# The Priory Hospital Preston

## 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 | Good |
| Are services safe? | Good |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive? | Good |
| Are services well-led? | Good |

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

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

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

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

# Summary of findings

## Overall summary

- We rated the Priory Hospital Preston as **good.**

Systems were in place to monitor and manage patient risk. Staff carried out comprehensive assessments in a timely manner and regularly reviewed these. Assessments of ligature risk (the risk created by places to which patients intent on self-harm might tie something to strangle themselves) were in place, along with policies to support the management of this risk. The hospital had embedded safeguarding throughout. Staff were aware of their responsibilities to report and raise any incidents and safeguarding issues. Staff had received up-to-date mandatory training. Managers assessed and reviewed staffing levels to keep patients safe.

Patients' care and treatment was planned, delivered and reviewed regularly, in line with best practice guidance. Staff routinely collected and monitored information about patient outcomes. There were systems in place to ensure adherence to the Mental Health Act (MHA) 1983, the MHA Code of Practice, the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Patients had access to psychological therapies. Plans were in place to review the provision and quality of these therapies.

Feedback from patients, carers and relatives at the hospital was positive. We observed staff treating patients in a respectful manner, and with a caring and empathetic approach. Staff involved patients in their own care. Managers regularly evaluated feedback from patients to improve inpatient care and treatment at the hospital.

The hospital planned services to meet the needs of patients. Patients were provided with continuity of care, with staff liaising with outside agencies when patients were discharged from the hospital. Managers ensured there were continuous environmental improvements to ensure patients received care in well-maintained ward environments.

Patients had access to the complaints process. Managers listened to complaints and concerns from patients and made improvements when required.

Senior managers were visible and proactively engaged staff in the vision and values of the organisation. Staff felt supported and consulted about their roles. Staff told us they were confident in approaching their line manager. There were good governance structures with individualised and group audits in place to support and deliver safe care and to monitor the performance of the hospital.

However, there were some issues the managers needed to continue to address. These included reviewing and monitoring the quality of the psychological therapies to ensure it met patients' needs; recruiting to the nursing staffing vacancies on Bartle ward and the maintenance of the perimeter fence.

# Summary of findings

## Contents

Good

# The Priory Hospital Preston

**Services we looked at**
Acute wards for adults of working age and psychiatric intensive care units

# Summary of this inspection

## Background to The Priory Hospital Preston

The Priory Hospital Preston is an independent adult mental health hospital, specialising in the management and treatment of a wide range of mental health problems. The Priory Hospital Preston provides a range of treatments and therapeutic services for patients diagnosed with general psychiatric disorders, addictions and eating disorders. These include anxiety, depression, stress, post-traumatic stress disorder, obsessive-compulsive disorder states, eating disorders, attention deficit hyperactivity disorder, schizophrenia, and all major acute psychiatric illnesses. The hospital provides treatment on an inpatient, day care and outpatient basis. The Priory Hospital Preston is part of the Priory Group which provides a range of independent health, social care and educational services across the UK.

The hospital director was the registered manager for the Priory Hospital Preston. There was an accountable officer in place.

The hospital has two ten-bed units. These are:

- Bartle unit (formerly Sion House) which is a specialist eating disorder unit
- Rosemary ward, which provides ten allocated beds for patients who require acute inpatient facilities, as well as providing for patients who may need to access an addictions treatment programme.

There have been three inspections carried out at the Priory Hospital Preston, most recently on 25 March 2014. At each of these inspections, we found the service was compliant in all the areas we assessed.

We have carried out unannounced Mental Health Act (MHA) monitoring visits at the Priory Hospital Preston. The most recent was 3 December 2014 when we visited both Bartle ward and Rosemary wards. We found good systems for adhering to the MHA. We found minor issues relating to the MHA. The provider submitted an action statement telling us how they would improve adherence to the MHA and MHA Code of Practice in these areas. These actions had been implemented at the time of our inspection.

## Our inspection team

The team was comprised of four CQC inspectors.

## Why we carried out this inspection

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

## How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both wards at the hospital site and looked at the quality of the ward environment
- observed how staff were caring for patients
- spoke with 11 patients who were using the service

# Summary of this inspection

- spoke with six carers
- spoke with both ward managers
- spoke with other staff members, including nurses, pharmacists, therapists, the medical director, and the governance lead
- interviewed the hospital director with responsibility for these wards
- attended one multidisciplinary meeting
- looked at five care and treatment records of patients
- carried out a specific check of the medication management
- looked at a range of policies, procedures and other documents relating to the running of the service.

## What people who use the service say

During this inspection, we spoke with 11 patients, who were inpatients at the hospital, and six carers who were relatives or family friends.

Most of the feedback from patients who we spoke with was positive. All of the patients and their relatives or carers were complimentary towards all the staff, and considered them caring and supportive.

Carers and family members reported that staff understood their needs and were supportive to them.

Carers we spoke to were also very positive about the service they had received. They all felt they had been involved and listened to in the care and treatment of their relative.

Two patients commented on the need for improved therapies on the eating disorder service.

# Summary of this inspection

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Are services safe?

