Partnerships in Care Limited

Priory Hospital Arnold

Inspection report

Ramsdale Park
Calverton Road, Arnold
Nottingham
NG5 8PT
Tel: 01159661500
www.partnershipsincare.co.uk

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Good
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

The Chief Inspector of Hospitals, Ted Baker, is placing Priory Hospital Arnold into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Our rating of this service stayed the same. We rated it as inadequate because:

The service did not always provide safe care. The ward environments were not always safe. The wards had enough nurses and doctors, but these were not always deployed effectively to keep patients safe. Staff did not always assess and manage risk well. Staff did not always administer medicines at the time they were prescribed and monitor the effects on patient's health.

They did not always provide a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. This was due to shortage of psychologists although these posts had been recruited to. Staff engaged in clinical audit, but this did not always effectively evaluate the quality of care they provided.

The ward teams did not include or have access to the full range of specialists required to meet the needs of patients on the wards. However, the provider had recruited to the psychology team and these staff were starting their induction in the week after our inspection.

The service was not always responsive to identified risks to the safety of patients and slow to identify new risks although some improvements had been made since our previous inspections.

The governance processes did not ensure that ward procedures effectively mitigated risks. Learning from incidents was slow to be embedded.

However:

The wards were clean, and this had improved since our previous inspections.

Staff minimised the use of restrictive practices.

Staff followed good practice with respect to safeguarding.

Staff developed holistic care plans informed by a comprehensive assessment.

Managers ensured that staff received training, supervision and appraisal.

Summary of findings

The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.

Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.

Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.

The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units	Inadequate 	Our rating of this service stayed the same. We rated it as inadequate because: The service did not always provide safe care. The ward environments were not always safe. The wards had enough nurses and doctors, but these were not always deployed effectively to keep patients safe. Staff did not always assess and manage risk well. Staff did not always administer medicines at the time they were prescribed and monitor the effects on patient's health. They did not always provide a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. This was due to shortage of psychologists although these posts had been recruited to. Staff engaged in clinical audit, but this did not always effectively evaluate the quality of care they provided. The ward teams did not include or have access to the full range of specialists required to meet the needs of patients on the wards. However, the provider had recruited to the psychology team and these staff were starting their induction in the week after our inspection. The service was not always responsive to identified risks to the safety of patients and slow to identify new risks although some improvements had been made since our previous inspections. The governance processes did not ensure that ward procedures effectively mitigated risks. Learning from incidents was slow to be embedded. However: The wards were clean, and this had improved since our previous inspections. Staff minimised the use of restrictive practices. Staff followed good practice with respect to safeguarding. Staff developed holistic care plans informed by a comprehensive assessment. Managers ensured that staff received training, supervision and appraisal.

Summary of findings

The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing aftercare.
Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They actively involved patients and families and carers in care decisions.
The service managed beds well so that a bed was always available locally to a person who would benefit from admission and patients were discharged promptly once their condition warranted this.

Summary of findings

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Summary of this inspection

Background to Priory Hospital Arnold

Priory Hospital Arnold is provided by Priory Healthcare Limited and registered with the CQC to provide the following regulated activities:

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

• Treatment of disease, disorder or injury

• Diagnostic and screening procedures.

The hospital offers two acute mental health wards for men and women on Newstead and Bestwood Wards and a psychiatric intensive care unit on Rufford Ward for women and for men on Clumber Ward. Following our inspection in March 2021 the provider closed Newstead and Clumber Wards. They reopened Newstead Ward in September 2021; Clumber Ward remains closed.

There were 16 beds on Bestwood Ward and Newstead Wards and 10 beds on Rufford Ward which were commissioned by Nottinghamshire Healthcare NHS Foundation Trust.

There have been 18 previous inspections to Priory Hospital Arnold. The latest was a follow up inspection in June 2021 following notification of concern about an incident involving a patient and to follow up on concerns and conditions that we imposed in March 2021. Following the inspection in March 2021 we placed the hospital into Special Measures and rated Safe as Inadequate and Well Led as Inadequate and Priory Hospital Arnold as Inadequate overall. We removed five of the seven conditions imposed in October 2021 following an application from the provider to remove all seven.

We visited Bestwood and Rufford Wards unannounced on the evening of 6 December 2021 and Bestwood, Rufford and Newstead Wards during the days of 7 and 8 December 2021. This was a comprehensive inspection where we inspected all five key questions: Safe, Effective, Caring, Responsive and Well led.

How we carried out this inspection

This was a comprehensive inspection and looked at all five key questions: Safe, effective, caring, Responsive and Well led.

