The Priory Hospital Preston

Quality Report

Rosemary Lane,
Bartle,
Preston,
Lancashire,
PR4 0HB
Tel: 01772 691122
Website: www.priorygroup.com

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

Ratings

Overall rating for this location	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	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 Priory Hospital Preston as good because:

- There were appropriate measures in place to safely manage the ward layout and environmental risks. This included the use of closed circuit television and the use of mirrors.
- Staffing levels were adequate and could be increased when needed. There were few vacancies and patients had regular one to one time with nurses. There were effective systems in place to ensure that all staff received appropriate mandatory training this ensured that staff were up to date with the correct training.
- Comprehensive care plans and risk assessments were fully completed and up to date. Care plans and risk assessments were reviewed regularly as part of a multi-disciplinary discussion. Patients were encouraged to be involved in their care plans and patient views were clearly documented within care plans.
- The electronic care record system was easy to navigate and locate patient documents. This meant that staff could work efficiently and access patient information without delay.
- There was good psychological provision on Bartle ward that was specific to eating disorders. This meant that patients were receiving holistic care as recommended by national guidance. There were structured patient activity programmes on each ward that were specific to meet patient needs. Patients met to discuss which activities they would prefer and suggestions were implemented where possible.
- Staff demonstrated kind and caring attitudes towards patients. Patients described staff as approachable and helpful. The values and behaviours of the hospital were embedded throughout the service. Staff were aware of the values and behaviours expected of them and were rewarded for demonstrating them in practice. Staff morale was high. Staff enjoyed their work and strived to achieve the best for patients. There were positive results from the staff engagement survey.
- There were many ways patients could give feedback about the service. We saw evidence of patient suggestions being considered and acted upon. There was a robust complaints procedure for staff to follow. Complaints were fully investigated and information shared with staff and other appropriate people.
- The service aimed to provide patients with continuity of care. The service had agreements with local NHS providers that patients admitted to the hospital would remain there until their inpatient treatment was complete. There was effective multi-disciplinary working on both wards. A range of staff disciplines met regularly to decide care and treatment options for patients.
- The food was described by patients as high quality. Patients gave very positive feedback about the food and choices available.
- The service was beginning to implement the safe wards programme. Staff were using positive words and relaxation boxes were available for patients.

However:

- There was no female only lounge on Bartle ward.
- Physical health assessments on admission to the hospital had been omitted and not followed up for two patients. This meant that staff were unaware of any potential physical health issues and unable to initiate treatment.
- Staff had a limited understanding of how to conduct a capacity assessment and implement the best interest's checklist.
- Staff had not received regular managerial supervision. This was not in line with the providers policy.
- As required medication was not being reviewed in accordance to the national guidance.

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; Specialist eating disorders services

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 hospital director was the registered manager for the Priory Hospital Preston. There was a controlled drugs accountable officer in place.

The hospital had two wards. These were:

• Bartle unit, which was a specialist ten bed eating disorder unit for male and female patients

• Rosemary ward, which provided thirteen allocated beds for male and female patients, who required acute inpatient facilities.

We carried out an unannounced inspection on 13 September 2017 following notifications received by CQC about absent without leave incidents. These had involved patients leaving the hospital through windows and doors. We were assured that the provider had taken appropriate actions to address these issues to avoid recurrence.

The hospital was registered with the CQC for the following regulated activities:

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

Our inspection team

The team that inspected the service comprised two CQC inspectors and a variety of specialists:

- two nurse specialist advisors
- a consultant psychiatrist
- an expert by experience (a person with lived experience of using mental health services)

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from patients at three focus groups.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with nine patients who were using the service;
- spoke with the registered manager and managers or acting managers for each of the wards;

Summary of this inspection

- spoke with 14 other staff members; including doctors, nurses, occupational therapist and psychologist
- spoke with an independent advocate;
- attended and observed two multi-disciplinary meetings;
- spoke to one carer of a patient using the service;
- collected feedback from two patients using comment cards;
- looked at 18 care and treatment records of patients:
- carried out a specific check of the medication management on both wards; and
- looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Patients described feeling safe in the hospital and told us that staff were respectful towards them. Patients explained they were involved in their care planning and were offered copies of their care plan. Patients said that staffing levels were generally good and that staff had time for them.

However, many patients complained that scheduled activities were often cancelled and there was a lack of activities at weekends.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- There was no female only lounge on Bartle ward.

However,

- Clinic rooms and ward areas were clean and tidy. Medical equipment was easily accessible and in good order.
- There were appropriate measures in place to safely manage the ward layout and environmental risks. This included the use of closed circuit television and the use of mirrors.
- Staffing levels were adequate and could be increased when needed. There were few vacancies and patients had regular one to one time with nurses.
- Comprehensive risk assessments were fully completed and up to date. Risk assessments were reviewed regularly as part of a multi-disciplinary discussion.

Are services effective?

Good

We rated effective as good because:

- Care plans were fully completed and up to date. Care plans contained patient views and patients had been offered a copy of their care plan.
- The electronic care record system was easy to navigate and locate patient documents. This meant that staff could work efficiently and access patient information without delay.
- There was good psychological provision on Bartle ward that was specific to eating disorders. This meant that patients were receiving holistic care as recommended by national guidance.
- There was effective multi-disciplinary working on both wards. A range of staff disciplines met regularly to decide care and treatment options for patients.

However,

- Physical health assessments on admission to the hospital had been omitted and not followed up for two patients. This meant that staff were unaware of any potential physical health issues and unable to initiate treatment.
- Staff had a limited understanding of how to conduct a capacity assessment and implement the best interests checklist.
- Staff had not received regular managerial supervision. This was not in line with the providers policy.

Summary of this inspection

- As required medication was not being reviewed in accordance with the national guidance.

Are services caring?

Good

We rated caring as good because:

- Staff demonstrated kind and caring attitudes towards patients. Patients described staff as approachable and helpful.
- Patients were encouraged to be involved in their care plans and patient views were clearly documented within care plans.
- There were many ways patients could give feedback about the service. We saw evidence of patient suggestions being considered and acted upon.

Are services responsive?

Good

We rated responsive as good because:

- The service aimed to provide patients with continuity of care. The service had agreements with local NHS providers that patients admitted to the hospital would remain there until their inpatient treatment was complete.
- The food was of excellent quality. Patients gave very positive feedback about the food and choices available.
- There were structured patient activity programmes on each ward that were specific to meet patient needs. Patients met to discuss which activities they would prefer and suggestions were implemented where possible.
- There was a robust complaints procedure for staff to follow. Complaints were fully investigated and information shared with staff and other appropriate people.

Are services well-led?

