- Staff ensured that Section 17 leave paperwork was completed and regularly reviewed. Staff ensured that young people were able to take section 17 leave when it had been granted.
- Staff stored copies of young people's detention papers and associated records correctly and they were available to all staff that needed access to them.
- All young people under 16 years of age had to be escorted when off the ward. However, the ward did not have a record that they had informed young people aged 16 and 17 that they could leave the ward freely. This was not in accordance with the MHA Code of Practice.
- Staff completed annual audits on the application of the Mental Health Act.

Good practice in applying the MCA

- Staff did not have a good understanding of the Mental Capacity Act (MCA). The MCA applies to young people over 16 years of age. Nursing staff told us that the doctors assessed the capacity of young people on admission; this was regarding the young person's capacity to consent to care and treatment. Staff did not understand that capacity was decision specific and not just regarding capacity to consent to care and treatment. During the inspection we did not identify any other decision-specific capacity assessments.
- Where a young person was under 16 years of age doctors assessed and recorded if they met Gillick competence or not. Gillick competence is a term in medical law to decide whether a young person under 16 is able to consent to their care and treatment, without the need for parental permission or knowledge.
- Care records included information about who had parental responsibility for the young person and who should be consulted about their care and treatment. The staff reviewed the young person's capacity to consent to their care and treatment at the weekly ward rounds.
- Staff received training in the MCA as part of their mandatory training.
- The service had a policy on the MCA, including deprivation of liberty safeguards.
- The service completed an annual audit on the MCA and consent.

Are child and adolescent mental health wards caring?

Requires improvement

Kindness, privacy, dignity, respect and compassion and support

- Staff attitudes and behaviours when interacting with young people showed they were discreet, respectful and responsive. Staff provided young people with help, emotional support and advice at the time they needed it. Young people told us that the majority of the permanent staff treated them well and behaved appropriately towards them. However, some staff, especially those that worked at night, did not always treat them with dignity and respect. Young people told us that night staff were sometimes patronising and unsympathetic, telling them to go to their rooms. One young person told us that a staff member had told them that head banging was 'copycat behaviour'.
- Staff directed young people to other services when appropriate and if required, supported them to access these services. One young person was in an acute hospital for their physical health care; a staff member was supporting them at all times.
- Staff did not always understand the needs of the young people. Staff could not clearly articulate the specific needs of individuals. For example, we were told that one young person had an autistic spectrum disorder. However it did not state in their care plan that they had autism or how their autism affected them.
- Staff maintained the confidentiality of information about young people.

The involvement of people in the care they receive

- Staff used the admission process to inform and orient young people to the wards. Young people received a welcome pack on admission to the wards.
- Most of the young people were not involved in co-producing or offering their views on their care plans. Young people told us that staff did not enable them to contribute to their care plans. We reviewed nine care plans; young people did not contribute in eight out of nine cases. However, we saw that one person had been involved in their treatment plan concerning their eating disorder. The voice of the young person did not come across in care plans, young people told us that they had not been involved and did not have copies.
- Young people were involved in ward rounds and Care Programme Approach meetings when they wanted to be.
- Staff tried to ensure that young people understood their care and treatment by explaining it to them in a way they understood on a regular basis. However, they did not have access to accessible means of communication such as 'easy read' for young people with learning difficulties or disabilities.
- Staff involved young people in decisions about the service when appropriate. Young people were involved in the recruitment of staff; they had recently interviewed a prospective new social worker. Two young people attended the hospital senior leadership meeting as representatives for the unit.
- Staff enabled young people to give feedback on the service they received. Both wards held weekly community meetings. In these meetings, young people met with staff to discuss any concerns they had about the ward and how to address these. Young people were asked to complete an exit interview on discharge where they could feedback about the care and treatment they had received.
- Staff ensured that young people could access advocacy. The information regarding how to contact an advocate was available on the ward for young people to see.
- When a young person was admitted their family and carers received a welcome pack containing information about the hospital and wards. This pack did not provide information about how to access a carer's assessment.
- Staff informed and involved families and carers appropriately. Staff contacted parents after incidents. A family that lived a distance from the hospital had been able to attend ward rounds through the use of conference calling. However, one family told us that they had not been informed about the death of one of the patients on the ward. They learnt of this incident when they visited their child, despite it having a negative impact on their child.
- The service held a monthly carers group where carers could feel supported and meet other carers. They could discuss any concerns that they had. Families and carers were able to give feedback on the service and support they had received as a carer through a questionnaire.

Inadequate

Child and adolescent mental health wards

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

Good

Access and discharge

- Average bed occupancy over the last 12 months was 90%.
- The wards admitted young people from around the country. However, the service had a contract with two local NHS mental health trusts to provide nine beds for their patients. This helped ensure local young people who needed a bed stayed within their local area.
- There was always a bed available when a young person returned from leave. Beds were not used for new young people until someone had been discharged.
- Young people were not moved between wards during an admission episode unless it was justified on clinical grounds and was in the interest of the young person.
- When young people were moved or discharged, this happened at an appropriate time of the day. Where possible the service ensured that new patients were admitted during the day.
- If a young person required more intensive care, staff would refer the person to a psychiatric intensive care unit (PICU). However, staff told us that this was often difficult due to a lack of PICU beds available for children and adolescents. At the time of our inspection there was one young person waiting for a PICU bed to become available.
- Delayed discharges had reduced since the start of the new models of care approach. The service was working closely with two local NHS trusts to avoid long admissions.
- Staff planned for young peoples' discharge from the point at which they were admitted. A discharge date was agreed at the first multi-disciplinary meeting after admission. Staff told us that they had good relationships with care managers. The service had a full time social worker who had recently left the service. The social worker worked with young people, their families and other professionals in the young peoples' home areas to help plan their discharge.
- Staff worked in partnership with teachers from the schools and colleges that the young people attended, community mental health teams and other external teams. If a young person was approaching 18 years of age, the staff team worked with the appropriate adult service, to plan for the young person's transition to adult services.
- Staff supported young people during referrals and transfers between services. For example, if they required treatment in an acute hospital or temporary transfer to a psychiatric intensive care unit.