We visited Rufford, Newstead and Bestwood Wards at this inspection. Clumber Ward remained closed at the time of this inspection.

Three CQC inspectors, one CQC inspection manager and one specialist advisor who was a nurse visited unannounced on the evening of 6 December 2021 and during the days of 7 and 8 December 2021. An expert by experience spoke with patients by telephone on 7 and 8 December 2021.

The inspection team:

• spoke with 15 patients who were using the hospital.

Summary of this inspection

• observed staff interacting with patients.

• observed the handovers from the day staff to the night staff for Rufford and Newstead wards on 6 December 2021.

• spoke with 21 staff members including nurses, support workers, occupational therapists, psychologists, ward managers and the hospital director.

• looked at the quality of the hospital environment.

• looked at 13 patient care and treatment records.

• looked at a range of documents relating to the running of the hospital.

What people who use the service said

Patients told us there were sometimes not enough staff and this made them feel unsafe. They said this meant they couldn't always go off the ward. Patients said there were fewer staff during the day than at night.

Two patients told us they didn't feel that their physical health needs were monitored by staff.

Patients told us they could access an advocate. They said they had their rights under the Mental Health Act 1983 explained to them by staff.

Most patients told us that the food was not what they wanted, there was limited choice, and it wasn't healthy. They said they did discuss food and complained about it in patient meetings, but nothing was done to improve it. However, two patients said they liked the food and choices.

Patients on Rufford Ward told us there were limited activities. Patients on other wards told us there were a lot of sport activities such as walking, football and volleyball but not much else although there was a relaxation group. Patients said there were not activities at weekends. The provider told us that activities were provided at weekends and each patient had an activity timetable.

Patients told us the wards were clean and the cleaners did an amazing job.

Three patients on Newstead Ward said they didn't feel safe because of another patient on the ward, staff did intervene, but this had not always reassured them.

Patients told us that staff were polite, respectful and knocked on their bedroom door before entering. They said staff respected their dignity and privacy.

Patients told us they knew how to make a complaint and would do so if they needed to.

Areas for improvement

The provider must ensure that audit systems assess and identify risks to patient's safety and the quality of care and take action to make improvements where needed.

Summary of this inspection

The provider must ensure that staff record and monitor patient's physical health needs and act to reduce the risk to their health and welfare where needed.

The provider must ensure that staff monitor and observe patients after they administer rapid tranquilisation to ensure their safety and wellbeing.

The provider must ensure that staff test equipment at the required frequency to make sure it is working and is safe to use.

The provider must ensure that the environment is always safe for patients.

The provider must ensure that medicines are given at the time they are prescribed.

The provider must ensure that staffing levels and skill mix are reviewed continuously and adapted to respond to patient's needs.

The provider must ensure that the views of patients are listened to on all wards and action taken to improve the service based on patients' views.

The provider should ensure that female and male lounges are identified as such. (Regulation 12)

Our findings

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	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Good	Requires Improvement	Inadequate	Inadequate

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

Inadequate

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

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

Inadequate

Safe and clean care environments

All wards were clean and well maintained. However, wards were not always safe and fit for purpose.

Safety of the ward layout

Staff had completed thorough risk assessments of all wards since our inspection in March 2021 and removed or reduced any risks they identified. However, these were not regularly updated, or ligature risks reviewed after maintenance work.

The provider had undertaken work to remove potential ligature anchor points in the service following our inspection in March 2021. They had removed wardrobe doors and completed work on panelling and corners of doors to remove potential ligature anchor points. They then updated their ligature risk assessment to show that risks identified in March 2021 had been reduced. The provider had also trained staff on ligature points and how to mitigate the risks to keep patients safe. However, we found a potential ligature anchor point which the provider had not identified following some maintenance work completed in patients' bedrooms. When we told the registered manager about this, they took immediate action to ensure this risk was removed. They also put in place a protocol to ensure staff checked any maintenance work completed to reduce any risks.

Staff could observe patients in all parts of the wards. Blind spots were reduced using mirrors. The provider used a company called Care Protect to manage its closed-circuit television cameras (CCTV). Staff from Care Protect alerted staff at the hospital to any risks to patients.

The wards complied with guidance on same sex accommodation. Rufford Ward admitted female patients only. Bestwood and Newstead Wards were mixed gender. Patient's bedrooms were in corridors separated into male and female and each patient had an ensuite toilet and shower. Each ward had separate male and female lounges. However, on Newstead Ward these were not identified as such and patients told us they did not often use these.

Staff had easy access to alarms and reported that the alarm system had improved since our previous inspections.

