The Priory Hospital Potters Bar

Quality Report

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

Ratings

Overall rating for this location

Are services safe?	
Are services effective?	

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

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

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

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

Overall summary

We carried out an unannounced inspection of The Priory Hospital Potters Bar, and focused on the areas of safe and

Summary of findings

effective in relation to staffing levels, care plans, risk assessments and observations levels. We did not rate the provider on this inspection. We did not look at the whole domains of safe and effective and focused only on specific issues.

We found:

- Physical health monitoring was being completed but not consistently recorded. Staff did not evidence how concerns about patients blood pressure or physical health was being managed effectively.
- Where physical health checks identified a physical health concern for example diabetes and high blood pressure, care plans were not in place.
- Patients had pre-leave risk assessments forms in place however these were not completed with the time due in or actual time back in.
- There were discrepancies in patients risk levels from the patient information board to those indicated in the patients risk assessment. However, risk levels and patients risk behaviours had been identified.
- Sleep charts and observation record sheets were not fully completed in line with the hospitals' policies. The observation sheets did not describe the patients mental state which is required as part of the observation and engagement policy.
- There was a high use of qualified agency nurses on both Crystal and Ruby ward on a daily basis.
- Care plans were not holistic or in the patient voice and not comprehensive.
- Care plans did not reflect the risks that had been identified in the risk assessments. Some care plans were in place and had been written for risks that had not been identified.

However:

- All patients were assessed by a qualified nurse and doctor within 24 hours of admission and were physically examined.
- The hospital had a staffing matrix in place and the staffing rotas we saw met the numbers required. There was a clear handover of patient information between shifts..
- Staff had policies in place that gave guidance on the Care Programme Approach, risk assessments, observations and engagement and the monitoring of physical health of inpatients. The provider had completed an audit on both wards that identified care plans that were due to be reviewed.

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

Summary of findings

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Summary of this inspection

Background to The Priory Hospital Potters Bar

The Priory Hospital Potters Bar offers two mixed sex acute wards providing 24 hour care and support, and a period of intensive assessment and stabilisation for service users suffering an acute mental health episode. Potters Bar hospital accepts referrals nationally,and admits patients 24 hours a day, 365 days a year. It provides full medical, clinical and therapeutic package including pharmacological interventions when required. The hospital also has two high dependency units. We did not include these in this inspection.

The Priory Hospital Potters Bar provides mental health care and treatment for adults of working age. We visited Crystal ward and Ruby ward during our inspection which are the acute admission wards. At the time of inspection Crystal ward, which was a 12 bed ward, had 11 patients and Ruby ward, which was a 20 bed ward, had 19 patients. Patients admitted to these wards have a range of presenting mental health conditions including depression, anxiety, bi-polar disorder and schizophrenia. Treatments include psychotropic medication, psychological therapies, occupational therapy, and support from nursing staff.

The hospital was last inspected 18 to 20 November 2015 and was rated good in all five domains with no compliance issues. However, a Mental Health Act review visit that took place on 19 May 2016 had identified concerns that the hospital had responded to with an action plan. All but one of these action points had been completed at the time of this inspection.

Our inspection team

Inspection lead: Vanessa Kinsey-Thatcher

The team was consisted of an inspection manager, two inspectors a Mental Health Act reviewer and an inspection planner.

The team would like to thank all those who met and spoke with the team during the inspection.

Why we carried out this inspection

We carried out an unannounced focused inspection of Ruby and Crystal wards on 15 September 2016 due to concerns that were raised with the Care Quality Commission.

The concerns included:

- A concerning number of absent without leave notifications to CQC for patients detained under the Mental Health Act 1983
- Intelligence received regarding care plans and risk assessments
- Outstanding actions arising from a Mental Health Act Review visit on 19 May 2016.

How we carried out this inspection

(This inspection was unannounced and looked at the safe and effective domains. We reviewed care plans and risk asesesements, including physical health care plans, and pre-leave risk assessment forms for informal patients who were having leave from the wards.)

This inspection was a focused inspection and asked the following questions of the service:

- Is it safe?
- Is it effective?

During the inspection visit, the inspection team:

Summary of this inspection

- visited the premises and looked at the quality of the environment within the two acute wards at the hospital
- observed staff providing support to patients in communal areas
- observed interactions between staff and patients
- looked at 13 care plans
- looked at 13 risk assessments
- looked at 19 observation and engagement recording sheets
- looked at nine section 17 leave forms and nine informal patients pre-leave forms
- looked at nine physical observation recording forms
- spoke with the managers or acting managers for each of the wards
- spoke with staff including two nurses, one doctor and two managers
- looked at policies relating to risk assessment,care plans and observations
- looked at staffing rotas for both wards and the use of agency staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

- The hospital had a high level of vacancies for qualified nurses and used agency nurses on a daily basis.
- Observations of patients were being recorded but not always within policy guidance putting patients at risk of harm.
- Risk levels and patients risk behaviours had been identified. However, there were discrepancies in patients risk levels from the patient information board to those indicated in the patients risk assessment.
- Risk assessments had incomplete information regarding historical risk behaviours and factors.
- Staff did not consistently complete comprehensive risk assessments that were linked to care plans.
- Escorted leave was rarely cancelled due to staff shortages.
- The provider had a mixture of qualified staff and healthcare assistants and the shifts always had the required amount of staff on duty in accordance with their own staffing matrix.
- The hospital had policies in place for the use of observations.
- Informal patients had a pre-leave assessment in place to manage risk factors.
- Detained patients had Section 17 leave forms in place

Are services effective?