Good

We rated well-led as good because:

- The values and behaviours of the hospital were embedded throughout the service. Staff were aware of the values and behaviours expected of them and were rewarded for demonstrating them in practice.
- There were effective systems in place to ensure that all staff received appropriate mandatory training. Managers had oversight of training figures and ensured that staff were up to date with the correct training.
- Staff morale was high. Staff enjoyed their work and strived to achieve the best for patients. There were positive results from the staff engagement survey.

Summary of this inspection

- The service was beginning to implement the safe wards programme. Staff were using positive words and relaxation boxes were available for patients.

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 were trained in and had a good understanding of the Mental Health Act with 87% of staff up to date with Mental Health Act training.

Mental Health Act paperwork in relation to consent to treatment and capacity to consent was in good order.

Records showed that detained patients were regularly informed of their rights under the Mental Health Act and the Mental Health Act administrator had oversight of this.

An independent mental health advocate was available and regularly visited the hospital.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were trained in the Mental Capacity Act and Deprivation of Liberty Safeguards with 85% of staff up to date with this training. However, staff remained unclear of how to proceed if a patient's capacity was in doubt or how to implement the best interest's checklist.

Consent to treatment and admission paperwork for informal patients was poorly recorded due to an administrative error. This was rectified during the inspection process.

There were policies regarding the Mental Capacity Act and Deprivation of Liberty Safeguards and the Mental Health Act administrator was available for advice and guidance.

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
Specialist eating disorder services	N/A	N/A	N/A	N/A	N/A	N/A
Overall	Requires improvement	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 intensive care unit services safe?

Good

Safe and clean environment

Rosemary ward was located on the first and ground floor. On the first floor there were bedrooms on one corridor with a main ward area where the lounge, nursing office and clinic were located. On the ground floor, there were further bedrooms, the occupational therapy lounge, an activities room and a female only lounge.

Rosemary ward provided accommodation for both male and female patients. Female patients' bedrooms were on the lower floor with a designated female lounge. Staff used handheld radios for communication between the two floors. Male bedrooms were located on the first floor and male patients had to walk through the female corridor to access the garden and the dining room. . A member of staff was allocated to the female corridor for support.

The ward layout meant staff could not observe all parts of the ward from one location; this was mitigated by the use of closed circuit cameras in corridors and mirrors where needed. There was signage to tell patients that closed circuit cameras were in operation. Additionally, staffing was planned to ensure that staff were present on both floors of Rosemary ward.

Two garden areas were accessible from the hospital. A secure garden area was accessible by patients if there were risk issues and this required staff to be present. A larger garden area was accessible to patients with open access.

The secure garden had tall wooden fencing to prevent patients absconding, with a lower height fence evident around the larger garden area. All fixtures and fences were in a good state of repair. Closed circuit cameras were in place over the garden areas and the main entrance, with signage indicating this on the walls.

Staff completed a comprehensive ligature risk audit every six months and it was clear what actions had been taken at each assessment. Six bedrooms were designated as reduced ligature bedrooms and were allocated on the basis of risk. These had flush fittings, including boxed in television sets. The up to date ligature risk assessment was kept in the nursing office and staff were aware of its location. All bedrooms had an ensuite bathroom with shower.

Window fittings within patient's bedrooms had been replaced with specialist anti-ligature designed windows. This was in response to recent incidents of patients being able to climb through windows. This work had been undertaken following review and evaluation of options, with care taken that actions should be proportionate and should not introduce additional ligature risks. Window fittings were checked on a monthly basis by the estates team and we saw completed checklists for the last twelve months.

We reviewed the clinic room, which was clean and tidy with sufficient storage. Resuscitation equipment was stored in the nursing office in grab bags so that these could be quickly located in the event of emergency. Emergency drugs were supplied by the pharmacy in a sealed box, which would be replaced if items expired or were used.

These were kept in a locked box in the clinic room. The defibrillator for the hospital was stored on the ward and staff were aware of its location in an emergency. Nurses checked the equipment on a daily basis.

All ward areas were clean with good quality, well maintained furnishings. Housekeeping staff kept a cleaning schedule, which covered the wards and rooms, and requests could be made for additional cleaning when needed. The ward kitchen was clean and tidy and was available for patients to use throughout the day and night.

We saw infection control practices being implemented. Regular audits were undertaken and actions completed. Additional audits were completed including water temperature, legionella and bed inspections.

Environmental audits were undertaken by a team from another hospital within the provider group on an annual basis. The most recent audit was thorough and identified actions needed, which had been updated once completed.

Safe staffing

Establishment levels of staff on Rosemary ward were eight qualified nurses and 14 nursing assistants. All qualified nursing posts had been filled and there were two nursing assistant vacant posts. Sickness levels were low over the last 12 months at 2% average. There were no staff currently off work due to work related illness or injury.

The hospital director and ward managers established the number and grade of staff needed for wards. We saw on individual ward duty rotas that the staffing number was always met or exceeded the planned provision. If additional staff were required, for example due to enhanced observations, there was an established nurse bank with regular bank staff employed. Agency nurses also covered shifts with agency nurses block booked to cover shifts to ensure continuity. There were no shifts in the last three months unfilled.

Escorted section 17 leave went ahead as planned. This information was collated by the hospital and monitored by the senior management team.

There was a doctor on site each day and during the night and weekends there was a doctor on call. Staff also had access to an on call GP service. There were measures in place to monitor the effectiveness of the on call system such as response times.

Mandatory training figures across the hospital site were satisfactory and above the 75% CQC benchmark. This consisted of 52 modules including:

- basic life support
- confidentiality
- health and safety
- Mental Capacity Act
- Mental Health Act
- safeguarding children
- safeguarding adults

Assessing and managing risk to patients and staff

We reviewed eight care and treatment records. We saw risk assessments completed at admission and frequently reviewed. These were always reviewed and updated following any incident. Staff completed risk management plans and these were incorporated into nursing care plans.

We reviewed care plans; these were thorough and had evidence of patient involvement.

There were some blanket restrictions in place which were about prohibited items. These were reasonable to maintain the safety of patients and staff. Restricted items that patients were individually risk assessed for included:

- razors
- spare batteries
- glue
- plastic bags
- lighters

We saw that the provider had reviewed restrictive practices and that if restrictions were needed these were care planned on an individual risk basis. We saw that patients were able to access the internet via wifi and could keep personal phones or other internet devices.

Staff followed up to date policies for observation and we saw staff allocated to observations at the commencement of the shift by the qualified nurse in charge. Patient's observation levels were reviewed with risk management and were clearly documented in observation care plans.

Staff were trained in de-escalation and restraint techniques. Restraint was used only as a last resort. Restraint had been used six times on six different patients between April and October 2017 on Rosemary ward. No prone restraint had been used.

There was no use of long term segregation or seclusion at this hospital.

Staff undertook training in safeguarding with 87% of staff up to date. We saw where staff had identified and raised safeguarding issues appropriately. Managers liaised with the local authority safeguarding team regarding referrals.