Good

We rated safe as good because:

- Patient risk assessments were carried out in a timely manner.
- Environmental ligature risk assessments and individual room ligature risk assessments had been completed. The service was taking action to reduce ligature risks.
- Ward staffing establishments had been determined against patient needs.
- Managers had access to regular bank staff and rarely used agency staff.
- Staff were aware of incident reporting procedures. Staff confirmed they had received feedback from incidents.
- Managers undertook weekly quality walk rounds to promote patient and staff safety.
- Staff had a good awareness of safeguarding, and safeguarding processes were in place.

However, there were some staffing vacancies on Bartle ward and managers were recruiting to fill these posts. The perimeter fence around the hospital was poorly maintained.

### Are services effective?

Good

We rated effective as good because:

- Patients were assessed patients within 24 hours of admission.
- Physical health checks were in place for all patients admitted to the hospital.
- Patients' care plans and progress were reviewed regularly within multidisciplinary meetings.
- Clinical staff delivered care and treatment in line with current guidance and monitored their compliance with this.
- Staff were appropriately skilled to deliver care and there was a range of staff disciplines that contributed to the wards.
- The hospital used the health of the nation outcome scales (HoNoS) and other tools to measure outcomes for patients.
- There was a strong programme of assurance and an annual audit calendar was in place.
- Mandatory training and appraisal uptake for staff was 100%.
- There were appropriate policies in place covering medical revalidation, staff appraisal and supervision.
- There were systems in place to ensure adherence with the Mental Health Act, the MHA Code of Practice and the Mental Capacity Act.

# Summary of this inspection

Some concerns were raised regarding psychological therapies. However the provider had acknowledged this and was in the process of reviewing the provision and quality of those therapies.

## Are services caring?

Good

We rated caring as good because:

- There were positive interactions between patients and staff, who provided practical and emotional support to patients during our visit.
- Feedback from patients about staff, and staff attitudes, were very positive. Patients, their carers and relatives felt staff treated them with respect, that they listened, and were caring and empathetic.
- Staff gave patients using the service the opportunity to be involved in decisions about their care.
- Staff facilitated and planned with patients their attendance at the multidisciplinary meetings and involved the patient's family or carers where this was appropriate
- Staff spent time talking to patients and their families.
- The wards held regular patient community meetings, and the meeting minutes demonstrated that the hospital took action in response to issues raised.
- People who had previously been patients at the hospital took part in walk rounds to assess the quality of the wards.
- Managers regularly evaluated feedback from patients to improve inpatient care and treatment at the hospital.

## Are services responsive?

Good

We rated responsive as good because:

- Where needed, the hospital had access to psychiatric intensive care beds through an arrangement with a sister hospital in the same Priory Group
- There was a good system in place in planning for patient discharge from the hospital.
- The facilities and premises provided patients with a range of rooms available for them to access and external garden areas.
- There was good access to ward-based activities as well as a range of activities outside of the hospital for patients.
- There was support for patients' spiritual and religious needs.
- Patients had access to hot drinks and snacks whenever they required and there were water machines present on the wards.
- There was a range of information leaflets available on both wards and these provided patients with information about various medications.

# Summary of this inspection

- There was access to a dietician, and an onsite chef produced food to meet dietary requirements.
- There was good access to the complaints process and good management of complaints.

## Are services well-led?

Good

We rated well-led as good because:

- Staff were engaged with the vision and values of the provider organisation.
- Senior managers were well known and had a visible presence at the hospital and in the ward areas.
- There was an open and transparent culture and staff were being consulted and encouraged to comment about service improvement.
- Staff stated managers supported them in their role and that the managers at the hospital were visible, accessible and approachable.
- There were processes in place to manage current and future performance of the hospital.
- There was a strong programme of assurance and audits in place to monitor the performance at the hospital.

# Detailed findings from this inspection

## Mental Health Act responsibilities

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

Staff we spoke to understood their responsibilities with regards to the Mental Health Act (MHA). The service delivered care in line with the MHA and the MHA Code of Practice (CoP). Relevant assessments and documentation had been completed. Patients were informed of their rights on admission and routinely thereafter.

Staff had access to training on the MHA. This was included as part of the mandatory training requirements and 80% of staff had completed the training.

Staff had access to advice and support around the MHA through an on-site MHA administrator and a central Priory MHA team. There were strong flagging and checking systems in place to ensure adherence to the MHA supported by a programme of audit.

Patients had access to independent mental health advocacy services (IMHAs). Staff we spoke to demonstrated an awareness of the IMHA services and how to support patients to access them.

## Mental Capacity Act and Deprivation of Liberty Safeguards

Staff we spoke to showed a good understanding of the Mental Capacity Act (MCA) and the five statutory principles. Patients' capacity and consent to treatment had been assessed and recorded. Capacity assessments were completed where required and reviewed regularly.

Staff had access to training on the MCA which incorporated training on Deprivation of Liberty Safeguards (DoLS). Ninety per cent of staff had completed the training. Staff we spoke to understood the MCA definition of restraint.

The hospital had policies covering the MCA and DoLS in place for staff to refer to on the computers. Staff carried out regular audits to monitor adherence to the MCA. Support and advice was available from a central team to promote adherence to the MCA and DoLS safeguards.

The service had not made a Deprivation of Liberty Safeguard (DoLS) application within the past six months. We saw no evidence that staff were depriving patients of their liberty.