Maintenance, cleanliness and infection control

Ward areas were clean, and this had improved since our inspections in March and June 2021. However, there were gaps in some cleaning records of touchpoint areas.

Staff followed infection control policy, including handwashing. This had improved since our inspection in March 2021. Staff had access to hand sanitiser, always wore masks and there were restrictions on how many people could be in a room to maintain social distancing in line with guidance on COVID -19.

Seclusion room

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock and were cleaner than at our previous inspections.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs. However, there were gaps in records that showed staff had not always checked the emergency equipment weekly on Newstead Ward. In November 2021 staff had recorded this as tested fortnightly. This could mean that equipment needed for resuscitation may not work when needed. There were also gaps in the weekly blood glucose calibration which could mean that inaccurate readings of patients' blood glucose levels could be made.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm. However, they were not always deployed effectively, and staff and patients told us this impacted on patient care.

Nursing staff

Rotas showed that the service had enough nursing and support staff to meet the staffing ladders on each ward. Managers assessed the number of staff needed and rotas showed they met these. However, staff gave examples of when the lack of staffing impacted on patient care and safety: staff told us there were not enough staff to respond to alarms. However, incident reports did not support what they had told us. Medicines were given later than prescribed because there was often only one registered nurse before 9am and they were called on to do other tasks. Patients and staff said their leave from the ward or activities were cancelled when occupational therapy staff were used to cover nursing staff. Staff did not have time for debrief after incidents.

The service had reducing vacancy rates. Recruitment was ongoing and at the time of our inspection 24 registered nurses were required to run the three open wards. The provider employed 16.6 registered nurses plus three agency registered nurses who worked there full time and three bank registered nurses. The provider had recruited another nine nurses, four of whom were on their induction and a further five were starting in January 2022. Eight nursing assistants had been recruited and were awaiting a start date. The provider had increased registered nurses and assistants pay by 9% to increase their staffing recruitment and retention.

The service had reducing rates of bank and agency nurses. There were six bank and two agency registered nurses working regularly at the hospital and 20 bank nursing assistants. Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. This had improved since our previous inspections.

The ward managers could adjust staffing levels according to the needs of the patients.

Staff shared key information to keep patients safe when handing over their care to others. The handover process had been developed and improved since our previous inspections.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency. There was one consultant vacancy for the fourth ward (Clumber) which was closed, and the provider had recruited a further two specialist doctors who were awaiting start dates.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up to date with their mandatory training. The mandatory training programme was comprehensive and met the needs of patients and staff and additional training such as ligature risks and relational security had been added. Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff did not always manage risks to patients well. Staff followed best practice in anticipating, de-escalating and managing the emotional distress experienced by patients and knew how to support them to minimise the need to restrict their freedom to keep them safe. Although there could be some delays as staff had to unlock rooms used for de-escalation. Staff used restraint and seclusion only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using the providers risk assessment tool, and reviewed this regularly, including after any incident. However, risk assessments did not give sufficient information to staff to guide them to manage risks to patients. For example, the risk assessment for a patient who was at risk of self-harm stated, “to work in collaboration with clinical team" and "to engage with staff when feeling distressed, staff to verbally de-escalate patient." It did not state how staff were to de-escalate the patient, how they were to encourage the patient to engage with them or the signs to show they could be distressed.

Management of patient risk

Staff did not always act to prevent or reduce risks to patients. The multidisciplinary team met each morning to discuss risk with some staff from the wards however it was not clear how this information was passed to all ward staff. Despite the measures in place, the risks to patients were not reduced and there was evidence of incidents of harm to patients.

Staff did not always follow procedures to minimise risks where they could not easily observe patients. Staff reported to us, and we reviewed an incident record where a staff member delayed making an observation on a patient which led to short term harm. Staff had not followed the patients risk assessment which stated that staff must clearly see the patient’s neck when observing. This meant the patient was put at risk of serious harm.

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

Inadequate

Staff did not always follow the providers policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm. There was an incident where a patient had tried to harm themselves with a plastic bag which was a restricted item on the ward. Staff had not followed the patient's risk assessment and did not search the patient on return from a visit or observe the patient while they went into their bedroom. This meant the patient was put at risk of serious harm.

Three patients on Newstead Ward told us they had not feel safe because of the emotional distress experienced by another patient on the ward. They said that staff did intervene, but this did not always allow them to feel safe.

Use of restrictive interventions

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. The registered manager told us that in October 2021 there were 144 incidents where physical intervention (no prone, two incidents of supine) was used but in November 2021 this reduced to 74 (no prone or supine restraint used).