We reviewed medicines management. We reviewed 13 prescription cards. Prescription cards were clearly written and stored with consent to treatment documentation where necessary. Nurses signed to show medicines were administered and there were no administration boxes unsigned. However, three patients had been prescribed as required medication that had not been reviewed for more than 14 days. This is not in line with National Institute of Health and Care Excellent guidance NG 10 the management of violence and aggression which states the multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used.

We saw good practice in terms of storage and ordering medicines. Medicine stocks were checked regularly. Controlled drugs were stored appropriately and registers were up to date with regular stock checks by both nurses and pharmacists. We saw that where electrocardiograms or blood monitoring was required this was completed. As a result of recent medication errors and a subsequent action plan, extra medication audits were completed weekly by doctors. We reviewed these for the last two months. There was evidence of medication charts being checked and errors corrected.

Track record on safety

We reviewed six serious incident reports from the last twelve months. Two of these related to medicines errors, three absent without leave incidents and one incident of serious self harm.

Medicines errors had been thoroughly investigated, with actions identified to prevent recurrence.

One absent without leave incident had occurred by a patient being able to force a magnetic lock on an external door. The door locks had been changed to stronger locks to prevent recurrence.

Two absent without leave incidents had occurred from windows in patient bedrooms. We reviewed the safety and fittings of the windows following the actions taken. The first incident was where a patient had been able to abscond from a ground floor window by over-riding the window restrictors which had been in place. Following this incident, all bedroom windows had been fitted with enhanced window restrictors and other measures had been put in place to prevent egress if the restrictors were to be broken.

An incident more recently had involved a determined attempt to leave the building via the window with the use of tools. Following this incident, an immediate investigation and environmental review had taken place, led by an external management team. This identified significant planning and determination to overcome the measures in place. The provider replaced all bedroom windows with different units which were specifically designed for use in mental health settings. There was a plan for the remainder of windows to be replaced over the next six to twelve months. We were reassured that measures in place were sufficient given the remit of the unit.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and followed the provider's policy. Staff reported incidents on an electronic system which alerted managers when incident reports were submitted. Incidents were reported appropriately and serious incidents had been notified to CQC and other agencies, e.g. Health and Safety Executive, where appropriate.

Lessons learnt alerts were shared with staff at team meetings, this included findings from other hospitals in the provider group.

We saw in investigation reports, that patients were involved in the review of incidents and staff were open and honest when incidents occurred which affected patients.

Staff were able to identify actions taken following incidents to prevent recurrence, for example, additional checks of prescription cards put in place to avoid transcribing errors.

Duty of Candour

We saw that where incidents had the potential to cause harm the duty of candour had been followed. This was in terms of patients and carers being given an apology and being involved in the investigation process and informed of outcomes.

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 eight patient care records and all had comprehensive and timely assessments completed following admission to the hospital. This included information relating to the reasons for admission and any previous mental health history if known.

A physical health examination had been carried out for seven patients as part of the admission process. For one patient the physical health examination had not been completed on admission or followed up at a later date. There was evidence that patients with ongoing physical health care needs were being treated and monitored appropriately.

All patients had fully completed, individualised and up to date care plans that contained the patients views. All care plans were holistic and recovery orientated. The electronic record system indicated that patients had been offered a copy of their care plan and patients confirmed they were involved in care planning and a copy had been offered to them.

All patient information was stored within the electronic record system that staff could access. The electronic record system was secure and accessed by passwords. Information was stored within the electronic record system in a format that made it easy for staff to locate the particular information quickly.

Best practice in treatment and care

We examined 13 patient prescription charts and eight patient care records on Rosemary ward. We found that prescribing was with British National Formulary prescribing limits. However, two patients were prescribed more than one anti-psychotic and two patients had been prescribed as required hypnotics for more than seven nights. Three patients had been prescribed as required medication for more than 14 days without being reviewed. This is not following best practice. However, patients had weekly ward reviews attended by doctors where medication could be discussed.

There were no psychological therapies available on Rosemary ward. Patients on Rosemary ward requiring psychological treatment were referred to community psychologists as part of the discharge planning process.

Patients had access to specialist physical health care if required. Patients were referred to local hospitals or specialists for individual health conditions. Staff prioritised medical appointments and transport and escorts were available. For patients with severe physical health problems an admission to the local acute hospital could be arranged if needed.

Rosemary ward used health of the nation outcome scales to assess the progress and severity of outcomes for patients. This was completed on admission, discharge and at six monthly reviews.

Ward managers and team leaders completed audits such as:

- environmental audits
- controlled drugs audits
- named nurse audits

Doctors completed medication audits.

Skilled staff to deliver care

There was a range of mental health disciplines providing input into Rosemary ward. Staff disciplines included; consultant psychiatrist, junior doctor, nurses, nursing assistants, occupational therapist art therapist and activity coordinators. Staff had the appropriate qualifications and experience for their roles.

Nursing assistants completed the care certificate qualification as part of the training and induction package. Progress in the care certificate was monitored by senior managers.

All relevant staff were receiving regular clinical supervision. From September 2016 and August 2017 clinical supervision averaged at 78% with the last three months increasing to 100%. Staff described feeling supported in their roles. Managerial supervision was not provided on a regular

basis. From June to November 2017 the average compliance for managerial supervision for Rosemary ward staff was 6%. The supervision policy stated that staff should receive management supervision every two months.

All staff were up to date with completing the appraisal process. Annual appraisal had been completed by 100% of staff.

Specialist training was available to staff who requested specific training and it was relevant to the role of the hospital.

Poor staff performance was addressed promptly and effectively. Managers were able to give a number of examples of how staff disciplinary matters had been resolved using support from a central human resources team. Managers were aware of how to manage and investigate issues relating to staff.

Multi-disciplinary and inter-agency team work

There were weekly multi-disciplinary meetings for each patient. Each meeting was attended by the following disciplines; consultant psychiatrist, junior doctor, named nurse or nurse in charge, occupational therapist, patient and carer if available. Advocates were also invited at the patients request or consent.

We reviewed handover records for the last six weeks. Hand over templates on Rosemary ward included patient presentation, medication, physical observations and observed risks. Staff stated handover meetings lasted for 30 minutes and were attended by all available staff including ward managers and doctors.

The service liaised with outside organisations to support repatriating patients back to their local NHS provider. Representatives from NHS trusts were regularly invited to weekly ward round meetings to assess the progress and needs of current patients. Representatives were provided with detailed information relating to the current care plan and patient needs following discharge. Liaison with some providers was facilitated by teleconferencing services due to the geographical distance involved.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training had been completed and was up to date for 87% of staff hospital wide. Staff had a good understanding of the Mental Health Act, the code of practice and guiding principles.

Consent to treatment and capacity to consent to treatment paperwork had been completed for detained patients and stored with medication charts.