## 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 | Good | Good | Good | Good | Good | Good |
| Overall | Good | Good | Good | Good | Good | Good |

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

Good

| | |
|---|---|
| Safe | Good |
| Effective | Good |
| Caring | Good |
| Responsive | Good |
| Well-led | Good |

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

Good

**Safe and clean environment**

The environment on Bartle and Rosemary ward was clean and well maintained. Each bedroom was spacious and comfortable and all provided en suite bathroom facilities. Although the majority of these rooms were not ligature free, there was one bedroom with a ligature free en suite bathroom in each ward area for individuals who posed a risk of ligaturing. Patients had open access to their room, alone or with support.

We saw work had begun to reduce environmental risks such as introducing doors to prevent access to the stairs at the back of the wards, the removal of bedside lamps to reduce the risk of ligaturing, and the placing of curved ceiling mirrors on corridors to remove the blind spots. Individual risk assessments and hourly checks were also in place to assess and check patients in the context of the environmental risks posed.

Although environmental difficulties existed relating to blind spots, ligature risks and poor perimeter fencing, managers had plans in place for work that would reduce these risks. There was a managed anti-ligature programme in place for 2015. The company's risk register recognised these risks.

There was mixed sex accommodation on Rosemary ward where the hospital had introduced zoning to mitigate risk. The zoning created separate male and female areas including separate sleeping areas. A female-only lounge was available for patients to use. Bartle ward was a designated female ward.

The garden was large with good leisure facilities. However, the hospital backed onto a busy motorway and the perimeter fencing was in poor repair. Patients who posed a higher risk of absconding were subject to higher levels of observation to prevent them going absent without leave.

Each ward had an air conditioned clinic room to ensure medicines were stored within safe temperatures. The fridges for the storing of certain medicines displayed the temperature on the outside and staff checked these and made records daily. This meant there were appropriate checks to ensure all medicines were stored at correct temperatures. There were clear systems in place to check and dispose of medicines. The pharmacist visited weekly to carry out checks. There was documented evidence of regular pharmacy audits. Audit results showed high levels of compliance in regards to medication management and prescribing. There was good communication of the findings of these audits to the staff team. Where issues were identified actions were put place and monitored through future audits. National drug alerts were shared with staff and appropriate action taken when necessary to ensure the safety of medicines. Staff checked all equipment regularly, including electrocardiogram (ECG) and blood pressure monitors, to ensure that they were safe to use and recording correct heart and blood pressure readings.

We saw that oxygen and resuscitation equipment were available on each ward area. The resuscitation kits contained defibrillators, oxygen masks suitable for adults and children, a master key for all bedrooms, adrenaline

and a flashlight. We noted the equipment was in date and checked regularly. The bags also contained a ligature knife to cut through the ligature if a patient used one to self-harm.

The local council had awarded The Priory Hospital Preston a food hygiene rating of five (very good) on 7th February 2014. This meant that food was prepared in a safe way and in a clean environment.

**Safe staffing**

During the day, Bartle ward had a minimum staffing level of two qualified members of staff and two unqualified, with support from the ward manager. Rosemary ward had a minimum day time staffing level of two qualified members of staff and one unqualified with support from the ward manager. In addition to these nursing establishments day time staffing levels also included psychologists and activity coordinators who were present on the wards. Bartle ward had a meals co-ordinator to support patients at mealtimes.

At the time of the inspection each ward had night time staffing levels of one qualified and one unqualified member of staff. The hospital was in the process of increasing these levels and an extra unqualified member of staff has been added to Rosemary ward. Staff who worked at night provided support to each other and worked across the two wards in the event of an incident.

The hospital held a daily meeting in which ward acuity and risk was discussed as well as the potential impact of planned admissions. This enabled managers to raise staffing levels in relation to the needs and risks of the patients. Where assessment indicated an increased risk or the need for one-to-one or enhanced observation levels managers accessed a regular cohort of bank staff to increase staffing levels. At the time of the inspection the service was recruiting three additional unqualified members of staff over the establishment levels to help provide consistent cover in this regard.

There was a regular cohort of bank staff who provided cover for sickness and vacancies. The hospital used agency staff infrequently. Where the hospital did have to access agency staff they used a regular agency to ensure consistency and quality.

Rosemary ward's establishment was 6.3 whole time equivalent (WTE) qualified nursing staff with one WTE vacancy and 5.1 WTE unqualified staff with no vacancies. In the three months prior to the inspection there had been six shifts covered by bank or agency staff. One shift had been unfilled.

Bartle ward's establishment was 6.4 WTE qualified nursing staff with one vacancy and 7.1 WTE unqualified staff with no vacancies. There were 91 shifts filled by bank or agency staff in the previous three months period. No shifts had been left unfilled.

Staffing rotas we reviewed showed that actual staffing levels matched established levels. None of the staff, patients or carers that we spoke to raised concerns over the level or availability of staff. Recruitment was under way to fill the nursing staff vacancies and plans were in place to support the retention of staff across the organisation.

Specialist input was available from occupational therapists, psychologists and dietitians. The hospital employed an activities co-ordinator to provide planned activities across both wards.

The hospital had recently filled a vacancy for a consultant psychiatrist. One full-time doctors covered both wards and there was an on-call system in place to cover for sickness and annual leave.

