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	Inspected but not rated
Are services safe?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

Priory Hospital Arnold is provided by Priory Healthcare Limited. 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. They also planned to open a psychiatric intensive care unit for men on Clumber Ward. There were 16 beds on each of Bestwood and Newstead Wards which were commissioned by Nottinghamshire Healthcare NHS Foundation Trust and 10 beds on Rufford Ward.

At the previous inspection in October 2019 we rated the hospital as requires improvement overall, inadequate for safe and requires improvement for effective, caring, responsive and well led.

Before this inspection we received information of concern from anonymous contacts about Newstead and Bestwood Wards. We were told that risks were not managed effectively, staffing levels were unsafe and there was a culture of bullying in the hospital.

We only visited Newstead and Bestwood Wards during this inspection. We also spoke with patients, their carers, and staff by telephone from Newstead and Bestwood Wards and staff from Rufford Ward as part of this inspection.

We only looked at parts of the Safe and Well led key questions during this inspection.

The provider had not employed enough permanent registered nurses to work on the wards. The provider was trying to recruit more registered nurses and employed locum staff to maintain safe staffing levels. The provider trained locum registered nurses in their induction and training programme.

The alarm system did not work effectively. Managers had put together a business case to replace this and in the interim the provider issued staff with personal alarms and staff used radios to summon help.

Staff had identified a ligature anchor point on ensuite doors on Newstead and Bestwood Wards and these were being replaced. Staff locked back the doors to reduce the risks in the interim until the work was completed.

Staff did not always manage risks well. Staff had not assessed a patient's mental state before they went on leave. Staff had not recorded patient's physical health observations on three patient records seen.

Five patients told us their complaints were not listened to or fully investigated.

Three staff were not aware of the vision and values of the organisation. There were not regular staff meetings on Newstead Ward.

However:

Staff practiced good infection control and followed the providers procedures. This reduced the spread of infection and staff had access to personal protective equipment.

Staff used restraint only after attempts at de-escalation had failed.

Summary of findings

Staff followed good practice with respect to safeguarding.

Staff recognised incidents and reported them appropriately.

Staff said that senior managers were visible, and managers sought various ways to engage with staff.

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	Inspected but not rated 	The provider had not employed enough permanent registered nurses. They were trying to recruit registered nurses and employed locum staff from agencies. The provider trained locums in their induction and mandatory training programme. The provider had put plans to open Clumber Ward on hold due to concerns about staffing particularly registered nurses and ward managers. The ward environments were not always safe. Staff had identified a ligature anchor point on the ensuite doors on Bestwood and Newstead Wards following the death of a patient. The provider was reducing this risk by replacing the doors with foam anti-ligature doors and had started this on Bestwood Ward. The provider had ordered the new doors for Newstead Ward and planned to fit them once received. Staff locked back ensuite doors to reduce the risk in the interim. The alarm system needed repairing so that staff could be confident that if they summoned for help staff from other wards would attend. The alarm system on Newstead Ward had a fault on it which staff had reported to maintenance. The registered manager told us following this inspection that maintenance staff were repairing this. Staff did not always assess risk well. Four out of 11 patient records we looked at had gaps in recording risk to the patient. Three staff were not aware of the provider's vision and values and how they were applied in the work of their team. Governance processes did not always operate effectively at ward level. For example, an audit completed in September 2020 identified gaps in patient risk assessments, but this had not improved in four of 11 patient records we looked at. There were not sufficient checks in place to ensure that kitchen areas were kept clean throughout the day. However:

Summary of findings

Staff followed the providers infection control procedures and had adequate supplies of personal protective equipment.
Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff recognised incidents and reported them appropriately.
Senior managers were visible in the service and most staff said they were approachable.

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. They also planned to open a psychiatric intensive care unit for men on Clumber Ward. There were 16 beds on each of Bestwood and Newstead Wards which were commissioned by Nottinghamshire Healthcare NHS Foundation Trust and 10 beds on Rufford Ward.

There have been 15 previous inspections to Priory Hospital Arnold. The latest was a follow up inspection in February 2020 following a warning notice relating to Regulation 12 served at the previous inspection in October 2019. At the inspection in October 2019 we rated the hospital as requires improvement overall, inadequate for safe and requires improvement for effective, caring, responsive and well led.

Before this inspection we received information of concern from anonymous contacts about Newstead and Bestwood Wards. We were told that risks were not managed effectively, staffing levels were unsafe and there was a culture of bullying in the hospital.

We had discussions with the provider before this inspection about the opening of the psychiatric intensive care unit for men on Clumber Ward and requested staff rotas. These showed that there were not always sufficient staff to safely staff four wards. The provider had put plans on hold to open Clumber Ward and were in the process of recruiting and inducting staff.

The provider informed us of the death of a patient following a ligature incident.

A CQC quality risk analysis indicated a high risk of evidence that any issues of concern led to negative outcomes (e.g. harm to people using a service) and a repeated pattern of risk where the same issue was evident throughout the time-period of the analysis, suggesting that the risk may not be well-managed by leaders and may re-occur.

How we carried out this inspection

This was a focussed inspection and therefore our inspection activity focussed on only part of the Safe and Well led key questions. This means we did not look at all key lines of enquiry in each of the domains.

Due to the Covid-19 pandemic, we conducted patient, carer and staff interviews by telephone. A small inspection team visited Newstead and Bestwood Wards unannounced for one day on 14 October 2020 to look at areas that could not be inspected remotely.In total three CQC inspectors, one CQC inspection manager, an Expert by Experience with experience of using mental health services and one specialist professional advisor, a nurse with experience of working on acute mental health wards, contributed to this inspection.

