Partnerships in Care Limited

Priory Hospital Arnold

Inspection report

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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

Due to the focused nature of this inspection, we did not re-rate this service. The previous rating of inadequate remains. At this inspection, we found:

- We have not seen sufficient improvement to the safety of patients since a previous inspection in August 2022, where the rating for safe was inadequate.
- The provider did not always deliver safe care to patients. Although they minimised the use of restrictive practices, they did not always manage this well.
- Staff did not complete searches of patients after leave in a timely way and according to care plans, to ensure contraband items had not been secreted onto the ward. This was an issue at the last inspection.
- The staff on Bestwood and Newstead were not aware of the missing persons policy or its whereabouts on the wards.
- Staff did not manage items which could present a risk to the patients, and this led to incidents where harm may occur. They had not learnt from previous incidents where patients had been harmed through access to items which should have been safely stored to keep patients safe.
- Staffing did not have the right number of gender specific staff to manage the risks and care needs of female patients.
- The number of new staff on the ward was high, and there was a lack of experienced staff who knew the patients well. The staff that were new to the service had not received sufficient training on how to safely manage the risks of the patients.
- The wards had a high proportion of staff on duty who were agency staff, who were unfamiliar with patients' needs and risks.
- Staff did not assess and manage risks well. Records showed inconsistent recording of injuries sustained following an incident. Staff did not know how to consistently manage patient risks post incident. Staff did not carry out enhanced observations in line with the way in which they had been prescribed.
- The patients enhanced observation records were not always completed properly to reflect when patients were accessing leave from the hospital.
- Staff did not understand and discharge their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- The service did not ensure that staff had received sufficient training to be able to care for patients is a safe and caring way.
- The service was not well led, and governance processes did not ensure that ward procedures ran smoothly, and patients remained safe.

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	Please see summary above.

Summary of findings

Contents

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 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 provides two acute mental health wards for men and women on Newstead and Bestwood wards. The Hospital provides a psychiatric intensive care unit on Rufford ward for women, and a psychiatric intensive care unit for men on Clumber ward.

There have been 20 previous CQC inspections of Priory Hospital Arnold.

We carried out a comprehensive inspection in August 2022, due to concerns raised by a Mental Health Act Reviewers (MHAR) visit in July 2022, along with whistleblowing concerns raised from staff and patients about patient safety. We inspected Bestwood, Newstead and Rufford Wards unannounced. We inspected all five key questions: Safe, Effective, Caring, Responsive and Well led. The service was rated inadequate overall, with safe and well led rated as inadequate and effective, caring, and responsive as requires improvement.

The previous report was published on 25 January 2023, and the service remains in special measures.

We issued requirement notices for breaches of regulation 9, 10, 12, 15, 17 and 18.

At this inspection, we visited Bestwood and Newstead Wards unannounced during the evening of 24 January 2023, due to concerns raised following incidents that had occurred at the hospital. On 28 December 2022, we were informed of the death of a patient following a period of leave without permission. We were informed of a further leave without permission on 15 January 2023, where a patient had left the hospital via the roof and sustained an injury.

There are16 beds on both Bestwood Ward and Newstead Wards. Wards at this location are commissioned by a local mental health trust.

This was a focused inspection where we inspected key elements of two of the five key questions: Safe and Well led. Safe and well led has consistently been rated as Inadequate since March 2021.

What people who use the service say

We did not speak to patients and carers during this inspection as it was an unannounced night visit.

How we carried out this inspection

This was a focused inspection and looked at two of the five key questions only: safe and well-led.

Summary of this inspection

We visited Bestwood and Newstead wards during the evening and early hours of the following morning. The inspection team comprised of two CQC inspectors.

The inspection team-

Observed how staff interacted with patients.

Spoke with 14 staff members including nurses, support workers, hospital security coordinator and a ward manager.

Reviewed 54 observation records.

Reviewed the quality of the hospital environment.