The facilities promote recovery, comfort, dignity and confidentiality

- Young people had their own en-suite bedrooms and were not expected to sleep in bed bays or dormitories.
- Young people could personalise their bedrooms. They had a secure locker available in the main corridor to store their possessions.
- Staff and young people had access to the full range of rooms and equipment to support treatment and care. The service had rooms for educational use, therapy rooms and an activity room.
- There were quiet areas on the ward. However, these needed to be unlocked for young people to use. Visitors could meet with young people in their bedrooms or use one of the quiet rooms.
- Young people were able to use their mobile phones in the evenings and at weekends. They could make calls from these in private.
- Young people had access to a garden. However, this was accessed with staff support as it was downstairs and away from the ward.
- Young people accessed meals from the hospital restaurant unless they were too unwell to leave the ward. Young people frequently discussed the quality of the food within community meetings, and felt that there was not enough choice. Young people said that it was not a child friendly menu and that they had often ran out of some things before they had their meal times.

Inadequate

Child and adolescent mental health wards

- A kitchen was available on both wards for young people to make hot drinks and snacks at any time of the day or night.
- Young people were expected to attend education that was provided on the ward. The school was Ofsted registered for up to 22 young people. Staff supported young people to be reintegrated back into their local school or college provision where possible.
- Staff supported young people to maintain contact with their families and carers. Families and carers were encouraged to attend ward rounds and care programme approach meetings. Where this was not possible staff gave other opportunities such as attending by conference call. Families could visit during the evenings and at weekends.
- Staff encouraged young people to maintain relationships with people that mattered to them. Friends could visit them, although not on the ward if they were under 18 years. Staff informed us about a young person they had supported to attend scouts to be able to build up a community connection.

Meeting the needs of all people who use the service

- The service was unable to admit young people who would need to use a wheelchair due to lack of access. However, staff told us that they could admit people with physical disabilities if they did not require a wheelchair and those with borderline or mild learning disabilities.
- Young people were given a welcome pack when they were admitted. This contained information on treatments, advocacy, young people's rights and how to complain. However, this was not available in an accessible format such as Easy Read.
- Staff would ensure that young people or their carers whose first language was not English had access to interpreters for meetings. Leaflets about medicines, treatment programmes and how to complain were available to young people. These leaflets and the welcome pack could be sent for full translation into any language by the hospital admissions team.
- Young people had a choice of food to meet the dietary requirements of religious and ethnic groups.
- Staff ensured that young people had access to appropriate spiritual support. The wards had information displayed on the notice board showing contact details for different religious leaders. The hospital did not have a multi faith room but the activity room on the ward could be used as a prayer room. The hospital had different religious texts and equipment available for patients use.

Listening to and learning from concerns and complaints

- Birch Ward had received two complaints in the last 12 months. One of these had been upheld and one was still being investigated. Oak Ward had received one complaint which was upheld.
- Complaints were acknowledged and responded to appropriately. Out of the ten complaints files we reviewed, across the hospital, six were responded to outside of the provider's 20 day response timeframe.
- Young people knew how to complain or raise concerns. Information was given in their welcome pack to inform them how to make a complaint. One young person told us that they had recently raised a complaint and that they had received a response to this.
- Staff knew how to manage complaints appropriately. Managers ensured that informal complaints were looked into and resolved as quickly as possible.
- Staff received feedback on the outcome of investigation of complaints through team meetings.

Are child and adolescent mental health wards well-led?

Inadequate

Vision and values

- The provider had set out a list of behaviours which underpinned the service. These were; putting people first, being supportive, acting with integrity, striving for excellence and being positive.Staff knew and understood the provider's vision and values. Staff were appraised each year against the provider's values.

- Staff had team away days every six months. This provided opportunities for learning, team building and discussions regarding the strategy and development of the service.
- Staff understood the hospitals objectives of delivering high quality care and providing value for money. For example, they had an understanding of the drive towards young people having shorter admissions to hospital. Staff were fully engaged with this process through the new models of care approach.

Good Governance

- There were insufficient governance systems in place to ensure that the wards were managed safely and effectively. Senior managers had not ensured that there was sufficient leadership on the wards to enable systems and processes to be effective and in place, which minimised potential risks to young people. Staff did not carry out checks to ensure that the environment was safe and clean or that clinical equipment was calibrated when necessary. There were not enough staff to meet the needs of the young people. Young people did not have comprehensive care plans or risk management plans and physical health care needs were not effectively assessed.
- Staff worked in partnership with community services to ensure effective discharge planning took place. The education and therapy services provided comprehensive programmes for the young people to support them with their recovery. The staff team worked in partnership with the local authority to ensure young people were safeguarded from abuse.
- Learning was identified following incidents and complaints and was used to improve the service. For example, the bathroom doors were changed to ones that were detachable and non-tamper proof screws were fitted to some furniture following two serious incidents. However, there were still many ligature risks on the ward and not all identified risks had been removed. The pace of change following serious incidents was not rapid enough to ensure that areas of potential high risk were suitably addressed. Following our inspection senior managers informed us that they had taken further action to mitigate risks.
- Staff undertook some clinical audits, however these were not effective in identifying concerns and ensuring action was taken. The pharmacist completed a weekly audit of medicines, which identified concerns and actions required. However, we found two medicine administration records that did not contain sufficient detail about whether medicines had been given intramuscularly or orally. Care records were audited regularly by staff. However, the audits did not assess the quality of the records in sufficient detail. Actions from the ligature risk assessment, which had taken place in January 2018, had not been completed. The service had not identified the absence of cleaning records or calibration records for medical equipment. This meant that the system of audits within the wards was not identifying areas of risk to ensure the safety of young people.
- Staff worked closely with the educational team and therapy team within the service. Staff from the educational and therapist teams were clear in their role and direction their service was developing in. Within the nursing team morale was poorer due to work pressures and there was less sense of direction and purpose.
- Staff maintained and had access to the risk register. Staff could escalate concerns to the ward manager or senior managers when necessary.
- The service had a business continuity plan in place. This meant that the delivery of care and treatment would continue if there was an unexpected event, such as a power failure..
- Staff had access to the equipment and information technology needed to do their work. The information technology and telephone system operated well.
- The hospital made notifications to external bodies such as the Care Quality Commission when required.