There was a system to prompt staff to explain to patients their rights under the Mental Health Act on admission and at regular intervals thereafter. Staff kept a ward diary and spreadsheet and the Mental Health Act administrator also held a record of when this was due. The ward spreadsheet demonstrated that all detained patients were up to date with Section 132 rights. However, the audit completed by the Mental Health Act administrator found that three out of four detained patients had not been informed of their rights on admission to the service.

The hospital employed an onsite Mental Health Act administrator who was available to offer legal advice on how to implement the Mental Health Act. The Mental Health Act administrator also completed a system of audits to ensure the Mental Health Act was being applied correctly.

Mental Health Act paperwork had been completed correctly and was up to date. However, we reviewed three Section 17 leave forms on Rosemary ward which did not fully explain whether leave should be escorted by male or female staff or whether staff should be registered nurses or nursing assistants. Managers explained this specific detail would be added if necessary for particular patients. Only one form had been signed by the patient. An audit completed by the Mental Health Act administrator also found section 17 leave forms were not always fully completed.

Patients had regular access to an independent mental health advocate who visited the ward weekly. Patients were offered the support of independent mental health advocates or automatically referred if they lacked capacity. Staff were aware of how to refer to independent mental health advocates and there was information about advocacy services in patient areas. Advocates were invited to patient ward round meetings but were not always informed if these were cancelled or re-arranged.

Good practice in applying the MCA

Mental Capacity Act training had been completed and was up to date for 85% of staff hospital wide. Deprivation of Liberty Safeguards training had been completed by 88% of staff. The hospital had not submitted any Deprivation of Liberty Safeguard applications in the last six months.

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

Good

Despite sufficient training levels staff were not fully competent in how to proceed if a patient lacked capacity. One patient was noted to have fluctuating capacity and there were financial safeguarding concerns. A capacity assessment had not been completed. Staff were not fully confident in identifying how to assess and proceed if patients lacked capacity.

There were policies on both the Mental Capacity Act and Deprivation of Liberty Safeguards available to staff electronically or in paper format. The Mental Health Act administrator was available to advise staff on the Mental Capacity Act and code of practice.

Staff had a limited knowledge of the best interest checklist and processes to follow should a patient lack capacity. There was a Mental Health Act administrator was available to assist staff and there were best interest checklist forms to guide staff.

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

Good

Kindness, dignity, respect and support

Staff and patient interactions were observed to be warm and friendly. Staff demonstrated a caring approach to patients that was respectful and supportive. Staff clearly understood individual patients' needs and were able to respond and engage appropriately.

Patients were positive about how staff treated them. Patients described staff as approachable and kind. Patients felt staff had time for them and were always polite and helpful.

The involvement of people in the care they receive

Patients were shown around their ward on admission and made aware any ward protocol. Information leaflets about each ward were being updated and were not available for current patients.

Care plans clearly evidenced patient input. Patient's views and goals had been documented. Most care plans had been written in the first person and patients had been offered a copy of their care plan. Patients were given opportunities to voice their opinions in ward reviews and this was recorded within the patient notes. Patients described feeling involved in their treatment and care and that their views were listened to.

There was good access to advocacy services. The hospital had good working relationships with independent mental health advocates and independent mental capacity advocates. Other advocacy services were available and could be referred to if needed.

Families and carers were given an information leaflet explaining visiting times and ward round protocols. Carers were invited to ward round meetings and could request telephone conference facilities if travelling to the location was difficult. Families and carers were encouraged to keep up to date with patient's progress by telephoning the ward and speaking to nursing staff. Regular carers meetings were not embedded in the service. Carers meetings had started again in November 2017 but were not attended by any family members or carers.

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Patients were able to give feedback about the service in a number of formats. This included:

- quarterly patient satisfaction survey
- complaints process
- comments box
- thank you cards
- weekly patient forum meetings

Data from the latest patient satisfaction survey showed positive results in 12 key areas such as feeling safe, being involved in their care and staff attitudes. The survey showed negative results in patients being appropriately occupied and supported to stay in contact with family and friends. There was a plan to discuss the survey results with patients and consider appropriate action.

Patients were consulted about changes to the hospital such as design for the new garden and smoking areas, the internal decoration and lighting options. Patients were encouraged to draft a list of questions to be added to the staff interview template to assist the recruitment of staff.

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

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

Good

(for example, to feedback?)

Good

Access and discharge

Rosemary ward had an average bed occupancy rate of 92% over the last six months.

The service accepted referrals nationally and therefore did not have a local catchment area. The majority of patients were from the north west of England. Over the last six months 27 patients had a home address that was more than 50 miles away.

All patients had access to a bed on return from leave. There were no problems relating to using leave beds to alleviate bed shortages.

Patients admitted to the service generally remained within the service for the duration of their inpatient stay. The service had contractual agreements with local NHS providers that patients would remain at the hospital until they were ready for discharge. This accounted for the majority of admissions. Other NHS providers from further afield repatriated patients back to their local area as soon as was reasonably possible. Patients were transferred to another Priory hospital site if their risks became unmanageable within the service. Patients could also return to their NHS provider for intensive nursing treatment.

Patient discharges and transfers were planned in advance and took place during daytime hours.

There were three delayed discharges during the last six months. Reasons for delayed discharge were relating to difficulties in locating appropriate placements and placement funding delays and changes to local care coordination.

The facilities promote recovery, comfort, dignity and confidentiality

There were a full range of rooms and equipment to support patient treatment and care including clinic rooms. Rosemary ward had recently been extended and now had larger communal areas. This included a larger lounge and an activities room.

The hospital had a large meeting room that was used for family visitors. The room was comfortable and children's toys were available.

All patients had access to their own mobile phones and could make private telephone calls in their bedrooms. For patients without mobile phones, patient payphones were available on the ward.

There was good access to outside space. Garden areas were pleasant and well kept. There was a covered smoking area. There were plans in place to increase the walking area for patients on Rosemary ward in order to increase physical activity.

The food was reported to be of high quality. Patients stated the food was tasty and fresh with lots of choice. The patient satisfaction survey scored the quality of food at 82%. Patients could make hot drinks and snacks at any time on Rosemary ward.

All patients were able to personalise their bedrooms with photographs and posters. Patients could store valuables or restricted items in a central store accessed by nurses. Patients could request their items at any time. This request would be granted based on the latest risk assessment.

Activity programmes were available seven days a week. On Rosemary ward activities available included: shopping trips, relaxation sessions, recovery groups, art and craft sessions, quizzes, badminton, bingo and baking. Evening and some weekend sessions were led by the nursing team and included board games, quizzes, film night, shopping and bingo. The ward had an activity room that was open from 10 am to 3.30 pm weekdays. The activity room had access to mindful colouring, sewing, knitting, painting, card making, jewellery making, and model building.

