The Priory Hospital Nottingham

Quality Report

Ransom Rd,
Nottingham,
NG3 5GS
Tel:0115 969 3388
Website:www.priorygroup.com

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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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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.

Summary of findings

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 rated The Priory Hospital, Nottingham as good because:

- Staff were positive, kind, and caring towards patients. Staff knew patients and understood their individual needs. Patients were routinely involved in their care planning and reviews.
- Families and carers were welcomed in the hospital and involved in care planning and decision-making where appropriate.
- There were enough staff on each shift to meet the needs of patients. This meant that activities and escorted leave were not cancelled.
- Detailed assessments of patients' mental and physical health needs were completed and used to inform care plans. Care plans were up to date, holistic and recovery orientated.
- Patients had access to psychological therapies, and therapeutic and social activities.
- The environment was clean and maintained, with areas for patients to see visitors and make phone calls in private.
- Ligature risks were reduced with individual up to date risk assessments and observations as required.
- Staff knew how to recognise different forms of abuse and how to report it.
- Patients had their rights under the Mental Health Act explained to them on admission.

Summary of findings

Contents

Good

The Priory Hospital Nottingham

Services we looked at:
Acute wards for adults of working age and psychiatric intensive care units.

Summary of this inspection

Background to The Priory Hospital Nottingham

The Priory Hospital Nottingham provided acute inpatient mental health care for up to 14 men and women. The hospital was full at the time of our inspection.

Referrals were from clinical commissioning groups (CCGs) and NHS trusts across England.

The registered activities for The Priory Hospital, Nottingham were:

Accommodation for persons who require treatment for substance misuse, assessment, or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures and treatment of disease, disorder, or injury.

There was a registered manager in place.

The Care Quality Commission last inspected the hospital on 23 December 2013. At the time of inspection, the provider was meeting essential standards, now known as fundamental standards.

Our inspection team

Team leader: Amy Owen CQC Inspector

The team that inspected the service comprised three CQC inspectors and an assistant inspector.

Why we carried out this inspection

We inspected this service as part of our on going comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with three patients who were using the service;
- spoke with the registered manager and manager or acting manager of the ward;
- spoke with five other staff members; including doctor, nurses, support worker and therapist
- received feedback about the service from other statutory organisations;
- received feedback from a previous patient via a letter;
- attended and observed two hand-over meetings and two multi-disciplinary meetings;
- looked at nine care and treatment records of patients;
- carried out a specific check of the medication management on the ward; and
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

- Patients told us they felt safe, and the ward was clean and comfortable, with bedding and towels changed daily. They told us staff were respectful and polite and were available to talk to, involving them in their care. They liked the activities on offer, and these were rarely cancelled.

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?

Good

We rated safe as good because:

- The environment was visibly clean and well maintained.
- Ligature points were risk assessed.
- The hospital had good staffing levels to meet patients' needs.
- There was evidence of good individualised risk assessments. Staff carried out an assessment of patients' potential risks promptly on admission. Staff recognised and reported safeguarding concerns.
- All incidents were reported to the manager and incidents logged on the provider incident reporting system.

However:

- Although staff checked emergency equipment regularly, missing items were not replaced and this could present a serious risk if required in an emergency.

Are services effective?

Good

We rated effective as good because:

- Assessments of patients' needs took place on admission and were reviewed and changed as necessary.

  Care plans were in place to address patients' needs and updated regularly. These included good oversight of patients' physical health.
- Staff promoted the use of de-escalation skills.
- Staff received appropriate induction, training, and appraisal.

  Patients had good access to psychological therapies.
- Staff were trained in, and had good knowledge of, the Mental Health Act and the Mental Capacity Act.

However,

- Staff told us they received regular supervision but not recorded. Staff did not receive regular team meetings, to enable better feedback and information sharing.

Are services caring?

Good

We rated caring as good because:

- Staff treated patients with dignity, respect and kindness
- Patients were actively involved in all aspects of their care

Summary of this inspection

- There were daily community meetings for patients and staff to support engagement
- Family and carers were able to attend ward meetings and staff were creative in using Skype for family who live a distance from the service.

Are services responsive?

Good

We rated responsive as good because:

- Patients were provided with an informative welcome pack on admission
- There were a variety of therapies to support recovery
- The service liaised with external agencies to support timely admission and discharge
- The service promoted human rights and diversity
- Quiet areas were available for patients to see their visitors

Patients knew how to complain and were supported by staff to do so.

