Partnerships in Care Limited

Priory Hospital East Midlands

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

Priory Hospital East Midlands is located in Annesley in Nottingham and is one of the hospitals of Partnership in Care Limited. It has two female wards; one specialist acute and one psychiatric intensive care ward. The service works with patients in achieving their goals and preparing them to move back into the community, or into other appropriate accommodation.

We carried out this unannounced inspection because we received information giving us concerns about the safety and quality of the service. We were notified of three recent medicines errors, which involved nurses administering intramuscular injections to a patient. This medicine had not been prescribed by a doctor. We also received information of concern relating to the restraint of people using the service. We only focused upon specific areas in the safe and well led key question. We did not inspect the effective, caring and responsive questions.

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:

- Staff had reported numerous medicines errors through the providers internal electronic incident reporting system.
- A visiting community pharmacist had identified recent medicines errors. The provider had not identified these independently due to a lack of oversight around medicines management.
- Doctors had not always ensured medicine charts were clear and concise, which increased the risks of errors.
- Doctors did not re-write medicines charts as and when needed. Numerous patients had several charts which was unnecessary. Additionally, doctors had not numbered the medicines charts correctly.
- Discontinued medicines charts remained in patient medicine files. Staff had not removed these.
- Some staff inaccurately recorded methods of physical interventions in patient records, which could lead to ambiguity around unapproved restraint methods being used.
- One patient care plan and positive behavioural support plan did not fully reflect specific risks in relation to staff restraining.
- Registered nurses had all completed training in medicines management, but we noted that some staff most recently completed in 2017.
- Staff did not consistently record conversations held with patients when medicine errors had been made.

However:

- We found staff had improved with recording physical health care observations after administration of rapid tranquillisation.
- Managers had taken appropriate actions with staff when they had been made aware of recent medicines errors.

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

Contents

Summary of this inspection

Background to Priory Hospital East Midlands

Priory Hospital East Midlands is in Annesley in Nottingham and is one of the hospitals of Partnerships in Care Limited.

Priory Hospital East Midlands is registered 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.

The provider offers specialised assessment and treatment to help patients for return to either local services or alternative appropriate accommodation. All bedrooms have private ensuite bathrooms. There is a secure garden for each ward and a gym which can be used under staff supervision.

The following service and wards were visited on this inspection:

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

- Littlemore Ward, a female psychiatric intensive care unit with ten beds.
- Barton Ward, an acute admission ward for females with nine beds.

The most recent focussed inspection of this location was between 30 May to 10 June 2022. The location was rated as inadequate in the safe and well led key questions. We served two warning notices following this inspection, under Regulation12, safe care and treatment, and Regulation 17 good governance, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Due to the concerns and ratings the service was placed into special measures.

We carried out this inspection as we were notified of three incidents where medicines errors were made.

Following this inspection, we served a warning notice under Regulation 12, safe care and treatment, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How we carried out this inspection

The inspection team visited the wards on 30 August 2022 and completed further off-site inspection activity. During the inspection we:

- visited the service and observed how staff cared for patients;
- reviewed 13 medicine charts and corresponding physical health observation records;
- reviewed electronic incident reports;
- reviewed CCTV to see how staff managed incidents;
- spoke with the registered manager and ward manager;
- reviewed medication training records;
- reviewed care plans of one patient to specifically look at physical intervention guidance;
- reviewed two individual patient risk assessments.

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.

Summary of this inspection

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that individual care plans have information and guidance around restraint for patients who have physical health concerns or conditions. (Regulations 12 (1) (2) (b))
- The service must establish systems and processes to assess, monitor and improve medication management. (Regulations 17 (1) (2) (a))
- The service must ensure staff inform patients of all updates relating to their care and treatment, including when things go wrong. (Regulations 17 (1) (2) (a) (b))

Action the service SHOULD take to improve:

- The service should ensure staff record physical health observations consistently in the same place.
- The service should ensure methods of physical interventions used are recorded accurately.

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

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

Safe and clean care environments

Clinic room and equipment

We went into the clinic rooms on Barton and Littlemore wards. The rooms were clean and tidy, fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed.