Mandatory training audit records showed that 92% of all staff were up-to-date with mandatory training. The figures showed across all disciplines and staff groups that mandatory training take up was high. This showed high uptake from doctors and from nurses on Rosemary and Bartle wards. Staff received regular clinical supervision and annual appraisals with 100% compliance.

Staff at the Priory had access to a telephone counselling service if they required support. This was also open to the families of the patients using the service.

**Assessing and managing risk to patients and staff**

Staff undertook risk assessments on admission and updated them regularly. The risk assessments were comprehensive and included discussion with the patients themselves. Staff also carried out risk assessments before allocating a bedroom to patients to assess their safety and risk issues. Identified risks were assessed using a traffic light system that clearly identified the risks – the highest being red, with amber as a medium risk. There were no blanket restrictions in place.

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

Good

Staff only used physical restraint as a last resort and did not use prone restraint or seclusion. Staff recorded seven incidents of the use of restraint in the period 1 January 2015 to 30 June 2015, with five incidents on Rosemary ward and two on Bartle ward. Of the total incidents of restraint, none involved staff restraining patients in the prone position. Of the seven incidents of restraint, six different patients were involved. Staff had received training in non-violent communication. There were post-incident reflective practice sessions with staff involved in an incident. Post-incident debriefs also occurred with patients to record the patient's perspective of what happened. This ensured that the patient's perspective of an incident was recorded and used to improve future responses to any disturbed behaviour. The hospital rarely used rapid tranquilisation, which is where strong sedatives control severely disturbed behaviour.

The hospital had access to two local safeguarding leads within the Priory organisation; one for adult safeguarding and one for children. Staff received training in safeguarding. Staff we spoke with knew how to recognise abuse and were aware of the hospital's safeguarding policy. They knew who to inform if they had safeguarding concerns. The hospital had good relationships with the local safeguarding teams in the local authority and used the multiagency safeguarding hub to raise alerts.

Visitors had access anywhere in the building. This was risk assessed with each patient. There was a dedicated visiting room available for child visitors and the hospital had a child visiting policy in place.

### Track record on safety

The CQC received four statutory notifications between 1 August 2014 and July 2015 from Priory Hospital Preston. There was one incident that related to serious injury and three that related to police incidents. We reviewed these before the inspection and saw that the managers had taken appropriate action to manage these.

Reporting incidents and learning from when things go wrong

Staff told us they reported all incidents on an electronic system. The parent organisation monitored these. Managers held weekly incident review and management meetings to discuss learning from serious incidents, with the recording and action logs distributed to all staff.

We saw records of these team meetings and the progress of action plans to improve safety. Staff were able to tell us about learning from serious incidents and the actions introduced to prevent further incidents. For example the hospital had recently supplied staff with wire cutters following a serious incident at another Priory Group hospital in which a patient had attempted to ligature using wire from a notebook.

Managers had recently introduced a weekly quality walk to identify local issues and talk to staff to capture and monitor issues relating to the safety of patients and staff. The hospital dealt with any issues identified, and fed back into the clinical governance structure. The hospital held monthly clinical governance meetings.

There was evidence of change as a result of feedback and learning from serious incidents across the organisation. The company e-mailed senior managers across the organisation, who in turn shared the information with staff.

The service had a policy in place around Duty of Candour (DoC). Staff demonstrated a knowledge of DoC and the processes in place to raise concerns.Start here...

## 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**

Patients received an initial assessment within 24 hours of admission. The full assessment process included a risk assessment, medical assessment, and nursing assessment. On Bartle wards, patients' assessments also included a dietician assessment. Assessments were in place and completed on five of the files we looked at. Staff we spoke to informed us this issue had been identified and work was ongoing to improve this.

Patients received a physical health assessments on admission, including an electrocardiogram and full blood count. The ward doctor carried out the assessments if the admission was during working hours. An on-call doctor carried out assessments for out of hours admissions. Additional physical health checks were completed where a

patient's presentation indicated, for example, where there was a history of alcohol dependence. The malnutrition universal screening tool (MUST) was also completed for patients on Rosemary ward. Care records showed recent physical health checks had been carried out and they captured patients' current physical health status. However, one of the records we saw did not capture historical information for one patient prior to their admission on transfer from an NHS hospital. We observed two care reviews as part of a ward round. In both of these reviews, physical health status was discussed and reviewed.

Care plans recorded both short and long-term treatment plans and objectives. Staff reviewed these regularly. Four out of five records captured the views and opinions of the patient. In the fifth record, the patient declined to engage. Staff were working proactively with the patient to encourage them to engage and were using techniques such as motivational interviewing.

Patient information was stored on the hospital's electronic care notes system. This was accessible to all staff.

**Best practice in treatment and care**

Staff demonstrated a good knowledge of relevant National Institute for Health and Care Excellence (NICE) guidance. For example staff on Rosemary ward were able to discuss NICE guidance around schizophrenia and depression. Staff on Bartle ward referred to NICE guidance and pathways around eating disorders, anorexia nervosa and bulimia nervosa.

Checks were made to ensure staff were following guidance through NICE audits built into the audit calendar. These included the national audit on schizophrenia and compliance against national standards for the treatment of depression. An external pharmacist monitored prescribing regimes to ensure medicine prescribing followed national guidance.