Are services well-led?

Good

We rated well-led as good because:

- Staff reflected the values of the organisation
- Senior managers were visible and supported their staff
- Staff were able to raise concerns with senior staff

Staff performance was regularly monitored.

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.

MHA documentation was clearly recorded and up to date. Patients' told us they had been fully informed of their rights. Documentation showed that patients regularly had their Section 132 rights discussed.

Consent to treatment paperwork was up to date and accurate. Prescription charts had medication authorised treatment certificates attached to them when required. They were fully completed and correct.

Staff had a good understanding of the Mental Health Act. Staff attended MHA training as part of their mandatory training.

Patients had access to an independent mental health advocate (IMHA) to support them should they choose to appeal their detention. Patients told us staff had fully informed them of their rights.

An audit system was in place to make sure all of the paperwork was up to date and in place.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were able to discuss the characteristics of the Mental Capacity Act (MCA) and the principles of Deprivation of Liberties Safeguards (DoLS).

The Mental Health Act training incorporated the Mental Capacity Act training and compliance was good and in line with the provider's own standards.

We saw from records that patients were involved in making decisions about their care and treatment. This involved making decisions about treatment options.

The hospital manager told us that had been no applications to restrict the liberty of patients, to which safeguards would apply, in the last six months.

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

Good

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good

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

Good

Safe and clean environment

- Staff positioned themselves on the upper floor of the ward to increase observation levels in all areas of the ward, to prevent incidents happening, as the design of the ward meant there were blind spots.
- The provider completed environmental ligature risk assessments twice a year. We saw evidence of a completed comprehensive ligature point audit on inspection. All the windows in the ward were anti-ligature. There were ligature points in nine of the bedrooms; these included bedside lamps with long power cords, doorknobs and wardrobe handles. The provider had refurbished five of the bedrooms to provide minimal risk of ligature. The provider planned to re-furbish two more bedrooms with minimal ligature risk furniture and fittings; however, at the time of inspection this had not been completed.
- All of the rooms were single occupancy and en suite. There were separate male and female corridors, bathrooms and a female only lounge, with appropriate signage displayed.
- The clinic room was clean and tidy. Weekly medication audits took place to identify any issues or shortfalls of stock, although there were copious amounts of medications, which were stored untidily. They were however, locked safely away. The emergency bag with resuscitation equipment was kept in the nursing office and checked weekly. Emergency bag equipment was present and in date, although only three sachets of saline were available, instead of the required four; this had been the case for three months. This meant staff had not dealt with any required actions from the weekly checks. This could have a serious impact if this item was required in a medical emergency. We shared this with the registered manager, who stated this would be addressed immediately.
- There was no seclusion room, which meant patients were not kept away from other people.
- The ward was clean, spacious and well maintained. It was decorated well with appropriate furniture and had a homely feel. The outside area was tidy and landscaped with provision for patients who smoked.
- Handwashing facilities were available and staff had completed infection control training.
- We reviewed the cleaning schedules on the ward; they were in place and up to date.
- Staff carried personal alarms to summon assistance when required.

Safe staffing

- There were establishment levels of eight qualified nurses and 19 healthcare support workers.
- There were nine whole time equivalent qualified nurses employed at the time of inspection and no nursing vacancies.
- There was a vacancy for a clinical lead and a therapy assistant, which the provider had plans to recruit to.
- Staffing levels across all shifts comprised of a minimum of two qualified nurses and two healthcare workers. Staff could increase these levels, dependent on needs of the patients.

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

Good

- Regular bank staff cover shifts when required, mainly due to staff sickness and increased patient observations; they have an induction and handover before commencement of the shift.
- We saw evidence of staff within the communal areas of the unit throughout the day, and patients told us staff had time to spend with them, including one to one time with their named nurse.
- Staff shortages did not affect activities or escorted leave.
- A locum provided medical cover during the day and the consultant psychiatrist provided out of hours cover.
- Ninety five per cent of staff had completed their mandatory training.