Leadership, morale and staff engagement

- There was a lack of clear leadership on the child and adolescent wards. At the time of the inspection neither ward had permanent ward managers available. One of the ward managers was on leave and the other ward manager post was vacant. Acting ward managers were in place, but were unable to describe how systems and processes minimised potential risks to clients. They were unable to describe what actions were taken to

ensure the safety of all clients on the wards. Acting managers were not equipped to take the necessary action to promote the continued safety of young people on the wards.

- Immediately after the inspection, the provider developed a detailed action plan for the wards. This included the immediate transfer of an experienced child and adolescent mental health service manager to the service to provide clear leadership.
- Staff told us that senior managers from the hospital were visible in the service and were approachable.
- The provider offered regular management training for new managers or for staff who wish to progress to management level.
- Staff we spoke with told us that they felt respected, supported, valued and enjoyed working for the service.
- Some staff members were elected by their peers to sit on the provider's 'you say' forum. Forum members raised issues from the wider staff group with the hospital's senior management team each month. The forum included the provider's executive team every three months.
- Managers dealt with instances of poor performance. The acting ward managers were able to give examples of where instances of poor performance were being managed.
- Nursing staff told us that morale had been very low following the serious incident of a death of a young person on the ward. They also told us that the low numbers of permanent staff on the wards affected morale. However, all staff felt that they had been supported following the death of the young person and morale of the teams was improving.
- They said that staff had opportunities for career progression and we saw that this was discussed during staff appraisals. Managers and staff came from diverse backgrounds.
- The dietitian supported staff to maintain a healthy lifestyle. They coached staff about how to maintain healthy eating habits when working long shifts.
- Following serious incidents staff were given support through group sessions and counselling. Staff told us that they had felt supported by the provider. Staff were able to access support for their own physical and emotional health needs through the provider's occupational health service.
- The provider recognised staff success within the service through staff awards. The provider had different categories which individual staff or staff teams could be nominated for. Awards were given out to staff at an award dinner.
- Staff had access to the equipment and information technology needed to do their work. The information technology and telephone system operated well.
- The hospital made notifications to external bodies such as the Care Quality Commission when required.
- Staff had access to up to date information about the work of the provider on the intranet system. The staff team received weekly bulletins, which outlined lessons that had been learnt from incidents or complaints across the hospital.
- Young people had opportunities to feedback about the service in different ways. The wards had weekly community meetings where young people could discuss any concerns they had. Young people were given an exit interview questionnaire to complete when they were discharged from the service. Parents, families and carers had the opportunity to attend a monthly carers meeting where they could meet other carers and discuss any issues or concerns that they had. Carers had the opportunity to feedback through a carer's questionnaire.
- The providers' senior leaders engaged with external stakeholders such as National Health Service England (NHSE).

Learning, continuous improvement and innovation

- Staff were not using quality improvement methods. We did not identify any examples of innovative practice taking place on the wards. However, staff had worked with the two local NHS trusts and NHS England to reduce the length of hospital admissions and to keep young people closer to home. Staff told us that this programme had good outcomes.
- The service was a member of the quality network for inpatient child and adolescent mental health services.

Substance misuse services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are substance misuse services safe?

Safe and clean environment

- A comprehensive risk assessment of the care environment took place in January 2018. Monthly quality walk arounds were also completed by staff. This included an assessment of the safety and suitability of the premises and equipment.
- During our last inspection in May 2016 we identified that the premises were not safe for their intended use. This was because there were a significant number of high-risk ligature points across the ward, some of which had not been identified by staff. During this inspection, work was still needed to ensure the premises were safe for their intended use.
- The provider had devised a programme of works to remove most of the ligatures and install mirrors to help staff observe blind spots more easily. There was no target date for completion of these works at the time of our inspection.
- The provider had devised a programme of works to remove most of the ligatures and install mirrors to help staff observe blind spots more easily. There was no target date for completion of these works at the time of our inspection.
- The ward treated people with mental health problems as well as substance misuse problems. The layout of the ward complied with guidance on same sex accommodation. Although the ward was mixed sex, all bedrooms had en-suite facilities and a female only corridor and female only lounge.
- All ward areas were clean, had good furnishings and were well-maintained. Cleaning records were maintained for the general ward environment, and showed that all areas were cleaned regularly.
- Staff adhered to infection control principles, including handwashing. Infection, prevention and control (IPC) and hand hygiene audits were completed regularly. Action plans were developed following these audits to ensure that the ward complied with IPC principles.
- Clinic rooms were fully equipped with accessible resuscitation equipment and emergency drugs. Resuscitation equipment and emergency drugs were checked each week. However, a weekly check to ensure equipment in the clinic room was in working order had only been in place since March 2018 and these checks had often since been missed.
- There was no system in place to alert staff on the ward to the dates by which physical health monitoring equipment needed to be either replaced or calibrated. Staff recorded they were not aware as to whether equipment had been tested and serviced as necessary during the March 2018 quality walk-round.
- Although clinical equipment appeared to be visibly clean, staff did not keep a record to show when items were last cleaned. A new clinic room cleaning record was implemented during our inspection visit.