Summary of this inspection

During the remote part of this inspection we completed telephone interviews with patients, staff and family/carers and reviewed a range of policies, procedures and other documents relating to the running of the hospital. During the site visit we visited Newstead and Bestwood Wards and reviewed the care and treatment records of patients.

During this inspection, the inspection team:

- spoke with 13 patients who were using the hospital.
- completed telephone interviews with five family members/carers
- completed telephone and face to face interviews with 17 staff members including doctors, nurses, support workers, psychologist, and occupational therapist
- looked at the quality of the hospital environment
- looked at 11 patient care and treatment records
- completed telephone interview with the independent advocate
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

Areas for improvement

The provider must replace the ensuite doors on Newstead and Bestwood wards with anti- ligature doors. (Regulation 12)

The provider must repair the alarm system so that staff will be confident that staff from other wards would attend in an emergency. The provider must repair the fault on the alarm system on Newstead Ward. (Regulation 12)

The provider should continue to engage with staff to improve staff morale.

The provider should ensure that staff monitor patients physical health observations.

The provider should ensure that staff risk assess patients before they go out on leave to ensure any risks are reduced.

The provider should continue to recruit staff and increase the number of permanent staff employed at the hospital.

The provider should continue to train all staff so that enough staff are trained in safely caring for patients.

The provider should ensure that there are formal staff meetings on all wards to enable staff to feedback on services and have the information they need to safely care for patients.

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	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

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

Inspected but not rated

Safe	Inspected but not rated
Well-led	Inspected but not rated

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

Inspected but not rated

We did not look at all parts of Safe at this inspection.

The service did not have enough registered nurses who knew the patients. The provider was recruiting staff and employed locum registered nurses who they trained to keep patients safe from avoidable harm. Some of these locum registered nurses had not attended this training so they no longer worked there. This meant the provider had to employ other locum registered nurses to fill these gaps and that staff would not know the patients' needs as well as permanent staff. There were enough staff on each shift of each grade to meet the assessed safe staffing level.

The ward environments were not always safe. Staff had identified a ligature anchor point on the ensuite doors on Bestwood and Newstead Wards following the death of a patient. The provider was replacing these with foam anti-ligature doors and in the interim staff locked back the doors to keep patients at risk of tying ligatures safe. The provider had started to replace these doors on Bestwood Ward and had ordered the new doors for Newstead Ward. The alarm system needed repairing so that staff could be confident that if they summoned for help staff from other wards would attend. The provider had put together a business case to replace this and in the interim provided staff with personal alarms and radios to summon help. The provider was not able to confirm a date for completion of this work. The alarm system on Newstead Ward had a fault on it which staff had reported to maintenance. The registered manager told us this was being repaired.

Staff did not always assess risk well. Four out of 11 patient records we looked at had gaps in recording risk to the patient. Staff had not assessed the risk of one patient as requested by their doctor before the patient went on leave. In three patient's records staff recording of their observations of the patient's physical health was inconsistent. An audit completed by the providers quality team in September 2020 identified gaps in recording of risk assessments and review of these. This had not improved for all patients' records reviewed at this inspection.

The provider had not trained sufficient numbers of staff in basic life support to ensure they knew how to keep patients safe. This was due to the COVID19 pandemic and staff were not able to complete face to face training. This meant that only 59% of staff on Rufford Ward had completed this training. However, the registered manager told us four staff were booked to complete this by November 2020 and a further six by January 2021.

We saw that the wards were clean, however some patients told us that as the day progressed the dining areas where drinks were made were dirty as staff and patients did not clean it up after use.

However:

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

Inspected but not rated

Staff followed the providers infection control procedures and had adequate supplies of personal protective equipment. This had helped to reduce the transmission of COVID-19 and there were no patients or staff who had tested positive at the time of our inspection. The provider tested patients on admission for COVID-19. The provider risk assessed staff for their health needs, racial background and age and put plans in place to reduce transmission in the hospital.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

Staff recognised incidents and reported them appropriately.

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

Inspected but not rated

We did not rate at this inspection.

We did not look at all parts of well led at this inspection.

Three staff we spoke with were not aware of the provider's vision and values and how they were applied in the work of their team.

Governance processes did not always operate effectively at ward level. For example, the providers quality team completed a care records audit that identified gaps in September 2020 and staff were to address this by 7 October 2020. However, we found some gaps in patient care records during this inspection. Checks were not completed during the day to ensure dining areas were always kept clean.

There had not been a staff meeting on Newstead Ward since March 2020 which meant that staff did not have regular opportunities to be involved in the day to day running of the ward. Staff told us they had regular bulletins by email and there were daily handovers where information about patients' needs was shared.

Five of 13 patients we spoke with said their complaints were not handled well. The registered manager told us that since January 2020, 34 complaints had been made by patients, their relatives and visiting professionals. Eight of these had been upheld, nine had been partially upheld, four had been withdrawn by the complainant, eight were not upheld and five were being investigated. We saw that action was taken to resolve complaints and apologies given where complaints had been upheld.

However:

Senior managers were visible in the service and most staff said they were approachable. They had sought ways to engage staff and developed a strategy to do this. This included breakfast meetings with the hospital manager, 'Your Say' forum for staff and team members nominated for monthly awards.

We did not see any evidence of a bullying culture during this inspection. Staff we spoke with were confident in using the whistleblowing process.

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 alarm system was not working effectively so staff were not confident they could get assistance from other staff when needed. There was a fault on the alarm on Newstead Ward. Staff had identified a ligature anchor point on ensuite doors on Bestwood and Newstead Wards. The provider had started to replace these but this work was not completed.

Inactive