The timetable on Rosemary ward was flexible to meet the needs of patients on a daily basis. Patients were able to make suggestions for activities which were implemented where possible. Patients described activities not going ahead as planned and that the timetable was not adhered to. Staff explained that if there was no interest in a particular planned activity, the activity coordinator would replace the activity with suggestions from patients.

Meeting the needs of all people who use the service

A lift was available for patients unable to use the stairs. There were no disabled access bathrooms on the ward. For patients with restricted mobility shower seats could be

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

Good

supplied to the walk in shower rooms. A new building was under construction to provide more acute beds. The new building had been designed to accommodate two disabled access ensuite bedrooms on the ground floor.

Leaflets were on display and accessible for complaint and advocacy services. Other leaflets relating to treatment and care were provided to patients on an individual basis by nurses. Leaflet could be produced in other languages on request. The service had access to an interpreter and signing service.

There was a choice of food to meet dietary, religious and ethnic needs. Food was prepared onsite and meals ordered on a daily basis.

Faith leaders regularly visited the hospital to meet with patients. Patients were encouraged to attend local religious services. Staff were available to escort and transport patients to access spiritual support.

Listening to and learning from concerns and complaints

There had been two complaints over the last 12 months. Neither of the complaints had been upheld and none had been referred to the ombudsman. There were no common themes identified within the complaints. The ward manager described other informal complaints such as lack of activities and short staffing that were addressed and resolved by ward staff.

Patients knew how to complain and felt confident raising issues with staff. Complaints leaflets were available and the complaints process was on display.

Staff understood how to proceed with complaints and raise concerns with senior managers. We saw evidence of complaints being addressed appropriately and information shared with staff, patients and carers. Formal complaints were investigated by the senior management team and outcomes shared with staff in team meetings and emails. Actions from complaints were discussed with staff during engagement sessions with the senior management team.

There had been four compliments from September 2016 to August 2017 directly relating to Rosemary ward. There were nine other compliments relating to the hospital in general.

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

Good

Vision and values

The service had the following behaviours that staff were to adhere to:

- putting people first
- being a family
- acting with integrity
- being positive
- striving for excellence

These behaviours were embedded in the service values. A copy of the purpose and behaviours had been sent to every employee with their wage slips. Posters were displayed on site and cards available for staff detailing the purpose and expected behaviours. The purpose and expected behaviours had also been integrated into the new care certificate workbooks for nursing assistants. For new employees, the purpose and behaviours were embedded into the induction course. In addition behaviours were also visible electronically for reference. Staff appraisals contain the priory behaviours and staff were nominated for employee of the month awards based on demonstrating these values and behaviours in their work. During the recruitment process, behaviours informed the selection process to ensure that candidates met the standards expected.

Senior managers within the hospital were a visible presence on the wards and other hospital areas. Staff described senior managers as approachable and supportive. Other senior executives from outside the hospital had recently visited the service and they were known to staff.

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There was an effective system in place to ensure all staff received the appropriate level of mandatory training and that training was kept up to date. There was a central electronic mandatory training compliance system that managers could access and maintain oversight of training needs.

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

Good

The appraisal system ensured that all staff received an annual appraisal and this information was recorded and shared with managers. There was also a central electronic system to ensure all staff were up to date with supervision. Despite this management supervision had fallen below the expected target due to changes in ward managers and clinical leads. This data was recorded and was accessible to managers to review.

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The electronic record system was user friendly and staff could navigate the system with ease. This allowed staff more quality time with patients.

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Staff could raise risk issues with the hospital director to be added to the risk register.

Leadership, morale and staff engagement

The service conducted an employee engagement survey in August 2017 which scored 85% positive results compared to the Priory organisational average of 78%. The highest scoring staff responses demonstrated that staff strongly enjoyed their work and wanted to do their best.

The overall sickness and absence rate for the last 12 months was low at 2%. There were no staff currently absent from work due to work related illness or injury. The service had a sickness policy and access to a human resources central team.

We saw evidence of how bullying and harassment cases were managed appropriately. We saw examples of managers following disciplinary procedures and staff being suspended or dismissed. The service had access to policies, procedures and legal advice to ensure the correct action was taken. Patients and staff were supported by the service if they had been victim of bullying or harassment.

Staff were aware of the whistleblowing procedure and were confident to raise issues. We saw evidence of staff raising concerns and managers dealing with the concerns appropriately.

Staff morale was good as noted in the employee engagement survey. Staff described working in a supportive environment and were motivated and committed to providing good patient care. Staff felt team working and mutual support were very high in the service.

Ward managers had access to leadership coaching from other senior staff and other formal internal training was available. Ward managers were encouraged to complete NVQ level 5 in leadership and management as part of their career development.

Staff were open and transparent and explained and apologised to patients if something went wrong.

Staff described being consulted regarding the expansion of the service. Managers confirmed that suggestions from staff regarding the running of the service were considered. The employee engagement survey scored 77% for staff feeling that they were encouraged by their manager to suggest new ideas for improvements.

Commitment to quality improvement and innovation

Rosemary ward was implementing a number of safe wards initiatives such as using positive words and having relaxation boxes available for patients to use as de-escalation techniques.

Senior managers completed quality walk rounds every two months which focussed on staff, patients, environment and documentation. Information was fed back immediately to ward staff and through governance structures. Other information could also be highlighted and addressed using this method.

Specialist eating disorder services

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are specialist eating disorder services safe?

Safe and clean environment

We undertook a detailed environmental inspection of the ward and communal areas at the hospital. Bartle ward was located on the second floor of the hospital, and had an 'L' shaped layout with bedrooms located on one corridor and communal areas on the other.

Bartle ward provided accommodation for both male and female patients. One male patient had recently been admitted to the ward. The male patient was allocated a bedroom near to the nursing station and all bedrooms had ensuite bathrooms. Other mitigation was in place such as mixed sex accommodation care plans. However, there was no female only lounge available. This meant that female patients did not have a communal area separated from male patients.

The ward layout meant staff could not observe all parts of the ward from one location, this was mitigated by the use of closed circuit cameras in corridors and mirrors where needed. There was signage to tell patients that closed circuit cameras were in operation.

Two garden areas were accessible from the hospital. A secure garden area was accessible by patients if there were risk issues and this required staff to be present. A larger garden area was accessible to patients with open access. The secure garden had tall wooden fencing to prevent patient absconsion, with a lower height fence evident around the larger garden area. All fixtures and fences were in a good state of repair. Closed circuit cameras were in place over the garden areas and the main entrance, with signage indicating this on the walls.

Staff completed a comprehensive ligature risk audit every six months and it was clear what actions had been taken at each assessment. One bedroom was designated as reduced ligature bedroom and was allocated on the basis of risk. This reduced ligature bedroom had flush fittings including a boxed in television set. The up to date ligature risk assessment was kept in the nursing office and staff were aware of its location. All bedrooms had an ensuite bathroom with shower.