Safe staffing

- During day and night shifts, there were two registered nurses and one healthcare assistant on the ward. Staff were available for all clients on the ward, including clients with mental health problems. Staffing levels increased to two registered nurses and two nursing assistants when 23 or more patients were present on the ward. Staffing levels met these establishment levels and in most cases exceeded them.

Substance misuse services

- During our last inspection in May 2016, we identified a number of nursing staff vacancies on the ward and staff turnover was high. During this inspection staff retention had improved. Staff turnover was 11.6% and had improved since the last inspection. The staff vacancy rate had also decreased to 7.8%. The provider had worked with long term agency staff to provide additional training and offer them positions as permanent staff members if appropriate.
- During the 12 months before our inspection, 1,300 shifts were covered by bank or agency staff. 3,143 shifts were not covered by bank or agency staff. However, these uncovered planned shifts were usually in addition to the minimum staffing establishment. Therefore, safe staffing levels were maintained.
- During the 12 months before our inspection, staff sickness was 6.4%. This was a slight increase from our last inspection in May 2016.
- The ward manager could adjust staffing levels according to case mix. For example, additional staff were rostered when patients required enhanced observations.
- Bank and agency staff received a comprehensive induction to the ward. This included environmental hazards including ligature points that had been identified, as well as an introduction to the patients.
- A senior nurse was due to be scheduled to work at the hospital each weekend, so that there was a senior nursing presence.
- Staff were mostly up to date with their mandatory training. Overall training compliance for the ward was 83% at the time of the inspection.
- The training courses with compliance rates were lower than 75% were rapid tranquilisation, maintaining professional boundaries, IT security, Deprivation of Liberty Safeguards, cyber security, clinical risk assessment and anaphylaxis.

Assessing and managing risk to clients and staff

- The inspection team reviewed five clients' care and treatment records. All clients in the service were known to the consultant psychiatrists prior to hospital admission. The consultant psychiatrists highlighted clients' potential risks at the time of admission. All clients were seen by the ward doctor within one hour of admission to the ward.
- Nursing staff undertook a risk assessment for each client on the day of their admission. This included risks to the clients' physical health which may be affected by treatment, such as alcohol withdrawal seizures. The risk assessment also included risks to clients' mental health, such as thoughts of suicide or self harm.
- Clients' risk assessments were reviewed regularly by the multi-disciplinary team. During these meetings, medical, nursing and therapy staff could discuss potential risks to clients. However, clients' potential risks were not always explored in detail at these meetings. During the inspection, two clients were identified by some members of the team as at risk of harming themselves. There was little discussion of basic information which the team could use to assess the potential risks more accurately. Following one of the multi-disciplinary discussions, some team members understood the level of a client's risks differently from others. There was confusion regarding what had been agreed at the meeting. The lack of a structured discussion concerning clients' potential risks and clear decisions could have affected the safety of clients.
- Staff observed clients' whereabouts and activities throughout the day. The frequency of visual observation of clients was determined by their assessed level of risk.
- Clients undertaking substance misuse treatment had some restrictions placed on them. Clients were unable keep mobile phones with them in the hospital. They were also required to provide breathalyser readings and urine specimens for drug testing regularly. Clients' rooms were searched randomly each week. They also had to attend all of the therapy groups. These restrictions are common in substance misuse services and are an accepted way to manage the risks of substances being brought into a service.
- Clients in the service did not have early exit plans. This meant that if clients left the service before detoxification treatment had finished there was no specific information given to them. When clients leave alcohol detoxification treatment early they are at increased risk of alcohol withdrawal seizures and delirium tremens.

These are serious, and potentially life threatening, conditions. When clients leave opiate detoxification treatment early, they are at increased risk of overdose if they use opiate drugs again. This is due to their decreased tolerance to opiates, and can be fatal. The risks to clients if they left treatment early were not minimised.

- Seventy nine per cent of staff had received training in safeguarding adults, and 93% of staff had received training in safeguarding children at the time of our inspection.
- Staff understood how to report safeguarding concerns and could give examples about the type of incident they would report as safeguarding. Staff from the ward made 28 safeguarding referrals to the local authority during the 12 months before our inspection. The ward manager met with the local authority safeguarding adults team each quarter to discuss progress with safeguarding investigations and safeguarding themes in the local area. Information about how to raise a safeguarding referral with the local authority was displayed for staff. Two designated safeguarding leads worked on the ward. Both the safeguarding leads and hospital social worker could be contacted by staff for advice on safeguarding.
- Staff followed safe procedures for children visiting patients. Rooms were booked outside the ward for patients to meet privately with young relatives.
- Staff followed good practice in medicines management in line with national professional guidance. Medicines reconciliation took place on admission. Medicines were stored securely and in well-organised cabinets and a medicines fridge, and were disposed of safely. Staff recorded ambient room and fridge temperatures daily. This meant the storage of medicines at the correct temperature was frequently checked.
- Controlled drugs were safely stored in a controlled drugs cabinet. Volumes of controlled drugs administered or destroyed were clearly recorded in the controlled drugs register.
- The medicine naloxone was stored on the ward. Naloxone is used to reverse the effects of an opiate overdose. Staff had been trained in how to administer it.
- Staff provided additional support to clients where specific risks had been identified. One client had been identified as at risk of falls. They were continuously observed by a member of staff.

Track record on safety

- There had been no serious incidents in the substance misuse service in the previous year.