On Bestwood and Newstead wards staff showed us the de-escalation rooms that were accessed through a locked door. Staff told us that they took patients to these rooms, sometimes under restraint, to calm down from their distress and stayed with them until they had. Care plans did not detail how staff were to assist individual patients to the de-escalation rooms. The registered manager showed us 'Staff Guidance for the use of De-Escalation Room Protocol/ Calming Suite' and this stated that this was not seclusion in line with the Mental Health Act code of practice. However, the registered manager told us they would get the locks removed from the doors to these rooms.

When staff placed a patient in seclusion, staff kept clear records and checks were done by doctors and nurses in line with seclusion guidance. However, a patient who was in seclusion was not offered foods that were hot due to the risks of staff going into the seclusion room. This limited the patient's choice and alternatives had not been considered.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up to date with their safeguarding training. At the time of our inspection 82% of staff including bank staff had completed e-learning in safeguarding adults and 92% had completed e-learning in safeguarding children. 84% of staff had completed face to face safeguarding adults and children from abuse training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. The local authority safeguarding team had a monthly meeting with Priory Hospital Arnold where they reviewed all safeguarding alerts and concerns reported to them and what action was taken. A copy of the minutes of these meetings was sent to CQC.

Staff knew how to make a safeguarding alert or concern and who to inform if they had concerns.

Staff access to essential information

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

Inadequate

Staff told us they did not have easy access to clinical information, and it was not always easy for them to maintain high quality clinical records – whether paper-based or electronic.

Staff told us they did not always have time to record in patient records and there were too many places where they had to record – on the electronic patient records system, on the electronic shared file and on various paper records. We saw that there were discrepancies in patient records where physical health observations information had been missed and in the recording of equipment testing.

Medicines management

The service used systems and processes to safely prescribe and store medicines. However, medicines were not always administered at the time prescribed and recorded as such. Staff did not always regularly review the effects of medications on each patient's mental and physical health.

Staff stored medicines safely on each ward in locked cabinets. Doctors reviewed the medicines prescribed to the patient on admission and prescribed further if needed on admission and throughout the patient's stay.

The morning medicines administration round was quite long due to the registered nurse being called on to do other tasks. On 8th December on Newstead Ward it did not finish until 10.30am. This meant that there was too little time between medicine rounds, which placed people at risk of being given their medicines too close together. Staff did not record the time they administered medicines, which meant that they could not tell when it was safe to give the next dose.

Staff did not always review the effects of each patient's medicines on their physical health according to National Institute for Health and Care Excellence (NICE) guidance. We saw one patient record where staff had not monitored the patient's physical health after giving rapid tranquilisation. They only recorded this once which meant that staff did not know if the patient suffered any ill effects from the medicine and take action to reduce the risks.

Track record on safety

The service did not have a good track record on safety. A patient died by suicide after tying a ligature in September 2020.The coroner recorded a narrative verdict and said the death was by suicide which was contributed to by neglect. The provider informed us that they had acted to improve the service by putting in place robust multidisciplinary working, better communication between doctors and nurses and improved nurse leadership and report writing skills. They had also replaced the ensuite doors following this patient's death which had removed the ligature anchor point.

Reporting incidents and learning from when things go wrong

The service did not always manage patient safety incidents well. Permanent staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Notifications received and incidents reviewed during this inspection showed that staff did not always follow the providers policies on observation, restricted items and searching patients which led to incidents which put patients at risk of serious harm.

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

Inadequate

Permanent staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with provider policy. Some staff told us there was often not time for debrief and the time they had for this was inconsistent.

Staff received feedback from investigation of incidents, both internal and external to the service via email, at staff meetings, weekly lessons learned meeting and at the daily risk meetings. These issues were then discussed at the monthly clinical governance meeting.

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

Requires Improvement

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission; however, they did not always monitor patient's physical health during admission. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans were personalised.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission however this was not always reviewed during their time on the ward. We found omissions in recording of physical health observations in four patient records. This included not regularly monitoring blood glucose levels for patients who were recorded as having diabetes, lack of monitoring for patient at risk of constipation, patient's skin integrity for patient at high risk of developing a pressure sore and for patient following rapid tranquilisation.

Staff regularly reviewed and updated care plans when patients' needs changed. The multidisciplinary team reviewed each patient weekly. Care plans were personalised.

Best practice in treatment and care

Staff did not always provide a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had access to physical healthcare although this was not always monitored during their admission and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit however the outcomes of these were not always effective in improving care to patients.

Staff could not always provide a range of care and treatment suitable for the patients in the service. Occupational therapists and psychologists worked on the wards. However, nursing staff said there had been a limited number of psychologists to refer patients to although this team had now been recruited to.