Reviewed a range of documents relating to the running of the hospital.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take to improve:

- The provider must ensure that all staff understand how to consistently manage items which may present a risk to patients. (Regulation 12 (1))
- The provider must ensure staff are up to date with their mandatory training. Regulation 18 (1)
- The provider must ensure that staff use least restrictive practice standards when searching patients. (Regulation (12) (1))
- The provider must ensure that effective governance processes are in place and maintained to improve safety and care to patients. (Regulation 17(1))

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

Is the service safe?

Inspected but not rated

Safe and clean care environments

Both wards were not safe because restricted items were not effectively managed or had enough female staff to keep patients safe. Some mandatory training courses had low compliance and new staff did not carry out enhanced observations well.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. However, at the time of our inspection we found inconsistencies in the recording and whereabouts of restricted and banned items on Bestwood and Newstead wards. Managers were able to find and locate the items that were deemed missing by the end of the inspection.

Staff could observe patients in all parts of the wards. The provider had installed convex mirrors to manage blind spots identified in the service and closed-circuit television cameras were present in communal areas of all wards.

The wards complied with mixed sex accommodation guidance as Bestwood and Newstead wards were mixed sex wards, both offered separate bedrooms corridors for each gender. The provider now displayed clearly that separate lounge areas were available for patients. This complied with guidance and expectations about governing the provision of single sex accommodation.

There were no potential ligature anchor points in the service and staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. The provider completed annual ligature assessment across the hospital. In addition, senior staff completed regular assessments of potential ligature anchor points in the service for their own assurance. Ligature points are fixtures to which people intent on self-harming, might use the anchor point to tie something to, which could result in the person being able to strangle themselves. Ward offices displayed a ligature map of the environment and patient bedrooms had ligature reducing fittings.

Staff had easy access to alarms and patients had easy access to nurse call systems. Staff collected personal alarms from the hospital reception, and they were checked daily to ensure they were charged and in working order. Patients had easy access to nurse call points, including from their bedroom and bathroom areas.

Safe staffing

The service did not have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

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

Inspected but not rated

Nursing staff

The service did not have enough nursing and support staff to keep patients safe. The hospital required 32 whole time equivalent registered nurses, 17 of which were vacant. This equates to 53% of registered nurse vacancies.

The service required 96 whole time equivalent support workers, 48 of which were vacant. This equates to 50% of support worker vacancies.

We found that there was the right number of staff on each shift required to care for patients. However, there was not the right number of gender specific staff to manage the risks and care needs of female patients. There were patients who had continence needs and required female staff to assist them with this. The staff mix did not meet the gender needs of the patients.

The service relied heavily on the use of bank and agency nurses. We found the number of new staff on the ward was high, and there was a lack of experienced staff who knew the patients well. There was a high proportion of staff on duty who were agency staff.

Managers did not limit their use of bank and agency staff requesting staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. However, when reviewing restricted item practices, we found the provider did not always check the competency of temporary staff and were not able to do so to manage this safely and in line with their policy.

The service had reducing turnover rates. From the data reviewed we saw that December 2022 had a turnover rate of 3%. This showed a decrease from the data reviewed from the previous month where it was 6%

Managers supported staff who needed time off for ill health. Managers told us that the current sickness rate within the service was at 7.5%.

Levels of sickness were higher than the previous four months. From the data reviewed, sickness had increased from October and November 2022 where it was 4.4% both months. September's sickness was 5% and August was 6%.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. At the time of the inspection all shifts were covered, and the ward managers told us they could adjust staffing levels according to the needs of the patients.

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

Patients had regular one to one sessions with their named nurse.This was supported in the care plans we looked at.

Staff shared key information to keep patients safe when handing over their care to others. We observed a staff handover from day shift to night shift. We saw that staff shared essential information including observation and risk factors.

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 a doctor on site 24 hours a day, seven days a week. The service had a full medical team and could call locum doctors when they needed additional medical cover. At the time of our inspection one consultant psychiatrist was employed in a locum capacity.

Managers made sure all locum staff had a full induction and understood the service before starting their shift. We found the locum consultant was involved in meetings attached to their role which included management meetings.