Assessment of patient risk

Staff completed risk assessments for each patient on admission and after each incident. The multidisciplinary team were involved in completing patient risk assessments, so all aspects of care and treatment were documented within the assessment. We reviewed two risk assessments and found them to be patient focused, covered all risk posed by the patient and individual triggers for risk and effective management tools if the patient was displaying risk behaviours.

Use of restrictive interventions

On reviewing a patient's care records prior to the inspection, we found entries within them that were a cause of concern. Firstly, staff had recorded within the notes they had used a "five man lift" to pick a patient up from the floor and relocated them to the calming suite. We discussed this with a manager who reported this was not a known restraint technique. Staff were trained to carry out assisted lifts to support patients to stand during a restraint. In order to do this, there needed to be a level of compliance form the patient. To confirm the staff had used the correct techniques we reviewed the closed-circuit television footage of this incident. We saw staff were calm and measured in their approach to the patient. They supported the patient to stand up and escorted them using low level restraint techniques to assist them to the calming suite.

A further care record entry stated that staff had used a bean bag to restrain a patient's legs. We spoke with the manager who confirmed staff used a safety pod during restraint when required to cover patients' legs if they were at risk of hurting themselves of others with their legs. Managers confirmed it was not a bean bag but a piece of approved equipment that staff could use if they had received relevant training. We reviewed closed circuit television footage of this incident and found one safety pod was used when the patient was moved into the calming suite for the patient and staff to sit on supported by staff. When the patient began kicking out at staff another safety pod was used to prevent the patient from making contact with staff and causing injury to themselves and others.

We reviewed the care plans and risk assessment of one particular patient who had physical health concerns. We found that these concerns had not been recorded by staff with regards to physical interventions, despite this being an action point from a multi-disciplinary meeting. We were concerned that staff may have been restraining in a way which would pose a risk to the patients' physical health.

We reviewed staff monitoring of patient's physical health after they had administered rapid tranquilisation. Staff had applied the National Institute for Health and Care Excellence (NICE) guidance and had attempted to monitor physical health regularly. On occasions where the patients had declined observations, staff had recorded this within the patient care records. We found staff had been recording physical health observations in three different places. We located rapid tranquilisation forms held within the patients' individual medicine file, a physical observation chart was also in the medicine file, and a duplicate chart within the patients' electronic care records. This made it difficult to track if physical health care monitoring had taken place. However, we were able to identify that physical health care monitoring had taken place in line with NICE guidance in the records we reviewed. Staff did not consistently record physical observations they had undertaken within individual daily care records.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and stored securely so all staff could access them easily. Managers provided agency staff with log in details to the electronic clinical note system. This was an improvement from the previous inspection.

Medicines management

The service did not have effective systems and processes to prescribe, administer, record and store medicines. However, we were concerned that the prescriptions were recorded in a way that could lead to undue medication errors.

At the previous inspection of the service between 30 May and 10 June 2022 we told the provider they must ensure the proper and safe management of medicines.

Prior to the inspection we were notified of three separate incidents where staff had administered intramuscular medicines without a valid prescription in place. A pharmacist had carried out a routine audit on 20 July 2022 and had alerted staff to this.

The audit found that a patient had been administered intramuscular promethazine 25mg on 13, 16 and 17 July 2022. The patient had only been prescribed promethazine 25mg orally.

We reviewed 13 medicine charts and found doctors had prescribed medicines in line with the British National Formulary.

The service did not have effective systems and processes in place to prescribe and administer medicines safely. Prescribers had not ensured medicine charts were re-written when medicines had been stopped or changes had been made. This had resulted in some patients having multiple medicine charts, which was unnecessary. For example, during the inspection a doctor had prescribed a patient a course of antibiotics during ward round. The doctor had prescribed this on a new medicines chart. On reviewing the patient's existing medicines chart, we found that due to different medicines that had been stopped, the doctor could have re-written a new chart which held all active prescriptions, thus reducing the risk of potential errors.