- Care plans did not reflect the risks that had been identified in the risk assessments. Some care plans were in place and had been written for risks that had not been identified.
- Care plans were not personalised, holistic or recovery focused.
- Care records showed that all patients received a physical examination upon admission however we found some patients with identified physical health issues e.g. diabetes and high blood pressure did not have care plans to support them.
- We found on two occasions that other patients information was filed in another patients paper file notes.
- All patients had blood pressure, pulse, temperature and respiration recording charts but all of the charts seen did not indicate how often these observations should be completed.
- Information was stored securely both electronically and in paper format
- For those patients on clozapine a designated care plan for physical healthcare monitoring was in place.

Summary of this inspection

- Patients had access to physical healthcare screening and monitoring including echocardiograms, blood tests and blood pressure checks.

Detailed findings from this inspection

Mental Health Act responsibilities

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

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

Safe	
Effective	

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

Safe staffing

- Ruby ward had a staffing establishment of five nurses and eight health care assistants for both day and night shifts. Crystal ward had a staffing establishment of two nurses and one health care assistant.
- At the time of inspection the provider had a vacancy rate of 47% for qualified nurses, which equated to 19.2 whole time equivalent vacancies. The provider had a vacancy rate of 24 % for health care assistants which equated to 21.6 whole time equivalent vacant posts. Both permanent and bank staff were used. The figures for shifts fulfilled by agency nurses were not available.
- We looked at rotas from July 2016 to September 2016 and noted that the staffing establishment was being met daily.
- The provider used regular agency and bank staff who were familiar with the ward and patient group, some agency nurses were on short term contracts.
- Staff were able to facilitate patients' leave on a daily basis and leave was rarely cancelled.

Assessing and managing risk to patients and staff

- Staff completed a risk assessment for patients upon admission. However, we found that risk assessments had incomplete information regarding historical risk behaviours and factors. However, risk assessments were reviewed and updated by staff on a regular basis within the care record commentary.
- Staff inconsistently recorded risks within risk assessments and did not write care plans to manage such risks. Staff had written care plans that had no links to any risks identified. In 13 patient records viewed, nine had risks identified but no care plan linked to these risks. Staff completed care plans for patients, however, care plans reviewed on Ruby ward identified six out of the eight records seen had care plans without an identified risk for that patient.
- Three informal patients had restrictions placed on them and were not able to leave the hospital freely. This included one patient who had to tend to their personal hygiene and tidy their room before leave would be granted.
- The provider had policies in place for use of observations. However, we found that for three out of 11 patients on Crystal ward there were discrepancies in the levels of observations being carried out.
- Staff had completed observation sheets for alll 19 patients on Ruby ward. However, for five patients there were longer gaps then the policy guidance stated between the checks. This meant that patients could be unobserved by staff for a longer time period.

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

(for example, treatment is effective)

Assessment of needs and planning of care

- We looked at 13 physical health care plans and found that not all patients were having their blood pressure, pulse, temperature and respiration rate recorded as frequently as indicated on their care plans.
- There were discrepancies in 10 out of the 13 care records reviewed. For example three care records did not have a care plan for physical health conditions identified. Another patient who had not eaten or drunk for several days had no care plan in place in order to manage this.
- Patients who had a physical health condition such as diabetes and tachycardia did not have a care plan specified to manage their condition.
- Care planning goals were not individualised, holistic or patient centred. Patients were referred to as "her" rather than "him" within two care plan we saw.
- Staff completed care plans for issues that had not been identified as a risk. On Ruby ward seven out of eight care plans seen did not have individual risks identified. For example two patients had care plans in place to

manage the risk of falls however falls had not been identified as a risk for those patients. One patient had tachycardia identified as a risk but had a care plan in place for their mental well-being. Another patient had care plans for violence and aggression and absconding but these risks were not identified on their risk assessment. There were three out of nine temperature, pulse, respiration and blood pressure charts seen that did not identify the frequency of physical observations to be taken written on them.

- We found on two occasions that other patients information was filed in another patients paper file notes.
- Staff completed care plans and risk assessments within 24 hours of admission, subsequent updates were completed at ward rounds and in line with internal policies. However six out of eight care records seen did not have care plans in place for all identified risks.

Best practice in treatment and care

- We spoke to medical staff who stated that electrocardiograms and blood samples are taken on the ward. There were physical health care plans in place for those patients who needed blood pressure, temperature, respiration and oxygen saturation monitoring. However, we found not all patients were having their physical observations recorded as prescribed.
- Staff had not developed physical health care plans for three patients that had specific health conditions.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff follow hospital policies to safeguard the patients mental and physical health, including monitoring patients vital signs such as blood pressure, pulse, respiration and temperature. This must be clearly indicated on the physical health monitoring sheets.
- The provider must ensure that patients with a physical health condition or at risk of one have a physical health care plan in place.
- The provider must review the quality of observations notes recorded by staff and the timings of prescribed observations to safeguard patients from risk.
- The provider must ensure that all risks identified for patients have corresponding care plans.
- The provider must ensure that care plans relate to existing risk behaviours identified.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • The provider did not assess the risks to health and safety of patients and did not do all that is reasonably practicable to mitigate such risks. • The provider did not assess and monitor patients physical health in a way that minimised risk to patients. • The care and treatment of patients was not appropriate and did not meet their needs. • The provider did not design care or treatment with a view to achieving patients needs. • Patients with physical health conditions that required monitoring did not have care plans. • Care plans did not reflect patients needs regarding assessed risks. This is a breach of Regulation 12 (1) (2) (a) (b)