Window fittings within patient's bedrooms had been replaced with specialist anti-ligature designed windows. This was in response to recent incidents of patients being able to climb through windows. This work had been undertaken following review and evaluation of options, with care taken that actions should be proportionate and should not introduce additional ligature risks. Window fittings were checked on a monthly basis by the estates team and we saw completed checklists for the last twelve months.

We reviewed the clinic room which was clean and tidy with sufficient storage. Resuscitation equipment was stored in the nursing office in a grab bag so that it could be quickly located in the event of emergency. Emergency drugs were supplied by the pharmacy in a sealed box which would be replaced if items expired or were used. These were kept in a locked box in the clinic room. The defibrillator for the hospital was stored on the ward and staff were aware of its location in an emergency. Nurses checked the equipment on a daily basis.

All ward areas were clean with good quality, well maintained furnishings. Housekeeping staff kept a cleaning schedule which covered the ward and rooms, and requests could be made for additional cleaning when needed. The ward kitchen was clean and tidy and was available for patients to use throughout the day and night.

We saw infection control practices being implemented. Regular audits were undertaken and actions completed. Additional audits were completed including water temperature, legionella and bed inspections.

Environmental audits were undertaken by a team from another hospital within the provider group on an annual basis. The most recent audit was thorough and identified actions needed, which had been updated once completed.

Safe staffing

Establishment levels of staff on Bartle ward were seven qualified nurses and 14 nursing assistants. All qualified nursing posts had been filled and there were two nursing assistant vacant posts. There was a minimum of two qualified nurses and two nursing assistants working on day shifts. Overnight there was one qualified nurse working with two nursing assistants. Sickness levels were low over the last 12 months at 2% average. There were no staff currently off work due to work related illness or injury.

The hospital director and ward managers established the number and grade of staff needed for Bartle ward. We saw on individual ward duty rotas that the staffing number was always met or exceeded the planned provision. If additional staff were required, for example due to enhanced observations, there was an established nurse bank with regular bank staff employed. Agency nurses also covered shifts with agency nurses block booked to cover shifts to ensure continuity. There were no shifts in the last three months unfilled.

Escorted section 17 leave went ahead as planned. This information was collated by the hospital and monitored by the senior management team.

There was a doctor on site each day and during the night and weekends there was a doctor on call. Staff also had access to an on call GP service. There were measures in place to monitor the effectiveness of the on call system such as response times.

Mandatory training figures across the hospital site were satisfactory and above the 75% CQC benchmark. This consisted of 52 modules including:

- basic life support
- confidentiality
- health and safety
- Mental Capacity Act
- Mental Health Act
- safeguarding children
- safeguarding adults

Assessing and managing risk to patients and staff

We reviewed all ten care and treatment records. We saw risk assessments completed at admission and frequently reviewed. These were always reviewed and updated following any incident. Staff completed risk management plans and these were incorporated into nursing care plans.

There were some blanket restrictions in place which were about prohibited items. These were reasonable to maintain the safety of patients and staff. Restricted items that patients were individually risk assessed for included:

- razors
- spare batteries
- glue
- plastic bags
- lighters

We saw that the provider had reviewed restrictive practices and that if restrictions were needed these were care planned on an individual risk basis. We saw that patients were able to access the internet via wifi and could keep personal phones or other internet devices.

Staff followed up to date policies for observation and we saw staff allocated to observations at the commencement of the shift by the qualified nurse in charge. Patient's observation levels were reviewed with risk management and were clearly documented in observation care plans.

Staff were trained in de-escalation and restraint techniques. Restraint was used only as a last resort. Restraint had been used 14 times between April and October 2017. No prone restraint had been used.

There was no use of long term segregation or seclusion at this hospital.

Staff undertook training in safeguarding with 87% of staff up to date. We saw where staff had identified and raised safeguarding issues appropriately. Managers liaised with the local authority safeguarding team regarding referrals.

We reviewed medicines management. We reviewed all ten prescription cards on Bartle ward. Prescription cards were clearly written and stored with consent to treatment documentation where necessary. Nurses signed to show medicines were administered and there were no administration boxes unsigned. However, eight patients

had been prescribed as required medication that had not been reviewed for more than 14 days. This is not in line with National Institute of Health and Care Excellent guidance NG 10 the management of violence and aggression which states the multidisciplinary team should review the pharmacological strategy and the use of medication at least once a week and more frequently if events are escalating and restrictive interventions are being planned or used.

We saw good practice in terms of storage and ordering medicines. Medicine stocks were checked regularly. Controlled drugs were stored appropriately and registers were up to date with regular stock checks by both nurses and pharmacists. We saw that were electrocardiograms or blood monitoring was required this was completed. As a result of recent medication errors and a subsequent action plan, extra medication audits were completed weekly by doctors. We reviewed these for the last two months. There was evidence of medication charts being checked and errors corrected.

Track record on safety

We reviewed six serious incident reports from the last twelve months from across the hospital site. Two of these related to medicines errors, three absent without leave incidents and one incident of serious self harm.

Medicines errors had been thoroughly investigated, with actions identified to prevent recurrence.

One absent without leave incident had occurred by a patient being able to force a magnetic lock on an external door. The door locks had been changed to stronger locks to prevent recurrence.

Two absent without leave incidents had occurred from windows in patient bedrooms. We reviewed the safety and fittings of the windows following the actions taken. The first incident was where a patient had been able to abscond from a ground floor window by over-riding the window restrictors which had been in place. Following this incident, all bedroom windows had been fitted with enhanced window restrictors and other measures had been put in place to prevent egress if the restrictors were to be broken.

An incident more recently had involved a determined attempt to leave the building via the window with the use of tools. Following this incident, an immediate investigation and environmental review had taken place, led by an external management team. This identified significant planning and determination to overcome the measures in place. The provider replaced all bedroom windows with different units which were specifically designed for use in mental health settings. There was a plan for the remainder of windows to be replaced over the next six to twelve months. We were reassured that measures in place were sufficient given the remit of the unit.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and followed the provider's policy. Staff reported incidents on an electronic system which alerted managers when incident reports were submitted. Incidents were reported appropriately and serious incidents had been notified to CQC and other agencies, e.g. Health and Safety Executive, where appropriate.

Lessons learnt alerts were shared with staff at team meetings, this included findings from other hospitals in the provider group.

We saw in investigation reports that patients were involved in the review of incidents and staff were open and honest when incidents occurred that affected patients.

Staff were able to identify actions taken following incidents to prevent recurrence, for example, additional checks of prescription cards put in place to avoid transcribing errors.

Duty of Candour

We saw that where incidents had the potential to cause harm the duty of candour had been followed. This was in terms of patients and carers being given an apology, being involved in the investigation process and informed of outcomes.

Are specialist eating disorder services effective?

(for example, treatment is effective)

Assessment of needs and planning of care

Specialist eating disorder services

We examined ten patient care records and all had comprehensive and timely assessments completed following admission to the hospital. This included information relating to the reasons for admission and any previous mental health history if known.