There was a range of therapists for each area of patient need including therapists in eating disorder, acute mental health and addiction who worked specifically with each patient group.

Patients that we spoke to on Rosemary ward did not raise concerns regarding the provision of psychological therapies. Patients could access psychological therapies and activities as part of their treatment. Therapies were delivered in both one-to-one and in group settings. This included family therapy and cognitive behavioural therapy (CBT).

Two patients that we spoke to on Bartle ward questioned the value and level of therapies provided and suggested that the focus was more on physical health and weight gain. As a result, both patients felt there was a chance of being readmitted because the underlying cause of their eating disorder was not being fully addressed. The service ran 'make and bake' and culinary skills sessions as recommended by national guidance. It was recognised that patients may not view these as therapeutic activity. We spoke to a further four patients who did not raise concerns regarding either the quality or provision of therapies. One patient we spoke with was complimentary about the family therapy she and her family had received.

We discussed the patients' perceptions with staff on Bartle ward. They explained that the service aimed to address both the physical and psychological elements of eating disorders. However, they stressed that a lot of the psychological work would be delivered in the community post discharge once physical stability had been achieved. Staff were aware that NICE guidance suggested that psychological therapies were less effective for patients with a body mass index (BMI) under 16.

We discussed the availability of psychological therapies with service managers. They acknowledged this was an area identified for improvement. A review of the provision and quality of psychological therapies was ongoing.

We reviewed data provided by the service, which showed that there were two patients who had been readmitted over the previous 12 months. The service had a quality target set by NHS commissioners related to readmissions, which showed that there was no patient readmitted five times or more over the last 12 months.

Staff told us that they had good relationships with local GP surgeries and hospitals. Staff were able to access specialist physical healthcare through these services.

Staff assessed patients for their nutritional and hydration needs and corresponding care plans were in place. The assessment process was assisted by dieticians. Staff monitored patients on an ongoing basis and appropriate records of the monitoring were kept within the care notes.

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

Good

The service used the health of the nation outcome scales to monitor outcomes. These were discussed in ward rounds and monitored through the governance process. In addition, the hospital used the recovery star which was a tool to identify and monitor patient's recovery from mental health problems.

There was a strong programme of assurance and an annual audit calendar was in place. Staff were aware of the audits being undertaken and participated in the audits where appropriate. Results and recommendations from audits were fed back through the governance structure and in team meetings and handovers to promote best practice.

**Skilled staff to deliver care**

The staff group on each ward represented a range of professional backgrounds including nurses, medics, occupational therapists (OT), psychologists, therapists and dieticians. Domestic and administrative staff supported wards. Staff were appropriately qualified for their post and senior staff were experienced within the roles.

The hospital had appropriate policies in place covering medical revalidation, staff appraisal and supervision. Staff underwent annual appraisal and received supervision carried out in both 1:1 and group formats. All 42 staff who had been in post for 12 months had received an appraisal including non-medical staff. All eight ward doctors and consultants had been revalidated.

Staff received an induction when starting their role. There were corporate and local-level induction packs for nurses and healthcare assistants to support this. An induction checklist was also in place for agency staff.

Specialist training aimed at enhancing skills was also available to staff, such as specialist eating disorder training for registered mental health nurses (RMNs), leadership training, and personality disorder awareness training. Staff could also apply for a diploma in personality disorder. This meant staff received specialist training to help them provide appropriate care for particular patients' needs, and ensure they worked in line with national guidance.

Managers were able to explain the process for addressing poor staff performance and the use of improvement plans. The hospital had a policy in place to support this process and support was available from a central human resource department.

**Multi-disciplinary and inter-agency team work**

Multi-disciplinary team (MDT) meetings were held weekly for each ward. We observed two MDT meetings. The meetings were well structured and attended by staff from all relevant disciplines. Patient involvement was encouraged and space was given for patients to air their views and opinions. All the staff contributed to the review of care and the care plan was agreed collaboratively with the patient. This meant that patients received care which was co-ordinated and agreed with the patient and between the MDT members.

Staff worked collaboratively to deliver patient care and there was good communication and handovers between disciplines. For example, the psychologist met with ward staff both before and after therapy sessions to share relevant information.

Staff told us that they had good relationships with local GPs, pharmacists, hospitals and safeguarding authorities. The service was implementing commissioning for quality and innovation (CQUIN) targets around further improving communication with GPs following care programme approach (CPA) meetings. The service had achieved 100% compliance over the previous 12 months.

Staff maintained regular contact with care coordinators including where a patient was from out of area. There was regular contact through telephone and email. Care coordinators were invited to attend MDTs and CPA meetings. When the care co-ordinator could not attend, notes of the meeting were sent to them.

**Adherence to the MHA and the MHA Code of Practice**

Staff had access to training on the Mental Health Act (MHA) and the MHA Code of Practice (CoP). This was included as part of the mandatory training requirements. Most of the staff had completed the training (35 out of 44 which amounts to 80%) with 20% (nine out of 44) not completing the training. Staff we spoke to showed a good understanding of the MHA and its application. Support for staff was available through a MHA administrator and a central MHA team. There were strong flagging and checking systems in place to ensure adherence to the MHA supported by a programme of audit.