Assessing and managing risk to patients and staff

- There were 34 episodes of restraint between 1 March 2015 and 30 September 2015, involving 15 different patients. There had been no episodes of prone restraint (person is lying face down) in the last 12 months.
- Staff rarely used the rapid tranquilisation, although told us they adhered to the policy when needed.
- The ward did not use seclusion.
- We reviewed nine care records; every patient was risk assessed on admission. All records had an up to date risk assessment and risk management plan, and staff updated them accordingly, following incidents and in multidisciplinary meetings. Nursing support could be adjusted dependent on patient need.
- Patients' had a ligature risk assessment completed upon admission. The multidisciplinary team reviewed these weekly during their stay; patients with identified risk of self-harm utilised the ligature free rooms.
- Informal patients were able to leave the building when they wanted and staff provided information explaining their rights.
- Patients were searched on admission in accordance with the policy, or when staff had a concern that a patient had an item of contraband, or there was an identified risk.
- Restraint was rarely used and only as a last resort following de-escalation techniques.
- Seventy eight per cent of clinical staff had trained in safeguarding adults to level three. The manager had booked staff in for training in the forthcoming weeks. The provider had plans for an additional staff member to attend a 'train the trainer' course, which meant that safeguarding training for staff would become more easily accessible. A safeguarding policy was in place. Staff knew how to make a safeguarding referral if necessary. The provider had made 17 safeguarding referrals from August 2015 to January 2016.
- Medicines were kept safe in a locked clinic room, although this was over stocked and not kept tidy. A pharmacist attended the unit weekly and checked medicine charts. The pharmacist did not attend multi-disciplinary meetings, but was available to patients on the day of his weekly visits. A pharmacist is available out of hours when required. We reviewed nine medicines charts. Prescriptions were legible, signed, dated and within British National Formulary (BNF) dosages. However, identified errors on prescription charts had not been actioned; we reported this to staff on the day of inspection. Recording of fridge temperatures were within normal range and completed regularly.
- There were rooms available for children to visit patients if appropriate.

Track record on safety

- There had been three serious incidents from January 2015 to January 2016.
- The local safeguarding authority and the police were investigating allegations against a former member of staff, which the provider had reported to them. There was a record of communication with the alleged victim and other agencies. This incident was ongoing at the time of the inspection.

Reporting incidents and learning from when things go wrong

- Staff knew how to recognise and report incidents and were confident at recording them on the provider's reporting system.
- Staff understood duty of candour and told us they had been open with patients, and explained when things had gone wrong.
- Senior staff attend monthly clinical governance meetings, and relevant learning is feedback to staff via supervision and meetings.
- An episode of uncertainty amongst the staff group regarding the transfer of detained patients to acute hospitals for medical care had prompted learning. The transfer had caused a delay in treatment; learning centred on understanding of the Mental Health Act and first aid following patient self-harm.

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

Good

- There was a protocol in place for debriefs following serious incidents and staff accessed this when required.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed nine care records; all contained an up to date and comprehensive admission assessment.
- Care plans were present, up to date, personalised, and holistic and contained a full range of individual needs. There was good recording of patient involvement and patient views.
- A psychiatrist and mental health nurse assessed patients on admission.
- A physical health assessment was completed on admission, including malnutrition screening and a falls risk assessment. There was evidence of ongoing physical care where needed.
- All patient information was stored securely within the nursing office and was accessible to staff. The provider was using Care notes, an electronic patient records system.

Best practice in treatment and care

- The provider followed National Institute for Health and Care Excellence (NICE) guidelines when prescribing medication. We saw evidence of this when we looked at medication charts.
- A full time therapist was in post and provided both group and individual sessions to patients, including Cognitive Behavioural Therapy.
- There was evidence of ongoing physical health care where needed.
- The medical staff carried out an audit of patient notes, for those commencing anti-psychotic medication in order to improve holistic care and ensured patients were involved in decisions about medications and had understanding of their treatment plan. There were other audits in place at the time of inspection; these included risk assessments, restrictive practice, safeguarding and physical healthcare monitoring.

Skilled staff to deliver care

- A wide range of professionals worked within the team. This included doctors, nurses, healthcare support workers, and a therapist. They were recruiting a therapy assistant. The medical team consisted of a locum consultant psychiatrist, who was familiar with the service, and a staff grade doctor. The provider had advertised two part time consultant posts to fill the consultant vacancy currently covered by a locum. The therapist is able to offer CBT and all clinical staff have had 'introduction in CBT training'.
- Appropriate numbers of trained and experienced staff covered shifts.
- Although there were no records to confirm if staff received supervision, staff said they accessed informal supervision monthly. All staff had received an appraisal in the last 12 months. There were no regular team meetings at the time of inspection.
- New starters received a comprehensive induction programme, which ensured they were aware of the provider's values, policies and procedures and mandatory training.
- The provider had changed the service from substance misuse to acute mental health 18 months previously. Staff had not received any specialist training in looking after acutely unwell patients, and some staff did not feel confident in their role.
- The provider had one disciplinary case between January 2015 and January 2016; they were dealing with this in accordance with their policy and in a timely manner.