Reporting incidents and learning from when things go wrong

- All staff knew what incidents to report and how to report them using an electronic incident reporting system. Staff could flag incidents as having safeguarding implications using the electronic form if necessary. The hospital senior management team reviewed all incidents each morning.
- Incidents that had recently taken place both on the ward and at other locations operated by the provider were discussed by staff at monthly clinical governance meetings. They identified what they could learn from recent incidents and how to implement feedback from recent incident investigations. For example, the medicines trolley was relocated within the clinic room following an incident where a patient told staff they were able to take medicine by reaching across the stable-door between the corridor and clinic room.
- Immediate debriefs took place following serious incidents, as well as ongoing reflection during staff meetings. Sessions with counsellors and other necessary adjustments were made for staff who needed time to reflect following serious incidents.

Duty of candour

- The duty of candour is a regulatory duty that relates to openness and transparency. It requires providers of health and social care services to notify patients, or other relevant persons, of certain notifiable safety incidents and provide reasonable support to that person. Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation when things went wrong. For example, following a near-miss where a patient was almost administered the incorrect medicine, the patient

received an apology and was kept updated about actions such as increasing training and medicines competency checks to prevent similar incidents re-occurring.

Are substance misuse services effective? (for example, treatment is effective)

Assessment of needs and planning of care

- When clients were admitted to the ward for substance misuse treatment they had a thorough assessment by the ward doctor within one hour of admission. This assessment included an assessment of the substances they used and of physical health problems. This also included an assessment of clients' mental health, an electrocardiogram and blood testing. Blood testing was for the clinical team to identify any liver damage or other physical health problems, which may have affected clients' treatment. Female clients were offered pregnancy tests during the assessment, and clients were also offered testing for sexually transmitted infections. However, clients were not routinely asked if they would like to be tested for blood borne viruses. The ward doctor said that this would be introduced.
- The assessment of clients with alcohol dependency did not include an assessment of the severity of their dependence, using the Severity of Alcohol Dependence Questionnaire (SADQ) or another validated tool. Best practice guidance recommends that a validated tool, such as the SADQ, is used during an assessment (National Institute for Health and Care Excellence (NICE), Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011). However, the consultants admitting clients had previous knowledge of them and the initial substance misuse assessment was thorough and detailed.
- Clients also had a nursing assessment on the day they were admitted to the ward. This assessment included clients' physical health, sexuality, relationships, religion and mood.
- Clients' care plans were not always detailed and specific. Most clients' care plans were limited to detoxification treatment and withdrawal symptoms. Care plans were similar for all clients. Clients' care plans were not holistic and not sufficiently personalised. However, they were recovery-orientated.

Best practice in treatment and care

- The inspection team reviewed five clients care and treatment records. Clients were prescribed medicines for detoxification from alcohol and opiates. This prescribing followed NICE best practice guidance (Alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence, 2011; Drug misuse in over 16s: opioid detoxification, 2007). Clients having alcohol detoxification were prescribed injectable vitamins to minimise long term memory loss, in accordance with best practice (NICE, 2011). Clients with other addictions, such as cocaine addiction, were not prescribed medicines and had psychosocial therapy. This was in accordance with best practice guidance (Drug misuse and dependence: UK guidelines on clinical management, Department of Health, 2017).
- Staff used validated assessment tools to assess the severity of clients' withdrawal symptoms when they were having detoxification. For clients undergoing alcohol detoxification, staff used the Clinical Institute Withdrawal Assessment for alcohol scale – revised (CIWA-Ar). The CIWA-Ar is recommended for this use (NICE, 2011). However, the CIWA-Ar was only used for the first two days of alcohol detoxification. Clients having alcohol detoxification are at risk of developing delirium tremens two to four days after alcohol detoxification starts. Stopping the CIWA-Ar after two days meant that early signs of delirium tremens may not be identified. Delirium tremens is a serious risk in alcohol detoxification. However, staff continued to monitor clients closely after the second day of alcohol detoxification. For clients having opiate detoxification, the Clinical Opiate Withdrawal Scale was used.
- When clients had completed alcohol detoxification, they were not prescribed medicines to assist in preventing relapse. Best practice guidance recommends that people with moderate or severe alcohol dependence are prescribed these medicines to assist with longer term abstinence (NICE, 2011).

Substance misuse services

- Clients attended a 28 day programme of therapy as part of their substance misuse treatment. The therapy programme was the 12 step programme, a recognised psychosocial treatment programme for substance misuse. This involved several hours of therapy each day and individual activities clients needed to complete outside of groups. The therapy programme included both the psychological and social aspects of addiction and dependence. This included clients exploring the reasons for their addiction and the effect that this had on relationships.
- Clients' physical health was reviewed throughout their treatment. Clients were referred to a range of specialists for physical health problems. This included clients being referred to neurology specialists due to the long term effects of their alcohol misuse. A dietitian visited the ward and was available to discuss healthy eating with clients. When urgent physical health problems arose, clients were escorted to the local emergency department.
- The Health of the Nation Outcome Scales (HoNoS) and the Physical Activity Readiness Questionnaire (PAR-Q) were used as outcome measures for clients undergoing substance misuse treatment.
- Staff undertook a range of clinical audits. These included medicines, physical health monitoring charts, alcohol and drug screening and room searches.