We reviewed five patient records and found that staff were delivering treatment in accordance with the MHA. Patient care records were in good order with relevant

documentation and assessments completed. Original detention paperwork was stored in a secure cabinet, which meant that staff could access the original legal documentation if required.

Patients were informed of their rights on admission and routinely thereafter. Staff recorded this in each patient's notes. Managers carried out an audit to check staff had told patients about their rights.

The hospital promoted independent mental health advocacy services (IMHA) on its wards. Staff we spoke to demonstrated an awareness of the IMHA services and how to support patients to access the service. Two patients we spoke with had used the IMHA service.

**Good practice in applying the MCA**

Staff had access to training on the Mental Capacity Act (MCA). The training also included Deprivation of Liberty Safeguards (DoLS). Ninety per cent of staff had completed the training (36 out of 40); one out of 40 staff was in the process of completing the training and three had not yet completed the training.

Staff we spoke to showed a good understanding of the MCA and the five statutory principles. They were applying the MCA in practice. Records showed that staff completed capacity assessments where it was appropriate to do so including on admission. Capacity assessments were completed on a decision specific basis and were reviewed and repeated accordingly. Staff we spoke to understood the MCA definition of restraint. There had been seven incidents of restraint over the previous six months. None of these had involved restraint in the prone position.

The hospital had a MCA policy in place for staff to refer to electronically. Staff carried out regular audits to monitor adherence to the MCA.

The service had not made a Deprivation of Liberty Safeguard (DoLS) application within the past six months. We saw no evidence that staff were depriving patients of their liberty. Staff we spoke to demonstrated knowledge of DoLS. There was an appropriate policy in place to support staff.

Support and advice was available from a central team to promote adherence to the MCA and DoLS rules.

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

Good

**Kindness, dignity, respect and support**

Our observations of staff showed that the interacted positively with patients. Staff engaged with patients who used the service in a respectful manner; allowing patients and carers to express their opinions. Staff were discreet and respectful when discussing personal issues with patients. We saw staff providing practical and emotional support to patients during our visit.

Patients all reported that staff treated them with respect and they were listened to. Patients commented that they had no problems approaching the staff and anybody could be approached. Patients told us the staff were very friendly, approachable and they were made to feel welcome. They also said nurses were always available to speak with.

Patients told us that they were involved in decisions about their care and treatment. They had a named individual (keyworker) allocated to them. This meant that patients were able to discuss any issues with an identified person who understood their individual needs.

Patients had access to therapy at the hospital and this was provided daily.

**The involvement of people in the care they receive**

The nurse in charge showed patients around the ward areas. Information packs were given to patients to inform them about their stay.

Patients and their carers or relatives were involved and encouraged to be involved in their care planning and risk assessments. Patients confirmed they were invited to the weekly multidisciplinary team (MDT) meetings. Carers were invited where the patient had agreed to this. We saw evidence that patients, carers and family members were involved in the decisions about the care and treatment planned through the MDT meetings. Patients were routinely offered copies of their care plans and confirmed they had been involved where they wanted to be.

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

Good

The service undertook quarterly patient satisfaction surveys. The results from the quarter one survey (April 2015 to July 2015) were positive. The survey was completed by 30 patients and showed that all 30 felt that they were involved as much as they had wanted to be in decisions about their care and treatment.

Information about how patients could access independent advocacy and the role of advocates was clearly displayed and available on the wards. Information was also displayed throughout the hospital.

Community meetings took place weekly on Rosemary ward. Current patients on Bartle ward were consulted and had made a decision that they did not want weekly community meetings.

All patients on discharge were asked to complete a questionnaire about their stay at the hospital.

This meant that patients were provided with the opportunity to provide feedback about all aspects of their care and treatment. Patients were asked about all aspects of their hospital stay including admission, diagnosis, information about how to access services in crisis on discharge from the hospital, being treated with privacy and dignity as well as meeting patient nutritional needs and overall satisfaction.

Results of the patient satisfaction survey in quarter one of 2015/16 (April –July 2015) showed that all of the four patients in addiction therapy who completed the survey considered their care to have been excellent or very good. All twenty one patients on general acute admission who completed the survey considered their care to have been excellent or very good. Three of the five respondents from the eating disorder service (60%) who completed the survey considered their care to have been excellent, very good or good.

People who had previously been patients at the hospital had been asked to partake in the walk round on wards to assess the quality of the wards.

Friends and family test had been introduced and data from January 2015 – July 2015 survey identified 26 patients and or carers and relatives had completed these with 21 out of 26 reporting that they would recommend the service to other people.

**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**

The Priory Hospital Preston accepted both NHS and private patients. Admissions to Rosemary ward for NHS patients were made by a referral from the local mental health trust and reviewed by senior staff on the ward to determine risk and impact on current patients. On Bartle ward, patient admissions were always planned. Senior staff carried out the preadmission assessments. These ensured patients were only admitted when necessary and beds were kept for those who needed them.

Patient treatment on Rosemary ward was arranged for some patients by the local mental health trust. Private patients accessed the service by a referral from their GP. NHS England funded patient treatment on Bartle ward; the contracts were managed by NHS England's Wessex area team.

Both wards were operating within safe bed numbers at the time of our visit. The bed occupancy rate since January 2015 had been 93% for Bartle ward and 85% for Rosemary ward.