Staff identified patients' physical health needs and recorded them in their care plans. However, we found gaps in physical health monitoring and observations. Staff made sure patients had access to physical health care, including specialists as required. However, two patients told us that staff did not monitor their physical health needs.

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

Inadequate

Staff completed assessments on admission about patients' nutrition and hydration needs.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. This included smoking cessation advice, access to the hospital gym and regular sports activities. However, patients said the food provided was not always balanced and they were not always offered healthy options.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients. Patients had access to a computer on the ward and we saw patients using this. Patients could keep in contact with their friends and relatives through video calls.

Staff took part in clinical audits although we found that these did not always identify where there were gaps and assess what improvements were needed. Managers did not always use results from audits to make improvements. The reducing restrictive practice audit completed on Rufford Ward in September 2021 stated that patients should have their own bedroom key, but no action had been taken on this to improve.

Skilled staff to deliver care

The ward teams had limited access to psychologists although these posts were being recruited to. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had seven occupational therapists and assistants and there was one vacancy which was being recruited to. They worked on the wards to support patients and were part of the multidisciplinary team. There was one lead psychologist who was part time and one qualified psychologist who was part time. The provider had recruited two full time assistant psychologists who were starting the week after our inspection. Nursing staff told us the shortage in the psychology team had meant they had not been able to refer patients who needed psychological support.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work. Managers supported staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. There were two staff meetings each month to cover as many staff as possible.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers made sure staff received any specialist training for their role.

Managers recognised poor performance but did not always take action to deal with this.

Multidisciplinary and interagency teamwork

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

Inadequate

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with external teams and organisations. They held monthly meetings with the local authority safeguarding teams where incidents on the wards were discussed. Ward teams liaised with the patient's local crisis and community mental health teams via telephone, video conferencing and invited them to the patients' multidisciplinary team meeting.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up to date with training on the Mental Health Act and the Mental Health Act Code of Practice.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. However, one nurse told us they did not know how to record this on the patient's records.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff said this was sometimes delayed when patients needed to be escorted due to staffing levels, but they always made sure patients had their leave.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

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

Inadequate

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up to date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access. Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly for decisions patients made.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history. We saw that a best interests meeting had been held with a patient's family to decide how to ensure the patient received personal care.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Staff gave patients help, emotional support and advice when they needed it. Patients said that staff were genuinely interested in their wellbeing.

Staff supported patients to understand and manage their own care and treatment. Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff treated them well and behaved kindly. Staff understood and respected the individual needs of each patient. Patients told us that staff respected their privacy and dignity and knocked on their bedroom door before entering.

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

Inadequate

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive actions or attitudes towards patients. Staff followed policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward as part of their admission. Staff involved patients and gave them access to their care planning and risk assessments. Patients said that they were involved in their care plans and their review meetings with the multidisciplinary team.

Staff made sure patients understood their care and treatment (and found ways to communicate with patients who had communication difficulties).

Staff involved patients in decisions about the service, when appropriate. Patients told us they could give feedback at patient meetings on the service however they had complained about the food, but nothing had been done about it. On Bestwood Ward we saw a 'You said, we did' board on the ward which showed patients views had been listened to about activities and equipment for the ward.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers. Managers had recognised that there was not a carers support group and now had a service they could refer them to.

Staff helped families to give feedback on the service. Staff gave carers information on how to find the carer's assessment.

Staff had supported patients to keep in contact with their relatives and friends during the COVID-19 pandemic through use of video calls and relatives were invited to patients' reviews using these calls. As restrictions lessened visitors could come to the hospital based on individual patient risk assessment and there were visitors' rooms in the reception area.

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

Requires Improvement

Access and discharge

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

Inadequate

Staff managed the number of patients admitted to the hospital well. A bed was available to a patient when needed and patients were not moved between wards unless this was for their benefit. Patients discharge from the hospital was rarely delayed for other than clinical reasons.

Bed management

Bed occupancy on Bestwood and Newstead Wards were at 100% at the time of our inspection. On Rufford Ward the bed occupancy was 50%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The average length of a patient stay was 42 days at the time of our inspection. The target set by the commissioners was 32 days. There were seven patients on Bestwood Ward and three on Newstead Ward who were exceeding this target due to clinical reasons, delays in housing, social care placements and support needed by the patient in the community. Managers and staff worked to make sure they did not discharge patients before they were ready.

The service had patients who were out of the area on Rufford Ward which were spot purchased. At the time of our inspection there were two patients from outside the Nottinghamshire area.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient.