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

Inspected but not rated

It was difficult to track the number of medicine charts in use as the prescribers had not ensured that the charts were numbered correctly. This increased the risk of nurses (the administrators) not checking all active medicine charts.

We found duplicated prescriptions of medicines for one patient on two separate charts. On the first chart was a prescription on 19 July 2022 for Lorazepam 1mg orally, up to 3mg in a 24-hour period. The other chart dated 1 August 2022, also had a prescription for the same medicine and dose. Staff had administered this correctly and had not exceeded the prescribed dose. However, we were concerned these duplicated prescriptions could increase the risk of medicine errors and have potential adverse effects for patients.

When doctors had written some prescriptions, they had written guidance on medicine charts that was not always clear or concise. On one medicine chart we saw the doctor had recorded, “leave two hours between Nitrazepam and the last dose of Lorazepam”. On another chart the doctor had recorded “leave two hours between Nitrazepam and Lorazepam”. We were concerned this was open to interpretation of the administering nurse and increased the risk of patients receiving medicines which could have a negative impact on their physical health.

When medicine charts had been discontinued, they remained in the patients’ medicine files. We did not know why this was and why they had not been removed to make the administration of medicines easier for nurses.

We reviewed the training records of qualified nurses for medicines management and found all nurses had received this training. This included four bank nurses. However, we noted that of the 17 substantive staff only five had completed this training in the 12 months prior to the inspection. Five had completed the training in 2017, five staff in 2018, two in 2019 and one in 2020. The four bank nurses had completed this training in 2016, 2017 and 2020. Due to the concerns identified with medicines management, prior to and during this inspection, as well as during and previous inspections, it was not clear whether the provider had considered refreshing this training or any additional support for administrators.

We reviewed electronic incident forms from 24 February 2022 to 21 August 2022 and found there had been 11 medication errors.

Three of the errors involved incorrect dispensing or administration of medicines. On one occasion a staff member dispensed 300mg Quetiapine for a patient who was prescribed 125mg and on another occasion staff had administered Zopiclone to a pregnant patient. The doctor had instructed this medicine to be stopped, but the medicines chart did not reflect this. A further incident involved staff administering 0.5mg of Fludrocortisone acetate incorrectly.

One incident involved a member of staff administering nicotine replacement therapy to a patient who did not have this prescribed.

A member of staff had raised concerns about the competency of a qualified nurse as they observed them make a medicines error.

A patient reported they had been given an additional dose of Olanzapine 10mg, one at 5pm and the other by a night nurse.

There were five incidents reported where staff had not carried out routine check of drugs liable for misuse or there were errors when checks had been carried out.

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

Inspected but not rated

On 24 February 2022, numerous medicines errors had been captured by a pharmacist during a routine audit on Barton ward.

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

Inspected but not rated

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

Governance

Our finding from this inspection and the safe key question demonstrated that governance process was not operating effectively at a team level. Risks related to medicines management were not managed as well as they could be.

We spoke with managers within the service about the concerns identified with medicines. We were told they had not been informed about the community pharmacist's audits of prescription charts. However, we found a completed electronic incident form for the errors that had been highlighted in an audit.

There was no oversight of the prescribing and administering of medication. Therefore, there were no plans in place to improve practice in these areas. However, when medicine errors had been found or reported, managers had taken action with the individuals involved, and had used disciplinary procedures if felt appropriate.

Staff did not consistently record discussions they held with patients when things went wrong. We noted some entries had been made in clinical notes, but not within all when medicine errors had been 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 service must ensure that individual care plans have information and guidance around restraint for patients who have physical health concerns or conditions. (Regulations 12 (1) (2) (b))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance • The service must establish systems and processes to assess, monitor and improve medication management. (Regulations 17 (1) (2) (a)) • The service must ensure staff inform patients of all updates relating to their care and treatment, including when things go wrong. (Regulations 17 (1) (2) (a) (b))

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
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 must ensure systems and processes to prescribe, administer, record and store medicines are effective to minimise the risk of errors. (Regulation 12 (1) (2) (b))