Staff planned for patient discharge with patients and their carers on both wards. Discharge of patients happened in a timely manner with no delays. We found there was good links between staff on the wards and local community mental health teams with staff from these teams attending meetings to plan and discuss treatment and discharge plans. In the last 6 months, there had been no delayed discharges from inpatient facilities.

Access to psychiatric intensive care units (PICU) for patients who needed more intensive care and treatment was arranged for individual patients when needed. This was arranged through liaison with local mental health trusts from where the patient was resident. The Priory Group also provided PICU care at a sister hospital in the same region and this could be offered dependent upon the patient's agreement or best interest and funding agreement.

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

Good

**The facilities promote recovery, comfort, dignity and confidentiality**

The ward environment was clean and comfortable. The furniture across the wards was in good condition. There was an assortment of pictures on the walls, which made the wards feel homely. Patients had good access to outdoor space on both wards. There was a range of rooms used for activities as well as quiet rooms and lounges, which the patients had access to 24 hours a day. Meeting room and activity space was limited but the rooms were utilised to make the most of the space available inside of the building.

There were quiet areas around the building, which patients had full access to and could be used for visiting by relatives and professionals. There was a private telephone booth on the ground floor and a portable phone on each ward which patients could use to make a private phone call. Patients had access to their own mobile phones. Patients had access to the internet via Wi-Fi.

Patients were able to securely store possessions in a lockable cupboard in their room. Patients told us that they felt their possessions were safe and that they had the key to the cupboard to store valuables in.

Food was prepared by a central kitchen with separate dining rooms for both ward areas. Each ward had a small kitchen for patient use to make snacks and warm drinks. Patients told us the food was of a very high quality. Patients confirmed that they had access to hot drinks and snacks whenever they required and there were water machines present on the wards.

There was good access to wards based activities as well as a range of activities outside of the hospital for patients. During our visit, we saw therapies and activities happening on both wards including addiction therapy for people who were admitted for their addictions. There was a good activity schedule and this was tailored to meet the needs of the patients. Some of the groups were patient led. Patients were given a personalised activity plan. Staff told us that the activity plans could be changed or modified if people were struggling with certain aspects. Patients told us that activities were never cancelled. Activities on the plans included swimming, attending the gym and walks within in the local area.

An activity co-ordinator worked across both wards. He was employed following patient comments at previous community meetings where patients had expressed a need for improved activities at the weekend and in the evenings. The occupational therapist and dietician also ran therapeutic groups on the wards.

**Meeting the needs of all people who use the service**

There was an adapted bedroom to allow access for patients who used a wheelchair. There was full disabled access throughout the building. The building also provided a lift for patients with any mobility issues to use.

There was a range of information leaflets available on both wards and this included a large file of medication leaflets which could also be downloaded from the pharmacy's website if patients wanted an easy read copy.

Patients' diversity and human rights were respected. Staff understood, promoted and supported patients and their differences. Staff working in the hospital were aware of patient's individual needs and tried to ensure these were met. This included cultural, language and religious needs. Any food could be prepared or ordered to meet dietary, religious, or cultural needs. Interpreters were available if required.

The food was cooked on site and the chefs worked closely with the dieticians especially for Bartle ward to make sure that patients with eating disorder had meals prepared using the calorie controlled diet plan drawn up by the dietician. The chef was able to visit the ward personally to discuss dietary needs with individual patients and specific cultural diets would be made available and accessed. This meant that the hospital could be flexible to meet individual patients' dietary needs.

**Listening to and learning from concerns and complaints**

Patients knew how to raise complaints and concerns and told us they felt confident to do so. Patients told us they had confidence that the ward managers and senior staff would take their complaint seriously.

Information on how to make a complaint was displayed on the wards and in welcome packs for patients. Information on mental health advocacy services was also displayed. Staff and patients told us that informal complaints were resolved at community meetings. The senior management team did a monthly service user quality walk-around where patients could raise any concerns to them as well.

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

Good

There had been eight complaints made by patients since July 2014. Three of these had been upheld. A record was kept of the time taken to complete the investigation and time taken to inform the complainant. Complaints had been investigated and responded to appropriately and took account of the complainant's point of view.

Themes and learning from complaints were fed back to staff via the ward managers who attended the clinical governance meetings. This was then fed back to ward staff through team meetings and supervision.

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

Good

### Vision and values

Staff were aware of the organisation's visions and values and focus groups have been conducted with staff at the hospital. The organisation had introduced a new statement of purpose with five chosen behaviours. These were:

- Putting people first
- Being a family
- Acting with integrity
- Being positive
- Striving for excellence

The hospital's objectives and values were being implemented and monitored. Staff were being consulted in team meetings, supervision and appraisals. Ward managers completed weekly reports, which fed up to the hospital director who reviewed the reports and escalated important themes to the regional manager.

The chief executive had visited the hospital and met with patients and staff. Staff knew who the senior managers were within the organisation. They felt the hospital management team were approachable. Staff reported that they felt able to speak to managers if they had any concerns. They also told us the new hospital director had an open door policy and was accessible.