Multi-disciplinary and inter-agency team work

- Multi-disciplinary meetings took place three times a week. Staff updated patient care records during the multi-disciplinary meetings to reflect change in their presentation or treatment. Patients had the opportunity to attend the meetings.
- Staff carried out patient handovers between each shift, to ensure all staff were up to date with clinical information.
- Referrals came from a wide geographical area; care co-ordinators and other professionals could not always attend ward rounds due to the distance, although were invited. Staff had telephone contact to share information when necessary.

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

Good

- We saw records of meetings about patients' care and treatment that included the attendance of members of the person's family and community psychiatric nurse. This meant that decisions made regarding treatment involved the right people and the hospital was cooperating with other providers.
- Staff had regular discussions with the Clinical Commissioning Groups (CCGs) from the area the patient came from.

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

- Ninety eight per cent of clinical staff had training in the Mental Health Act (MHA); this training was mandatory.
- Staff told us they had a good understanding of the Mental Health Act.
- Consent to treatment paperwork was up to date and accurate. Prescription charts had medication authorised treatment certificates attached to them when required. They were fully completed and correct.
- Staff explained MHA rights to patients on admission and at regular intervals. Patients told us staff had fully informed them of their rights.
- A MHA administrator and an audit system were in place to make sure all of the paperwork was completed correctly, up to date and stored safely on the unit.
- Patients had access to an Independent Mental Health Advocate (IMHA) to support them during their detention.

Good practice in applying the Mental Capacity Act

- Ninety three per cent of all clinical staff had training in the Mental Capacity Act (MCA) and 100% of staff had training in Deprivation of Liberty Safeguards (DoLS).
- One DoLS application was made in September 2015, which had not been upheld. No current DoLS applications were pending.
- Staff we spoke to had an understanding of the five statutory principles of the MCA and 'best interest' decision making.
- The provider had a draft MCA policy and procedure. The policy linked to the current MCA Code of Practice.
- Staff told us it was the doctor's responsibility to formally assess capacity. We saw evidence in the patient notes of capacity assessments made; recording of this was evident on medicine charts.
- There are currently no routine visits from an Independent Mental Capacity Advocate (IMCA); staff told us they could provide one if required.

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

Good

Kindness, dignity, respect and support

- We observed staff interacting with patients in a respectful and caring manner, and discussing activities for the forthcoming day.
- Patients told us staff were kind and responsive to their needs. Staff spent time with them and were supportive when they were distressed.
- Staff demonstrated a good understanding of individual patient need. Patients described staff offering them choice and supporting them when acutely unwell.

The involvement of people in the care they receive

- Staff routinely showed patients around the ward on admission. All the bedrooms had a patient handbook in them detailing information of ward facilities, activities, expectations and ground rules.
- Patients had an active role in the care planning process. All patient records showed that patients had signed and received a copy of their care plan. Care plans were recovery- focused with clear aims and goals to support patients, including their needs and wishes. One patient told us they had been too unwell on admission to be involved in planning their care, staff had respected this choice and the patient became more involved as they recovered.
- Patients had access to advocacy when required and they attend the unit on a weekly basis. Posters and leaflets were visible explaining the role and function of advocacy.
- Families and carers were able to attend weekly multi-disciplinary meetings, with the agreement of patients. Where family members lived a long distance away, the ward had used Skype to involve them.
- Patients attended daily community meetings to receive and provide information. They also received feedback on complaints during these meetings. Patients were asked to complete a service user satisfaction questionnaire at discharge
- Patients were not involved in recruitment.

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

Good

- None of the patients on the ward at the time of inspection had advance statements in place.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