A physical health examination had been carried out for nine patients as part of the admission process. For one patient the physical health examination had not been completed on admission or followed up at a later date. There was evidence that patients with ongoing physical health care needs were being treated and monitored appropriately.

All patients had fully completed, individualised and up to date care plans that contained the patients views. Three care plans were not holistic and seven were not recovery orientated. The electronic record system indicated that patients had been offered a copy of their care plan and patients confirmed they were involved in care planning and a copy had been offered to them.

All patient information was stored within the electronic record system that staff could access. The electronic record system was secure and accessed by passwords. Information was stored within the electronic record system in a format that made it easy for staff to locate the particular information quickly.

Best practice in treatment and care

We examined ten patient prescription charts and ten patient care records. We found that prescribing was with British National Formulary prescribing limits. However, one patient had been prescribed as required hypnotics for more than seven nights. Eight patients had been prescribed as required medication for more than 14 days without being reviewed. This is not following best practice. However, patients did have access to weekly ward reviews where medication could be discussed.

Psychological therapy was available to patients on Bartle ward. This consisted of:

- cognitive behavioural therapy
- Maudsley anorexia nervosa treatment for adults
- specialist supportive clinical management

These therapies were recommended by the national institute of health and care excellence for the treatment of eating disorders.

Patients had access to specialist physical health care if required. Patients were referred to local hospitals or specialists for individual health conditions. Staff prioritised medical appointments and transport and escorts were available.

Patients on Bartle ward were weighed weekly and their food and fluid intake monitored closely. For patients unable to eat, nasal gastric feeding was available. A dietician was available onsite to advice regarding dietary intake and calories amounts. Patients were closely observed during mealtimes and after meals. Regular blood testing was carried out to assess and monitor the physical health of eating disorder patients. For patients with severe physical health problems an admission to the local acute hospital could be arranged if needed.

The ward used health of the nation outcome scales to assess the progress and severity of outcomes for patients. This was completed on admission, discharge and at six monthly reviews.

The ward manager and team leader completed audits such as:

- environmental audits
- controlled drugs audits
- named nurse audits

Doctors completed medication audits.

Skilled staff to deliver care

There was a full range of mental health disciplines providing input into Bartle ward. This included; consultant psychiatrist, junior doctor, nurses, nursing assistants, occupational therapist, activity coordinators, psychologist and dietician. Staff had the appropriate qualifications and experience for their roles.

Nursing assistants completed the care certificate qualification as part of the training and induction package. Progress in the care certificate was monitored by senior managers.

All relevant staff were receiving regular clinical supervision. From September 2016 to August 2017 clinical supervision averaged at 83% with the last three months increasing to 100%. Staff described feeling supported in their roles. Managerial supervision was not provided on a regular

basis. From June to November 2017 the average compliance for managerial supervision for Bartle ward staff was 20%. The supervision policy stated that staff should receive management supervision every two months.

All staff were up to date with completing the appraisal process. Annual appraisal had been completed by 100% of staff.

Specialist training was available to staff who requested specific training and it was relevant to the role of the hospital. The psychologist had completed Maudsley anorexia nervosa treatment for adults training in London and was due to attend a conference in Manchester relating to eating disorders practice.

Poor staff performance was addressed promptly and effectively. Managers were able to give a number of examples of how staff disciplinary matters had been resolved using support from a central human resources team. Managers were aware of how to manage and investigate issues relating to staff.

Multi-disciplinary and inter-agency team work

There was a weekly multi-disciplinary meeting for each patient. Each meeting was attended by the following disciplines; consultant psychiatrist, junior doctor, named nurse or nurse in charge, occupational therapist, psychologist, dietician patient and carer if available. Advocates were also invited at the patients request or consent. We observed two multi-disciplinary meetings which were effective and patient centred.

We reviewed handover records for the last six weeks. Hand over templates on Bartle ward included information relating to diet, exercise and medication compliance, mood and behaviour, physical health, leave and activities, any problems and positive words. Staff stated handover meetings lasted for 30 minutes and were attended by all available staff including ward managers and doctors.

The service liaised with outside organisations to support repatriating patients back to their local NHS provider. Representatives from NHS trusts were regularly invited to weekly ward round meetings to assess the progress and needs of current patients. Representatives were provided with detailed information relating to the current care plan and patient needs following discharge. Liaison with some providers was facilitated by teleconferencing services due to the geographical distance involved.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training had been completed and was up to date for 87% of staff across the hospital site. Staff had a good understanding of the Mental Health Act, the code of practice and guiding principles.

Consent to treatment and capacity to consent to treatment paperwork had been completed for detained patients and stored with medication charts.

There was a system to prompt staff to explain to patients their rights under the Mental Health Act on admission and at regular intervals thereafter. Staff kept a ward diary and spreadsheet and the Mental Health Act administrator also held a record of when this was due. The ward spreadsheet demonstrated that all detained patients were up to date with Section 132 rights. However, the audit completed by the Mental Health Act administrator found that three out of four detained patients had not been informed of their rights on admission to the service.

The hospital employed an onsite Mental Health Act administrator who was available to offer legal advice on how to implement the Mental Health Act. The Mental Health Act administrator also completed a system of audits to ensure the Mental Health Act was being applied correctly. Mental Health Act paperwork had been completed correctly and was up to date.

Patients had regular access to an independent mental health advocate who visited the wards weekly. Patients were offered the support of independent mental health advocates or automatically referred if they lacked capacity. Staff were aware of how to refer to independent mental health advocates and there was information about advocacy services in patient areas. Advocates were invited to patient ward round meetings but were not always informed if these were cancelled or re-arranged.

Good practice in applying the MCA

Mental Capacity Act training had been completed and was up to date for 85% of staff across the hospital site. Deprivation of Liberty Safeguards training had been completed by 88% of staff. The hospital had not submitted any Deprivation of Liberty Safeguard applications in the last six months.

Specialist eating disorder services

Despite sufficient training levels staff were not fully competent in how to proceed if a patient lacked capacity. Staff were not fully confident in identifying how to assess and proceed if patients lacked capacity.

Informal patients consent to admission and treatment forms had not been completed for six informally admitted patients. This was due to consent to admission forms being omitted from the admission pack in error. Managers agreed to rectify this immediately during the inspection.

There were policies on both the Mental Capacity Act and Deprivation of Liberty Safeguards available to staff electronically or in paper format. The Mental Health Act administrator was available to advise staff on the Mental Capacity Act and code of practice.

Staff had a limited knowledge of the best interest checklist and processes to follow should a patient lack capacity. There was a Mental Health Act administrator was available to assist staff and there were best interest checklist forms to guide staff.

Are specialist eating disorder services caring?