Skilled staff to deliver care

- The ward team consisted of consultant psychiatrists, nurses, therapists, healthcare assistants, occupational therapists, a pharmacist and a dietitian.
- Staff were experienced and had the knowledge and skills to undertake their role. A nurse was the substance misuse lead on the ward. Three staff were 'train the trainers' concerning the CIWA-Ar detoxification tool. All registered nurses had been trained in substance misuse and the use of CIWA-Ar. They also had their competency checked for using the CIWA-Ar, including agency nurses. All of the consultant psychiatrists had attended recent training on substance misuse and detoxification. Nursing staff also undertook other additional training, including phlebotomy, physical health monitoring and conducting room searches. However, therapists were required to apply for funding for further training. Some therapists paid for their own training and development.
- Managers provided staff, including agency staff, with appropriate inductions. This included immediate training in how to operate systems such as telephones, alarms and patient care records. A structured programme ensured the new staff member completed their mandatory training within the first few weeks of employment. During the first few weeks in post staff worked alongside experienced colleagues to familiarise themselves with the policies, procedures and protocols of the ward.
- During our last inspection in May 2016 not all staff received regular one-to-one supervision. During this inspection we identified that staff received monthly one-to-one supervision. Supervision compliance during the 12 months before our inspection was 74%. This figure also accounted for staff on long-term sickness or long periods of annual leave, meaning that they missed scheduled supervision sessions. Group supervision also took place every three months. Staff discussed clinical issues and updates to clinical guidance during these sessions. Staff discussed queries about how best to manage and support individual clients as well as compliance with training and completion of audits during one to one supervision. In addition, nursing staff had group clinical supervision for substance misuse every week. This allowed time for staff to discuss clients with substance misuse problems with senior staff.
- Ninety nine per cent of staff had received an annual appraisal during the 12 months before our inspection. In-depth discussions about individual performance, development needs and career aspirations took place during appraisals.
- Managers supported staff through periods of poor performance. Staff were monitored constructively during supervision sessions and accessed additional training and competency checks following incidents.

Multidisciplinary and inter-agency team work

- Clients' ward rounds took place every week with all members of the team present. However, these meetings were not always effective in ensuring that the doctors, therapists and nursing staff effectively communicated with each other. Various staff reported difficulties with communication between disciplines.
- Nursing handovers took place at the change of each shift and were effective in communicating changes which had occurred with clients. In addition, the

managers in the hospital met every weekday morning to discuss any incidents and events. Therapists also provided a handover to nursing staff at the end of the day's therapy groups.

- Staff had built strong links with the local authority safeguarding team, and wrote to clients' GPs when they were discharged from treatment.

Good practice in applying the MCA

- During our last inspection in May 2016 we identified that staff were not familiar with the Mental Capacity Act (MCA). During this inspection, 79% of staff had received training in the MCA. Staff were clear about the principles relating to the MCA including when a capacity assessment would be necessary. However, they told us that doctors took full responsibility for completing capacity assessments.
- The ward doctor undertook a capacity assessment of clients during the assessment when they were admitted to the ward. However, the capacity assessment was not detailed and it was unclear how the client's capacity had been assessed. Clients also had a capacity assessment the day after admission. This is good practice, as clients' who are intoxicated or withdrawing from substances may lack capacity. There were no other examples of when capacity assessments were required for clients.
- There had been no Deprivation of Liberty Safeguards (DoLS) applications made for patients during the 12 months before our inspection.
- Policies on the use of the MCA and DoLS were available for staff to access. The Mental Health Act administrator supported staff with queries about the MCA.

Are substance misuse services caring?

Kindness, dignity, respect and support

- Staff were discreet, respectful and supportive when talking with clients. Staff were alert to clients' distress and provided emotional support to them.
- Clients reported that all staff were helpful and supportive. Clients said they felt safe and that nursing staff were observant. They also praised the therapists.
- Staff had a good understanding of clients' needs. Regular meetings between the therapists, nurses and ward doctor ensured staff understood clients' needs from different perspectives. Staff used their knowledge to support clients in treatment, maintain clients' safety, and to monitor clients' relationships with each other.

The involvement of clients in the care they receive

- Clients were orientated to the ward and the treatment programme when they were admitted. A welcome book provided information to clients, including visiting times and how to make a complaint.
- Clients were involved in decision making regarding their care and treatment. They found therapy useful and challenging. However, clients also wanted the same nurse for one-to-one meetings and more one-to-one time. Clients were involved in their care plans. However, of five clients, only one had a copy of their care plan.
- Staff ensured that patients could access advocacy. Patients told us they knew how to contact the advocate. A poster containing information about how to contact the advocate was displayed in the main lounge.
- Clients' family and carers were involved in their care as much as clients wished. Clients' families and carers could contact the ward or visit outside of therapy times. Staff and clients agreed with what information could be disclosed to relatives. For example, the content of discussions in therapy groups could not be discussed with relatives. The service held a monthly carers group. Carers could obtain peer support at these meetings.
- Clients were able to provide feedback in the community meetings and from periodic feedback surveys undertaken. Feedback from community meetings was displayed on the ward outlining actions taken in response to feedback. Clients' family and carers were also able to provide feedback. Staff were receptive to feedback in order to improve the service.
- At the time of the inspection, a feedback survey was undertaken of recently discharged and current patients, clients and young people. The survey consisted of fourteen positive statements about peoples' care and treatment. For ten statements, over 70% of people agreed or strongly agreed. However, for statements regarding staff listening and understanding them, and there always being plenty of things to do, just over half (54%) of people agreed or strongly agreed. The

feedback survey was completed by 13 patients. The number of people completing the feedback was small, and did not identify which wards the feedback related to.

- There were 35 peer workers for the substance misuse service. The peer workers had successfully completed substance misuse treatment and supported other clients. One of the peer workers had started training to become a therapist at the service.

Are substance misuse services responsive to people's needs?
(for example, to feedback?)

Access and discharge

- Average bed occupancy for the whole ward during the 12 months before our inspection was 88%.
- There were no waiting lists for the substance misuse service, and clients could usually access a bed immediately. However, almost all admissions for substance misuse treatment were planned admissions.
- Discharge planning for clients took place from the second week of treatment. Clients were encouraged to consider the options available to them. Staff contacted clients' employers advising a graded return to work, where appropriate.