Good

Access and discharge

- Referrals came from a wide geographical area; the hospital worked with NHS staff to coordinate the transfer of people into this hospital, including transferring patients detained under the Mental Health Act. The provider had a care pathway that clearly determined its admission criteria. As the hospital was independent, it needed the agreement of the relevant clinical commissioning groups who contracted the hospital to provide a bed before admission. Staff were able to refuse an admission; they consider whether they are able to safely manage the patient's needs.
- Between 1 March 2015 and 30 September 2015, bed occupancy was 91%. Average length of stay for patients was three to four weeks. Patients were able to access a bed when they returned from leave.
- The hospital manager told us discharges took place during the day, and not out of hours.
- Staff would liaise with the patient's host team if they required a psychiatric intensive care unit.
- There were no delayed discharges at the time of the inspection.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit provided a range of rooms such as a sitting room, clinic area and dining room. There was not an activity room available; the provider had plans to develop this. The main sitting room was being used for all activities.
- Patients had access to quiet areas on the ward. Rooms to meet visitors in private were available.
- The ward telephone was in an open area and was not private; however, patients also have access to their mobile phones.
- Patients had access to a well-maintained garden. Patients said access was flexible, including patients who wished to smoke at night.
- A varied menu was available; patients had choice of the food they ate, and told us that it was good.
- Patients could make hot and cold drinks when they wanted.
- Patients had their own individual bedrooms and were able to personalise their rooms; they felt their possessions were secure and safe.
- Patients were able to attend daily activities. The therapist organised activities and developed two programmes, depending on patient's abilities. Patients told us activities were also available on the weekends. We saw evidence of activities such as arts and crafts, and puzzles on the unit.

Meeting the needs of all people who use the service

- Staff understood, promoted and supported patients and their differences.
- Patients with mobility needs would be able to access the ground floor bedrooms, including other facilities such as bathrooms and day areas.
- Information in other languages and in easy read format was available when required.
- The service provided patients' with welcome packs on admission; information included patient rights, visiting times, how to complain and treatments available.
- A varied menu was available that enabled patients to access a range of food. The service enabled patients with particular dietary needs connected to their religion or individual needs to eat appropriately.
- Patients had access to spiritual support. Staff showed good understanding and awareness of patient's individual needs.
- There were tools available to assist with assessing capacity; these included a checklist, policy, and flashcards for patients who may not be able to read.

Listening to and learning from concerns and complaints

- There had been eleven complaints from January 2015 to January 2016; the provider had upheld five. Four complaints had concerned staff attitude. The provider

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

Good

had responded by ending the probation period of one staff member and stopped using one particular agency worker. No complaints were referred to the ombudsman during this time.

- All patients we spoke with knew how to make a complaint. We found posters, leaflets and information within the admission packs on the wards, informing patients how to raise a concern, complaint or compliment.
- We saw the complaint policy; staff were able to describe the process clearly.

Staff received feedback from complaints. All staff had received appropriate first aid training following a complaint.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Good

Vision and values

- The provider's values were on display across the service. Staff knew and agreed these values and used them to influence care.
- Staff knew who the senior managers were in the organisation and that the senior management team visited recently. Staff felt supported and valued by the hospital manager.

Good governance

- Ninety five per cent of staff had completed mandatory training. Staff were booked onto courses to complete out of date training.
- All staff had an up to date appraisal. Staff told us they received regular supervision although they did not make records of this.
- Records we looked at show that staff report incidents. All staff described what to report, and the processes in place for doing so. We were able to review completed incident forms and what outcomes had taken place as a result.
- Procedures relating to safeguarding, MCA and MHA were widely followed
- The unit used quality performance indicators to monitor performance. These included; care note quality, agency nurse use, sickness rates, mandatory training, incidents, staff turnover, and work related incidents.
- There were numerous audits in place at the time of inspection; these included risk assessments, restrictive practice, safeguarding and physical healthcare monitoring. Audits of patient records ensured they accurately reflected care and treatment provided. Staff would be required to follow any action points.
- We reviewed the risk register. We saw action plans to reduce identified risks, such as whistles given to staff as a precaution if the alarms did not work outside the building.

Leadership, morale and staff engagement

- Staff sickness was low at 2.3%, which meant there were sufficient staff on shift.
- There were no current bullying and harassment cases.
- Staff said that they would feel comfortable to raise concerns without fear or victimisation.
- Staff we spoke with said morale was generally good, and were aware of their responsibilities.
- Staff told us managers informed them about developments within the organisation.
- Staff had opportunities for leadership development. Health care support workers were encouraged to consider formal nurse training.
- Team working was positive and staff felt they mutually supported each other. The team felt supported by senior managers.
- Staff were able to feedback into their service via staff surveys. There were no regular team meetings at the time of inspection; staff told us they would like to participate in these.

Commitment to quality improvement and innovation

- The provider was not participating in any national quality improvement programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that supervision records are completed in order to ensure staff are being supported and issues are identified in a timely manner.
- The provider should ensure that stock is replaced following checks on emergency equipment.
- Staff should be provided with specialist training to meet the needs of patients' on an acute ward.