Discharge and transfers of care

Managers monitored the number of patients whose discharge was delayed. The only reasons for delaying a patients' discharge from the service were clinical.

Staff carefully planned patients' discharge and worked with their care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Most patients did not like the food and patients told us they couldn't make hot drinks at any time.

Each patient had their own bedroom, which they could personalise. Patients had a secure place to store personal possessions.

Staff on all wards did not use a full range of rooms and equipment to support treatment and care. On Newstead Ward patients said they did not often use the male and female lounges, one had activity equipment stored in it and the other was labelled as a group room. Following feedback to the registered manager, ward staff met with patients to discuss how these lounges could be used to support their treatment and care.

There was a room in the main reception area where patients could meet with visitors in private. Patients could make phone calls in private and had access to a computer on each ward.

The service had an outside space that patients could access easily.

Some patients said they could make their own hot drinks and snacks and were not dependent on staff to do this, but other patients said they had to ask staff and they were not always available. Patients on Bestwood Ward told us the water was not hot enough to make hot drinks with, so their hot drinks were lukewarm. However, the provider told us they had tested the temperature of this and the hot water dispenser was at the optimum temperature.

Most patients told us there was not a variety of food offered and it was not always what they wanted or supported them to have a healthy diet. However, three patients told us there was a lot of choice and their dietary needs were catered for. The provider told us from their patient feedback about food that 21 of 29 patients said they were always satisfied with the choice of food, two patients said mostly, three patients said sometimes and three patients said they were never satisfied.

Patients' engagement with the wider community

Staff supported patients with family relationships. However, patients did not benefit from a range of activities to keep them engaged with their local community.

Staff helped patients to stay in contact with families and carers. Staff supported patients with visits from their relatives and friends where appropriate. Patients had access to the computer on each ward where they could email or video call their relatives and friends.

Patients on Rufford Ward told us there were limited activities to do and all patients told us there were not activities available at weekends. The occupational therapy staff did work at weekends and did an assessment of each patients needs. Each morning an occupational therapist led a daily activities community meeting on each ward to plan the days activities. One patient told us there were sports activities available, but they were aware that not all patients enjoyed these. Another patient told us that a staff member had come to work on their day off so they could continue to train for their sport and attend a match locally. They said this was the only way they could do this due to staffing. Patients also said there were arts and craft activities available. We observed occupational therapists on the wards engaging patients in arts and crafts and sports activities and taking patients into the grounds for walks. Occupational therapists also facilitated a relaxation group.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

Staff made sure patients could access information on treatment, local service, their rights and how to complain. The service had information leaflets available in languages spoken by the patients and local community. Managers made sure staff and patients could get help from interpreters or signers when needed.

The service provided foods to meet the dietary and cultural needs of individual patients, however patients told us the menus were not always varied and lacked choice. They said they had complained about this at patient meetings, but nothing had changed.

Patients had access to spiritual, religious and cultural support. Staff respected patients who identified as a different gender to that of their birth. They addressed them in records and when speaking to them in their preferred pronouns.

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

Inadequate

Listening to and learning from concerns and complaints

The service investigated concerns and complaints and learned lessons from the results, which they shared these with the whole team. However, some patients said their complaints about food had not been listened to.

Patients knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. Patients received feedback from managers after the investigation into their complaint. However, patients told us their complaints about the food had not been listened to.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Are Acute wards for adults of working age and psychiatric intensive care units well-led?

Inadequate

Leadership

The leadership team was experienced however the registered manager had been in post since April 2021 and the improvements they made had not been fully embedded. Leaders were visible in the service and approachable for patients and staff.

We found that improvements had been made since our previous inspections in March 2021. The registered manager had changed and had been in post since April 2021. They had made several changes to the service however these were not all embedded at the time of our inspection. The male and female lounges on Newstead Ward were not designated as such and were not often used by patients as activity equipment was stored there. Following feedback to the registered manager the ward manager met with patients and asked for their views on how the lounges could be used. Patients and staff had several ideas on how these areas could be used but had not been asked for their views previously.

Most staff told us that the registered manager and the director of clinical services were visible in the service and often visited the wards. Staff told us the managers sometimes visited the wards during the night to meet with night staff which they thought was good.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff were able to tell us the providers vision and values and how this applied to the work they did. They said this was discussed during their induction and the values were displayed around the hospital.

Culture

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

Inadequate

Staff did not always feel respected, supported and valued. Staff could raise any concerns without fear.