### Good governance

The provider had a corporate assurance policy and organisational requirements. This outlined the integrated approach to quality, safety and compliance across the whole group. It aimed to ensure that patients, staff, commissioners and regulators were assured that continuous monitoring and improvement of the quality of care, support, education and treatment took place. It included the purpose of the Priory Group, set out the behaviours Priory Group aspired to and clarified the responsibilities of the assurance team. Priory Hospital Preston embedded these approaches and requirements within their governance structure and audit checks.

Systems were in place to ensure that staff were appropriately recruited and trained and ensure that there were appropriate human resource processes. There were well-developed plans to recruit to vacant posts. Plans were in place to support the retention of staff across the organisation. Systems were in place to capture and monitor that staff had received mandatory training, annual staff appraisal occurred and supervision was happening regularly.

There was a strong programme of assurance through robust audits and an annual audit calendar was in place. Staff were aware of the audits being undertaken and participated in audits where appropriate. Results and recommendations from audits were fed back through the governance structure and in team meetings and handovers. Results were collated and action plans produced to implement improvements at the hospital.

There were strong systems in place to ensure adherence to the Mental Health Act and the Mental Capacity Act supported by a programme of audit.

Senior managers completed monthly spot checks at the hospital. The records checked on patients, staff numbers and staff breaks, observation levels and any incidents during the night as well as site security. These were reviewed and monitored by the hospital director and, where needed, appropriate action taken and monitoring by the provider's governance team. A weekly quality walk round from managers had recently been introduced to identify local issues and talk to staff in order to capture and monitor issues relating to the safety of patients and staff. Where issues had been identified, these were dealt with by the hospital, and fed back into the clinical governance structure.

There was evidence of managers making changes as a result of feedback and learning from serious incidents

across the organisation. These were emailed to the senior managers across the organisation and were then cascaded to staff. Patient feedback was shared with the hospital team at team meetings and within supervision.

Quality performance indicators (QPIs) were in place and these were monitored by the organisation to gauge the performance of the hospital monthly in relation to other hospitals across the provider group. The measures were produced in an accessible format and used by the staff team who developed action plans where issues were identified. These included data about:

- Completion of patient treatment.
- Improvements in the mental health and social functioning during their treatment measured using the Health of the Nation Outcome Scores.
- Abstinence from alcohol during treatment.
- Quality of life rating where patients should increase their quality of life because of completing their treatment, specific to substance misuse via the treatment outcome profile (ToP).
- Friends and family test – patients should be satisfied with the service and should be likely to recommend the service to their friend or relative.
- Satisfaction with the hotel services - patients should be satisfied with the greeting and are happy with the environment and food.

Data provided from January – July 2015 identified that the Priory Hospital Preston had good performance across these indicators with no data outliers in the above areas and improvements had been made in all areas.

Bartle ward adhered to the guidance provided by the Royal College of Psychiatrists on the management of sick patients with anorexia nervosa (MARSIPAN). QPIs in the eating disorder service were monitored and staff provided care and treatment based on national guidance from the National Institute for Health and Care Excellence (NICE).

The hospital director and staff had the ability to submit items to the organisation's risk register and these were monitored by the organisation. Monthly clinical risk meetings were in place at the hospital and these fed into the monthly hospital clinical governance meetings.

**Leadership, morale and staff engagement**

The provider carried out a staff survey for shaping staff engagement initiatives for 2015. They also had staff improvement objectives for 2015, which identified areas for the staff team and directors to make improvements within their service.

Staff we spoke with reported recent changes in the managers at the hospital. Staff told us they had been consulted with about the transition and felt well supported by the managers at the hospital. Staff commented that they could not fault the level of dedication of the hospital director; that she was good, very open and communicates well. They confirmed that the hospital director involving them and informing them about what was going on.

Staff could make suggestions regarding service development. We saw staff were consulted about their opportunities to improve and some leadership opportunities had been developed.

Staff had been asked to attend governance meetings; this meant staff were involved and could engage about issues relating to the hospital.

The highest sickness rate was 13% for 15 staff in the therapy services. The service was utilising sessions by psychologists external to the Preston Priory but part of the Priory group to cover any gaps and ensure therapies were delivered. A review of psychological input was ongoing at the time of the inspection. The lowest sickness rate was 1% of the doctors employed at the hospital. This data was specific to 14 July 2015.

Staff we spoke to were aware of the whistleblowing process. All of the staff we spoke with were confident about raising any issues with the managers and did not fear they would be victimised if they did. Staff were open and supportive towards each other. They were committed to continuous improvement and were positive about the changes.

Staff were open and transparent to patients and explained issues sensitively to patients.

**Commitment to quality improvement and innovation**

The provider was accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation for inpatient mental health services (AIMS) scheme for adult inpatient areas. The provider was also accredited through the Quality Network for Eating Disorders for eating disorder services.

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

Good

These accreditation schemes assessed services to assure and improve their safety, quality and environments against agreed standards. It engaged staff and patients in a comprehensive process of review, through which good practice and high quality care were recognised. Wards were supported to identify areas for improvement and set achievable targets for change.

# Outstanding practice and areas for improvement

## Areas for improvement

**Action the provider SHOULD take to improve**

**Action the provider SHOULD take to improve**

- The provider should continue to review and monitor the quality of the psychological therapies.
- The provider should address the maintenance of the perimeter fence.
- The provider should continue to implement recruitment of nursing staff vacancies on Bartle ward.