Mandatory training

Staff had completed and kept up to date with their mandatory training. At the time of our inspection, the provider reported an overall staff completion rate of 88%. This was an increase since the last inspection when it was 83%. Two training modules fell below the providers target which was "Safe Handling of Medicines". This was at a completion rate of 67%. Training for the "Mental Capacity Act" was at a completion rate of 69%. The hospital training programme covered different modules. For example, reducing restrictive intervention breakaway training, infection control and basic life support, which included how to use a defibrillator and air way management, with a completion rate of 88% on this module. Qualified nurses and healthcare support workers, including bank and agency staff who work clinically with patients within the service had all completed training in managing patients risks. In particular patients who are at risk of being absent without leave, and who either abscond from, or are absent without leave, from the hospital.

The mandatory training programme was comprehensive and met the needs of patients and staff. However, some staff we spoke with, were new to the service and had not received sufficient training on how to safely manage the risks of the patients. We saw staff undertaking enhanced observations which had been prescribed as 2 to 1 arm's length. However, staff did not know how to carry this out correctly and were seen to be more than arm's length away from the patient. When asked when they would engage with the patient, staff responded it would only be when the patient became anxious. We observed a staff member, new to their role, responding to a patient request in a manner which did not reassure the patient and resulted in the patient getting increasingly anxious and upset. We also observed two staff speak about a patient without compassion and kindness. We were not assured that staff had received sufficient training to be able to care for patients in a safe and caring way. We observed high acuity on the ward and examples above show a continued risk to patients due to the lack of training and experience of staff.

Managers monitored mandatory training and alerted staff when they needed to update their training. Although training was a regular agenda item in governance meetings, the compliance figures for some mandatory courses remained low.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well or follow best practice in anticipating, de-escalating, and managing challenging behaviour. Absconsion incidents were managed ineffectively. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident.

Staff used a recognised risk assessment tool. The multidisciplinary team were involved in completing patient risk assessments.However, we found inconsistencies in risk assessments completed on both wards.

Management of patient risk

Staff did not know about risks to each patient and did not act appropriately to prevent or reduce risks. We reviewed observation records and Section 17 leave records over a 17-day period. Enhanced observation records were contradictory of Section 17 leave records. Enhanced observation records documented patients were engaged in on ward activities such as showering, or in bedrooms. Section 17 leave records documented the patient had left the ward and taken Section 17 leave at the same time.

Section 17 leave forms had missing information. We found 7 out of the 14 section 17 signing out and in forms used on the day of inspection had 'time due back' section missing. We were not assured that staff knew when detained patients must return to the ward.

We looked at 54 observation records for one patient, and on only 7 occasions, the absconsion risk of the patient had been recorded and referred to. When we compared it to their care plan, this absconsion risk was clearly identified.

Staff did not accurately record incidents in both incident records and daily records. We found that following one incident on 15 January 2023 the incident record differed from the daily record. We found one patient who had a history of 13 absconsion since admission. The care record had one incident of absconsion that lasted 68 hours, missing. During this episode, there was one day of missing daily records.

Staff did not respond in a timely way to post incident injuries. We reviewed one incident on 15 January 2023, the records show inconsistent recording of injuries sustained. We could not find a risk assessment in place for the supportive boot that had been prescribed. This patient had a history of violence and aggression and there was no mitigation to ensure the safe use of the supportive boot. This posed a continued risk in the safe management of patient risk.

Staff did not always identify and respond to any changes in risks to, or posed by, patients. This included up dated risk assessments and risk management plans as risks changed. We found examples where risk assessments were completed but corresponding documents were not reflecting the highlighted risks.

Staff could observe patients in all areas of the wards and staff followed procedures to minimise risks where they could not easily observe patients. This included convex mirrors to manage blind spots. Closed circuit television was installed in communal areas of both wards.