The facilities promote recovery, comfort, dignity and confidentiality

- All clients had their own en-suite bedrooms. The ward also had a clinic room and a therapy room for substance misuse therapy groups. A lounge specifically for clients having substance misuse treatment was also available on the ward. However, there was a shortage of group and individual meeting rooms. This meant there were few options for clients to have a private conversation with staff apart from their bedroom.
- Clients could meet visitors in quiet areas of the ward. They could also meet visitors in separate rooms off the ward.
- Clients were able to contact family and friends by telephone from the ward. The times when clients could contact family or carers was restricted. Clients could not make calls during therapy times. This is a standard restriction for substance misuse services so that clients attend all therapy groups.
- The hospital had large grounds. Clients could generally access this space after they had completed detoxification.
- Clients reported the food was of good quality. However, they also reported that sometimes preferred food options ran out.
- A kitchen area was available on the ward for patients to freely access. They could store and prepare snacks and hot drinks in this area.
- Bedrooms were personalised, and clients were able to bring their own possessions and electrical equipment with them. Clients did not have keys to their bedrooms and staff could lock the bedrooms at a client's request. A safe was available for clients to store valuable possessions.
- Clients having substance misuse treatment had individual work to complete at the weekends as part of their group therapy. They were also some group activities at weekends.

Meeting the needs of all clients

- The service made adjustments for disabled patients. There was one fully accessible bedroom and wet room available on the ward, and a second bedroom was planned to be made fully accessible in the near future. A client had been using a wheelchair on the ward due to the risk of falls.
- Leaflets about medicines, treatment programmes and how to complain were available to patients. These leaflets and the patient welcome pack could be sent for full translation into any language by the hospital admissions team.
- Staff could access an interpreting service. Interpreting needs were assessed on admission. Interpreters were then booked for each assessment and clinical consultations with the patient and their family.
- Dietary requirements were met for different religious and ethnic groups. Clients' needs regarding dietary

requirements were identified on admission to hospital. The on-site catering team arranged for suitable meals. However, clients reported that there was very little choice for vegetarians and vegans.

- Staff accessed different ministers of religion on behalf of clients and facilitated prayer in quiet spaces when necessary.

Listening to and learning from concerns and complaints

- During the 12 months before our inspection, eight formal complaints were made from clients on the ward. One of these was upheld, five were partially upheld, and two were not upheld.
- Complaints were acknowledged and responded to appropriately. However, in cases where responses to complaints were delayed, it was not always apparent that holding letters had been sent to the complainant to inform them of the delay. Out of the ten complaints we reviewed, across the hospital, six were responded to outside of the provider's 20 day response timeframe.
- Patients knew about the formal complaints process and how to make a complaint. Staff were able to support patients to make a complaint in the most appropriate format. Information about how to complain was provided in the patient welcome pack.
- Complaints featured as a standard item on the agenda for the monthly clinical governance meeting.

Are substance misuse services well-led?

Vision and values

- The provider had set out a list of behaviours which underpinned the service. These were; putting people first, being supportive, acting with integrity, striving for excellence and being positive. Staff knew and understood the provider's vision and values. Staff demonstrated the providers values in their day to day work.
- All staff had completed 'putting people first' training, which was aligned to the providers values. Staff were appraised each year against the providers values.
- Staff contributed to discussions about the vision and strategy for the service during team away days, which took place every six months.

Good governance

- Good systems were in place to ensure that incidents were reported and discussed. Lessons from incidents were shared and actions implemented, and safe staffing levels were always in place.
- Staff identified ligatures and a programme of works was planned to help staff manage ligatures and blind spots in the long term. However, there was a lack of information available to staff about how to manage these identified risks whilst these works were pending.
- Although physical health monitoring equipment appeared to be clean and in working order, the service did not have a robust system in place to alert staff on the ward to the need for equipment to be calibrated or disposed of. A record to show how frequently the clinic room and its equipment was cleaned was implemented during our inspection.
- Audits were in place to monitor the safety and quality of care and treatment. However, the audit did not review the quality of patient care records in detail.
- A monthly clinical governance meeting was in place for staff working on the ward. Standing agenda items included learning from complaints and incidents.
- Staff implemented recommendations from reviews of incidents. Although the final investigation reports relating to the recent serious incidents were ongoing, initial actions had been identified by staff and changes made.
- Staff maintained and had access to the hospital risk register. Senior staff reviewed items on the risk register and could escalate issues to the provider's risk register if needed, which was reviewed by the executive board of directors.
- The service had a business continuity plan in place, meaning that the delivery of care and treatment could continue in an adverse event.
- The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.
- Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well.

- Staff made notifications to the relevant external bodies as needed.
- Staff, patients and carers had access to up-to-date information about the work of the provider. This information could be accessed online and staff received regular bulletins.
- Patients and carers could feedback about the service informally, by using the formal complaints process, or in routine satisfaction surveys.
- Managers had access to feedback relating to their ward and discussed it with staff at clinical governance meetings and considers ways to improve the service.