Kindness, dignity, respect and support

Staff and patient interactions were observed to be warm and friendly. Staff demonstrated a caring approach to patients that was respectful and supportive. Staff clearly understood individual patients' needs and were able to respond and engage appropriately.

Patients were positive about how staff treated them. Patients described staff as approachable and kind. Patients felt staff had time for them and were always polite and helpful.

The involvement of people in the care they receive

Patients were shown around the ward on admission and made aware any ward protocol. Information leaflets about the ward were being updated and were not available for current patients.

Care plans clearly evidenced patient input. Patient's views and goals had been documented. Most care plans had been written in the first person and patients had been offered a copy of their care plan. Patients were given opportunities to voice their opinions in ward reviews and this was recorded within the patient notes. Patients described feeling involved in their treatment and care and that their views were listened to.

There was good access to advocacy services. The hospital had good working relationships with independent mental health advocates and independent mental capacity advocates. Other advocacy services were available and could be referred to if needed.

Families and carers were given an information leaflet explaining visiting times and ward round protocols. Carers were invited to ward round meetings and could request telephone conference facilities if travelling to the location was difficult. Families and carers were encouraged to keep up to date with patient's progress by telephoning the ward and speaking to nursing staff. Regular carers meetings were not embedded in the service. Carers meetings had started again in November 2017 and were not attended by any family members or carers.

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Patients were able to give feedback about the service in a number of formats. This included:

- quarterly patient satisfaction survey
- complaints process
- comments box
- thank you cards
- weekly patient forum meetings

Data from the latest patient satisfaction survey showed positive results in 12 key areas such as feeling safe, being involved in their care and staff attitudes. The survey showed negative results in patients being appropriately occupied and supported to stay in contact with family and friends. There was a plan to discuss the survey results with patients and consider appropriate action.

Patients were consulted about changes to the hospital such as design for the new garden and smoking areas, the internal decoration and lighting options. Patients were encouraged to draft a list of questions to be added to the staff interview template to assist the recruitment of staff.

Specialist eating disorder services

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

Access and discharge

The average bed occupancy rate was 97% over the last six months. The average length of stay for patients on Bartle ward was approximately six months.

The service accepted referrals nationally and therefore did not have a local catchment area. The majority of patients were from the north west of England.

All patients had access to a bed on return from leave. There were no problems relating to using leave beds to alleviate bed shortages.

Patients admitted to the service generally remained within the service for the duration of their inpatient stay. The service had contractual agreements with local NHS providers that patients would remain at the hospital until they were ready for discharge. This accounted for the majority of admissions. Other NHS providers from further afield repatriated patients back to their local area as soon as was reasonably possible. Patients were transferred to another Priory hospital site if their risks became unmanageable within the service. Patients could also return to their NHS provider for intensive nursing treatment.

Patient discharges and transfers were planned in advance and took place during daytime hours.

The facilities promote recovery, comfort, dignity and confidentiality

There were a full range of rooms and equipment to support patient treatment and care including clinic rooms. Bartle ward was small but had a lounge and a therapy room. There was no female only lounge on Bartle ward despite being mixed sex accommodation.

The hospital had a large meeting room that was used for family visitors. The room was comfortable and children's toys were available.

All patients had access to their own mobile phones and could make private telephone calls in their bedrooms. For patients without mobile phones, patient payphones were available on each ward.

There was good access to outside space. There were garden areas that were pleasant and well kept. There was a covered smoking area.

The food was reported to be of high quality. Patients stated the food was tasty and fresh with lots of choice. The patient satisfaction survey scored the quality of food at 82%.

Most patients were adhering to individual diet plans that included observation following meals and snacks. Therefore, drinks were available at all times and snacks were limited due to risks of re-feeding syndrome.

All patients were able to personalise their bedrooms with photographs and posters. Patients could store valuables or restricted items in a central store accessed by nurses. Patients could request their items at any time. This request would be granted based on the latest risk assessment.

Activity programmes were available seven days a week. Activities were more psychologically based to meet the needs of patients with eating disorders. They included mindfulness, medical consequences group, group therapy, relaxation and other therapeutic groups. Evening and some weekend sessions were led by the nursing team and included board games, quizzes, film night, shopping and bingo. The activity room was open from 10 am to 3.30 pm weekdays. The activity room had access to mindful colouring, sewing, knitting, painting, card making, jewellery making, and model building. Activities on Bartle ward followed a structured timetable that reflected each client's care plan.

Meeting the needs of all people who use the service

A lift was available for patients unable to use the stairs. There were no disabled access bathrooms. For patients with restricted mobility shower seats could be supplied to the walk in shower rooms.

Leaflets were on display and accessible for complaint and advocacy services. Other leaflets relating to treatment and care were provided to patients on an individual basis by nurses. Leaflet could be produced in other languages on request. The service had access to an interpreter and signing service.

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Are specialist eating disorder services well-led?

Vision and values

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These behaviours were embedded in the service values. A copy of the purpose and behaviours had been sent to every employee with their wage slips. Posters were displayed on site and cards available for staff detailing the purpose and expected behaviours. The purpose and expected behaviours had also been integrated into the new care certificate workbooks for nursing assistants. For new employees, the purpose and behaviours were embedded into the induction course. In addition behaviours were also visible electronically for reference. Staff appraisals contain the priory behaviours and staff were nominated for employee of the month awards based on demonstrating these values and behaviours in their work. During the recruitment process, behaviours informed the selection process to ensure that candidates met the standards expected.

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Ward managers had access to leadership coaching from other senior staff and other formal internal training was available. Ward managers were encouraged to complete NVQ level 5 in leadership and management as part of their career development.

Staff were open and transparent and explained and apologised to patients if something went wrong.

Staff described being consulted regarding the expansion of the service. Managers confirmed that suggestions from staff regarding the running of the service were considered. The employee engagement survey scored 77% for staff feeling that they were encouraged by their manager to suggest new ideas for improvements.

Commitment to quality improvement and innovation

The eating disorder unit was implementing a number of safe wards initiatives such as using positive words and having relaxation boxes available for patients to use as de-escalation techniques. The ward was accredited by the quality network for eating disorders until April 2018.

Senior managers completed quality walk rounds every two months which focussed on staff, patients, environment and documentation. Information was fed back immediately to ward staff and through governance structures. Other information could also be highlighted and addressed using this method.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that there is a female only lounge available on Bartle ward.

Action the provider SHOULD take to improve

- The provider should ensure that staff on both wards have a clear understanding of how to implement the Mental Capacity Act and best interest's checklist in practice.
- The provider should ensure that full physical health checks are completed for all patients on admission.
- The provider should ensure that all staff receive the appropriate level of management supervision for their role.
- The provider should ensure that as required medication is reviewed regularly in line with national guidance and clearly recorded in patient records.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Patients were not protected against the risks associated with mixed sex accommodation. There was no female only lounge on Bartle ward. This was a breach of regulation 17 (2) (b)