Some staff said that they did not always feel supported, but others said a lot of work had been done since our previous inspections to improve the culture at the hospital but thought further work was needed. Managers had identified culture as one of the key risks in June 2021. They had identified improvements that were needed, for example, communication at ward level and handovers needed to improve. They developed new handover documentation and we saw that handovers had improved since our previous inspections. The provider had completed internal audits which showed the culture was improving. However, some staff told us that there was a blame culture. They said if things went wrong during their shift, they were blamed rather than looking at the wider picture such as staffing and resources on the ward.

Staff told us they could raise any concerns without fear and were aware of how to contact the providers Freedom to Speak Up Guardian if they needed to.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not always managed well.

Since our previous inspection the governance systems had been strengthened. However, they did not always assess the risks to patients so that action could be taken to reduce these. The systems in place did not ensure that staff working on the wards were aware of individual patient risk and take action to reduce these. There were incidents where staff had not followed the providers policies and procedures which put patients at risk of harm.

Incidents had not been managed well and staff had not always followed providers policies and procedures. The provider had submitted statutory notifications when required about incidents but had not always shown how they had assessed staff performance and reduced the risks to patients.

Management of risk, issues and performance

Ward teams did not always have access to the information they needed to provide safe and effective care and did not always use that information to good effect. Staff on the wards told us of four different places that they had to record things which resulted in them sometimes omitting recording of patients' needs and risks.

Our findings from this inspection showed that although systems to assess and identify risk had improved these were not embedded and did not always ensure the safety of patients and staff. The service held daily risk meetings attended by the multidisciplinary team and some ward staff, but these discussions were not always communicated to all staff working on the wards. Therefore, incidents continue to occur where staff had failed to follow the providers policies or individual patient risk assessments despite recent relevant learning. This put patients at risk of serious harm.

Information management

Staff collected analysed data about outcomes and performance however our findings from this inspection did not show this always led to improvement.

The systems to embed data and use it to improve the service were in their infancy and were not embedded into the work on the wards to improve patient care.

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

Inadequate

Engagement

Managers engaged actively with their commissioners and with the local authority safeguarding team. They had worked with their commissioners to improve the information received on the referral form. This gave registered nurses on the wards the confidence to refuse admission if they thought they could not meet the patients' needs.

Managers from the service participated actively in the work of the local transforming care partnership. One patient had a recent care and treatment review which they participated in.

Learning, continuous improvement and innovation

The findings from this inspection showed that systems were not yet fully embedded to proactively manage the service provided. Managers reacted when we raised risks and took action to reduce at the time. However, learning from these lessons was not always successfully embedded into the work of staff on the wards to reduce future risk.

For example, we saw that staff did not follow the providers restricted items policy for a patient which led to an incident where a patient could have been seriously harmed. However, a further incident occurred with the same patient where staff allowed the patient access to another item that they harmed themselves with. There was not ongoing oversight from managers to ensure that risks to patients were reduced.

The provider had responded to enforcement action following our inspection in March 2021and reduced ligature risks. However, at this inspection we found an additional ligature risk that the provider had not identified created by maintenance work on site. Managers had not been alerted to identifying new risks through their monitoring systems. This did not demonstrate that the provider had used previous learning to drive continuous improvement and embed systems.

Managers shared learning with staff at daily risk meetings, team meetings on the wards, staff supervision and reflective practice sessions. However, the governance was not robust enough to identify and assess ongoing risks as change was embedded so that managers could take action to reduce continuing risks and be alert to new risks without external prompts.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that medicines are given to patients at the time they are prescribed.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that the views of patients are listened to on all wards and action taken to improve the service based on patients' views.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure that staffing levels and skill mix are reviewed continuously and adapted to respond to patient's needs.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance 2.1 The Care Quality Commission conducted an inspection at the location stated in this notice on 6, 7 and 8 December 2021 and found you had failed to ensure the quality of the care and service provided was regularly monitored, assessed and steps taken to improve the quality and safety of the services provided in the carrying on of regulated activity. 2.2 We found potential ligature points in patients ensuites on Rufford Ward following maintenance work. We reviewed the ligature risk assessment, and these risks were not identified. There were no systems in place for clinical staff to check the risks to patients were reduced following completion of maintenance work. 2.3 We found that the quality of the care provided was not regularly monitored, assessed and steps were not taken to improve the quality and safety of the services provided. 2.4 Audit systems had not assessed discrepancies in patient records that we found during our inspection: A. Patient (Rufford Ward) staff had not monitored their bowel movements, but their care plan stated, "has chronic constipation and incontinence - this will be monitored on a day- to- day basis and be reviewed by MDT weekly." B. Patient (Rufford Ward) staff had not monitored their skin integrity, but their records had an alert that they were at high risk of developing a pressure sore. C. Care records for two patients on Newstead Ward stated that the patients had diabetes and required staff to do daily blood glucose monitoring for one patient for three days and other patient daily. Staff had not completed these daily and following the inspection the registered manager told us these two patients did not have diabetes.