Staff did not follow the service's policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.Staff did not complete post leave searches in a timely way and according to care plans, to ensure contraband items had not been secreted onto the ward. We found 7 incidents that related to the discovery of contraband items on the ward. For example, following an absconsion by a patient, cigarettes were found secreted in a hoody of the same patient and in previous incidents in December 2022, further lighters had been found in possession by two other patients. This issue was identified at our previous inspection and had not been properly addressed. We were concerned or continued risk to patients, and they were at potential risk of harm from contraband items.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. Ward managers completed a "restrictive practice self-assessment audit tool" on each ward monthly. This ensured that most care and treatment was provided in the least restrictive way for patients but not in the case of searches.

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. Between September 2022 and November 2022, the provider recorded an average of 30 incidents of physical interventions with patients per month. This showed a decrease from the figures reported in the last report which were at an average of 70 incidents of physical interventions with patients per month. The provider reported, there were no supine (face up) and no prone (face down) restraints in September 2022 and November 2022.

Training figures showed the provider trained staff in the use of physical interventions with patients had increased. The provider recorded staff completion rate had increased from 85% to 91%.

Staff we spoke with understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Evidence from the provider showed that between September 2022 and November 2022, rapid tranquilisation was used 18 times across the service. The breakdown of the month-by-month figures did show a reduction in use. For example, in September 2022, staff used rapid tranquilisation 9 times compared to October 2022 when staff used it four times. We found evidence of correct record keeping on this procedure.

Track record on safety

The service did not have a good track record on safety.

This service was placed into special measures following the previous inspection of August 2021. The service remained in special measures following three further inspections of June 2021 December 2021 and March 2022. Records showed there had been 443 incidents involving patients since September 2022 to November 2022.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. Staff did not recognise incidents and report them appropriately. Managers investigated incidents when reported and shared lessons learned with the whole team and the wider service. However, during our inspection we found lessons learnt were not embedded with staff. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff were unclear on what incidents to report and how to report them. An absconsion pack that was implemented by the provider and shared with staff on 24 January 2023, was not known to 12 members of staff we spoke with. The nurse in charge on Bestwood ward knew about the absconsion pack but that information had not been shared. The handover to night staff on 24 January 2023, did not make mention of the absconsion pack. The absconsion pack is designed to support staff when someone absconds and comprises of equipment such as torch, Hi-Viz jacket and maps of the local area. A copy of the pack was given to the inspection team which detailed how staff were to proceed if a patient was missing off a ward. It quoted the Priory provider policy (H126) and gave details about a grab bag at reception and its contents. The nurse in charge informed us at approximately 7pm that they had not printed this information out but was going to.

Staff did not raise concerns, report incidents and near misses in line with provider policy.

There was insufficient clarity amongst staff on Bestwood and Newstead wards on the policies to be used when patients are missing or absent without leave, and there was not clarity on accessibility to these documents. Three staff on Bestwood knew there was a policy and could be found on the service's intranet. The nurse in charge on Bestwood ward on the day shift said there was a copy of the policy (H126) in the staff communication folder. However, we found that the policy was not present. A copy of policy MHA09 was given to the inspection team on Newstead ward which was a supplementary policy to policy H126.

Staff did not report serious incidents clearly and in line with trust policy. We spoke to 4 members of staff on Bestwood ward and 6 staff on Newstead ward who told us that they would contact the nurse in charge if a patient was missing. However, staff were not able to say with confidence, what would happen to support finding a missing patient. Two staff members told us that they think they would look around the hospital where the patients have their walks, 1 staff

member on Bestwood ward told us they think they would look around the smoking area and down the lane to the main road. One staff member on Newstead told us they would search up to 2-3 miles in the local area. One staff member told us that they would use their own car if there was no one able to use the hospital vehicle. However, they would not be able to transport the patient back to the hospital if found as they were not insured to do that.

Staff told us they understood the duty of candour. They said they were open and transparent and gave patients and families a full explanation if and when things went wrong. However, we were not able to speak to patients and their families to confirm this, during this inspection as it was a night time inspection.

Managers debriefed and supported staff after any serious incident. Staff told us debriefs occurred and managers told us there were opportunities for staff to attend reflective practice sessions with psychology.

Managers told us they investigated incidents thoroughly and spoke with the patients and their families. However, we were not able to speak to patients and their families to confirm this, during this inspection as it was a night-time inspection.