Leadership, morale and staff engagement

- The ward manager had been in post for a number of years. The organisation supported them to gain the necessary skills required for the job, by giving them the opportunity to initially act up to ward manager level, and be supporting them to access additional specialist training. They felt that leadership development opportunities in the organisation had recently improved and management training was available for new managers.
- Staff and patients reported that leaders within the hospital were visible and approachable at all times. Leaders demonstrated a thorough understanding of the services they managed.
- Staff reported that they felt respected, supported and valued. We received consistently positive feedback about working for the provider and the culture of the staff team.
- Although staff felt able to raise concerns with their managers without fear of retribution, some staff were unclear about the whistleblowing process.
- Some staff members were elected by their peers to sit on the providers 'you say' forum. Forum members raised issues from the wider staff group with the hospital's senior management team each month. The forum included the providers executive team every three months.
- We identified positive examples where managers had supported staff through periods of poor performance, by implementing individual goals and access to additional training.
- Staff specifically reported that people from diverse backgrounds were represented at all levels of the staff structure and that there were equal opportunities for career development. Individual development needs were discussed during annual appraisals.
- The dietitian supported staff to maintain a healthy lifestyle. They coached staff about how to maintain healthy eating habits when working long shifts.
- Sickness rates at the time of the inspection had increased slightly to 6.4%. We were told this increase was generally because of staff on long term sick leave.
- An occupational health service was available to all staff working for the provider. Staff were reminded of this service following the serious incidents that had recently occurred in the hospital. In addition to the occupational health service, leaders had organised for therapists to run supportive sessions for staff immediately following serious incidents.
- The organisation recognised positive staff success. Every two months staff voted for a colleague to receive a £50 prize for outstanding achievement. Teams across the organisation also competed for an annual outstanding achievement prize to attend a black tie dinner at a hotel.

Commitment to quality improvement and innovation

- We did not identify any examples of quality improvement initiatives taking place.

Outstanding practice and areas for improvement

Outstanding practice

Chronotherapy was used to treat patients' depressive symptoms. Chronotherapy involves a variety of strategies that control exposure to environmental factors that may influence depressive symptoms. This treatment is not widely used in the United Kingdom but has a strong international evidence base.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that ligature points on all wards are minimised. High risk ligature points must be minimised as soon as possible, and there must be a clear timetable for the minimisation or removal of all ligature points.
- The provider must ensure that the required number and type of nursing staff are on duty each day on the child and adolescent wards. Nursing staff must be trained to meet the needs of the client group.
- The provider must ensure that all patient risk assessments contain details of all patient risks. Patients must have detailed risk management plans focussing on the minimisation of patient risks.
- The provider must ensure that emergency alarms on the child and adolescent wards are responded to immediately. Staff must be able to contact the on-call doctor immediately in an emergency.
- The provider must ensure that young people have a full physical health assessment on admission. Staff must complete young peoples' paediatric early warning score correctly.
- The provider must ensure that clients having substance misuse detoxification treatment have early exit plans.
- The provider must ensure that all patients and young people have personalised, holistic, recovery-orientated care plans. Patients and young people must be able to contribute to their care plans and be offered a copy of them.
- The provider must ensure that staff on the child and adolescent wards understand what constitutes restraint. Staff must record each episode of restraint in detail.
- The provider must ensure that the prescription of 'as required' medicines on the child and adolescent wards clearly states a specific route for administration. Staff must record a rationale for administering 'as required' medicines.
- The provider must ensure that young people on the child and adolescent wards are treated with dignity and respect at all times.
- The provider must ensure that systems and processes are effective in identifying potential risks and in monitoring the quality of care on the child and adolescent wards.
- The provider must ensure that medical equipment on the wards is suitable for the client age group and within it's expiry date. There must be a system for staff to monitor the calibration of equipment.

Action the provider SHOULD take to improve

- The provider should ensure that staff on the child and adolescent wards have a good understanding of the Mental Capacity Act 2005.
- The provider should ensure that informal patients are aware of their right to leave the ward at any time.
- The provider should consider using the CIWA-Ar tool for more than two days for clients receiving alcohol detoxification treatment.
- The provider should ensure that information is available in an 'easy read' format for people with learning disabilities or difficulties.

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 9 HSCA (RA) Regulations 2014 Person-centred care On all of the wards, patients and young peoples' care plans did not always reflect their needs. Care plans were not always personalised, holistic or recovery-orientated. This was a breach of Regulation 9(1)(a)(b)(c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Young people on the child and adolescent wards told us that some staff did not treat them with respect and dignity. They found some staff patronising and unsympathetic. This was a breach of Regulation 10(1)

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 Ligature risks were present on all of the wards, including high risk ligatures in young peoples' bedrooms. Patients' and young peoples' risk assessments were not detailed and risk management plans did not always identify how staff could minimise risks effectively. Young people did not always have a full physical health assessment on admission to the hospital.

This section is primarily information for the provider

Requirement notices

On the child and adolescent wards, emergency alarms and call buttons were not always responded to in a timely manner.

Paediatric early warning scores were not completed correctly. Possible deterioration in a young person's physical health may not have been escalated appropriately.

Staff on the child and adolescent wards did not understand what constituted restraint. There was inconsistent recording of restraint of young people, and a lack of planning of how to support young people in the least restrictive way possible.

The out of hours doctor did not carry and alarm or pager. Staff may not have been able to contact the doctor in an emergency.

Clients having substance misuse treatment did not have early exit plans.

The prescription of 'as required' medicines on the child and adolescent wards did not always clearly describe the route for administration. There was not always a recorded rationale for the administration of 'as required' medicines.

The provider did not ensure that appropriate medical equipment was within it's expiry date and was suitable for the client age group.

This was a breach of Regulation 12(1)(a)(b)(e)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance On the child and adolescent wards the governance and risk management systems and processes had not been effective. Potential risks to young people had not been proactively identified and addressed. Monitoring of the quality of care on the child and adolescent wards had been ineffective.

This section is primarily information for the provider

Requirement notices

The pace of change following serious incidents on the child and adolescent wards was not rapid enough to ensure that areas of potential high risk were addressed.

This was breach of Regulation 17(1)(2)(a)(b)

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 Staffing levels for nursing on the child and adolescent wards were not safe. On a number of day shifts, there was one registered nurse rather than the minimum of two. Young people did not always receive one to one nursing sessions and their escorted leave was sometimes cancelled due to staffing levels on the wards. Nursing staff on the child and adolescent wards had not received specialist training in epilepsy, autism or eating disorders. Staff had not received suitable training to meet the specific needs of young people in their care. This was a breach of Regulation 18(1)(2)(a)