This section is primarily information for the provider

Enforcement actions

2.5 On Bestwood Ward, staff did not follow the provider policy in relation to testing of emergency equipment. Records showed that in November 2021 they were only tested twice not four times.

2.6 We saw the reducing restrictive practice audit on Rufford Ward in September 2021 identified that patients did not have their own bedroom key. This has not yet been actioned and there was no date for this to be completed. The ward manager agreed that this should have been actioned.

2.7 The inspections of March 2021 and June 2021 found breaches of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The findings of the inspection 6, 7 and 8 December 2021 found that robust systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of regulated activity are still not effective.

2.8
Records did not show that risk to patient's health and safety had been assessed and monitored and equipment and the environment was safe.

2.9 This was a risk to patients because: The lapses in recording or monitoring patient's physical health needs could have been a risk to their health and welfare and put them at risk of serious harm.

2.10 Patients did not receive a service that was least restrictive.

Compliance by 14/03/2022

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Why you are failing to comply with this regulation: 1.1 The Care Quality Commission conducted an inspection at the location stated in this notice on 6, 7 and 8 December 2021 and found risks to the health, safety and welfare of people using the service.

This section is primarily information for the provider

Enforcement actions

1.2 During a tour of Rufford Ward we found ligature points in six of the bedroom ensuites that had occurred following work to replace plug waste dispensers in November 2021. These had not been identified as a risk. You took immediate action to remove these points and put in place a protocol to ensure clinical staff reviewed all work when completed by the maintenance team. However, this omission presented a risk to the health, safety and welfare of people using the service.

1.3 We found that there was an incident on Rufford Ward on 26/11/21 where a patient was found by staff in their bedroom with a plastic bag over their head. Staff had not followed Priory Hospital Arnold restricted items policy which put the patient at serious risk of harm. The patient's risk assessment stated that any form of shopping bags are a banned item on Rufford Ward.

1.4 There was a further incident on 27/11/21 on Rufford Ward where the same patient tied a ligature around their neck with their clothing. A male staff member who was responsible for observing the patient delayed entering their bedroom as they were worried that the patient may make allegations about them as a male member of staff. On entering the bedroom, staff found the patient was cyanosed. This delay could have caused serious harm to the patient. The patient's risk assessment stated that staff must ensure they can clearly see their neck when checking the patient during intermittent checks.

1.5 We looked at one patient's records on Rufford Ward. Their records stated on 2/12/2021, "has chronic constipation and incontinence - this will be monitored on a day-to-day basis and be reviewed by MDT weekly" (2/12/21). However, there were no bowel movement charts or any mention of the patient's bowel movements in their care records since admission on 1/11/2021 which was not following her care plan and put the patient at risk of harm. We discussed this with the ward manager who immediately rectified this (added to handover) and added to the patient's records.

1.6 Patient records (Rufford Ward) had an alert on them that said the patient was at high risk of developing a pressure sore. Their records stated that staff were to check

Enforcement actions

her skin daily to identify any risk of breakdown of her skin. Records we looked at from 1/12/2021 to 7/12/2021 had no evidence of staff documenting review of their skin. This could have put the patient at risk of harm.

1.7 We saw for patient on Newstead Ward that they were administered IM lorazepam and IM Promethazine, but staff had only recorded their physical observations once on the rapid tranquilisation form. Priory Hospital Arnold rapid tranquilisation policy states that staff should do these checks at least hourly in line with NICE guidance and if increased monitoring needed to be determined by doctor and nurse in charge. This meant that staff would not know if the patient was at risk of harm from the rapid tranquilisation so they could not take action to reduce the risk.

1.8 We reviewed records on Bestwood Ward of staff weekly testing of emergency equipment. These showed in November 2021 they were only tested twice not four times. This could result in equipment not being safe to use in an emergency.

1.9 We found that identified risks were not well managed and control measures were not implemented to reduce and manage risk. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities)

1.10 These were risks to patients' safety because:

1.11 Lapses in environmental and relational security in 1.2 1.3 and 1.4 led to temporary or potentially serious harm to the patient.

1.12 The absence of any monitoring of the impact of known risks to patients' mental and physical health (1.5 -1.7) was an omission and could have led to serious harm to the patients.

1.14 The failure to complete regular checks on emergency equipment (1.8) could jeopardise the effectiveness of a resuscitation effort.

Compliance by 28/01/2022.