Is the service well-led?

Inspected but not rated

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles. They did not have a good understanding of the services they managed. However, they were visible in the service and approachable for patients and staff. The previous registered manager had left the service in March 2022 and an interim hospital director was appointed to cover the position. The interim hospital director left in December 2022 and a further new hospital director was in place. The change of leadership meant that the improvements the service was working towards had not been fully embedded.

Breaches of the regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3) had continued since March 2020 meaning that leaders have not consistently made patients safe in the service.

Governance

The service was not improving quickly enough to mitigate risk to patients and support a pathway to recovery. Our findings from the safe key question demonstrated that governance processes did not always operate effectively at ward level and that performance and risk were not managed well.

Although policies were in place at the service that provided assurance that staff should consistently complete contemporaneous records for patients, the provider did not ensure effective audit of these records and remedial action was not taken where there were failings in record keeping. In particular, the forms used for Section 17 leave of the Mental Health Act 1983 against the records for patients who were on enhanced observations and records following all incidents were not always accurate.

We found that implementation of the restricted items policy was not effective, and staff had not prevented restricted items being brought onto the wards. In addition, managers had not ensured compliance of agency staff to follow the policy had been effective. Staff were not clear at the time of our inspection whose role it was to check on this.

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

Inspected but not rated

Managers had audits in place, which would be discussed at governance meetings, this included audits of ward walk rounds, cleaning, maintenance and clinic rooms. On review of the governance meeting minutes we did see that lessons learnt were shared to all staff across the service. For example, on Bestwood ward the minutes state that staff must be offered a debrief after each incident for both patients and staff, this must also be documented. The minutes also stated it was important that staff are providing a comprehensive overview of each incident when completing an incident recording form, as on occasions these forms had been brief and staff had failed to document which least restrictive interventions were used prior to the administering of medication.

On Newstead ward the shared lessons learnt at governance meetings were in relation to patients searches, patients are to be requested to be searched on return from community access. The minutes from Newstead ward also recorded that there had been a significant increase of incidents relating to alcohol and or drugs due to several patients on the ward. Staff must continue to complete environmental checks and complete reactive room searches as required. However, during the inspection we found that these messages were not inconsistently being understood and complied with on ward level.

During the inspection we found that there was enough staff on shift required to care for patients. However, there was not the right number of gender specific staff to manage the risks and care needs of female patients.

Staff did not know how to safely carry out correctly enhanced observations which had been prescribed as 2 to 1 arm's length.

Overall mandatory training rates for staff were 88% compared to the last inspection when it was 83%, but 2 courses had low compliance rates.

Management of risk, issues and performance

The service did not ensure that all staff who worked clinically with patients within the hospital had completed training or achieved the necessary competencies, in managing patients who are at risk of absconsion and being absent without leave, and who either abscond from, or are absent without leave, from the hospital.

The service had the correct policies in place for patients who use section 17 leave of the Mental Health Act 1983 we found inconsistencies of staff completing the correct paperwork and procedures that went with the policy.

The service did not ensure that effective audits were in place of contemporaneous records and therefore did not take remedial action when there were failings in record keeping.

Staff did not accurately record incidents in both incident reporting form and daily records. This posed a continued risk in the safe management of patient risk.

The service did not ensure that staff completed post leave searches in a timely way and according to care plans, to ensure contraband items had not been secreted onto the ward. This was a continued risk to patients, and they were at potential risk of harm from contraband items.

Managers within the service did not always share learning with staff at daily risk meetings, team meetings on the wards, during staff supervision and through reflective practice sessions as evidenced throughout this report. Governance was not robust enough to ensure these messages were fully embedded. For example, the practice of the management of risk items did not demonstrate effectiveness of shared learning.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider must ensure staff are up to date with their mandatory training.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that staff use least restrictive practice standards when searching patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must ensure that effective governance processes are in place and maintained to improve safety and care to patients.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider must ensure that all staff understand how to consistently manage items which may present a risk to patients.