

# The Priory Hospital Dewsbury

## 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?

Are services caring?

Are services well-led?

#### 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 found that:

- Staff managed medicines safely. The hospital had improved medicines management arrangements as robust arrangements were in place. This meant that

# Summary of findings

staff administered medicines as prescribed. The hospital had accurate and up to date records for medicines in stock. Staff regularly checked dates to make sure they were safe to use.

- The provider had systems in place to monitor the side effects of anti-psychotic medicines. This meant if patients had any adverse effects from anti-psychotic medication, appropriate action was taken including alterations made to the dosage or frequency or alternative medication sought. Where patient's self-administered medicines the appropriate risk assessments were in place.
- We observed kind and compassionate interactions between staff and patients. Staff were motivated and had good morale. Patients told us that they were happy with the care they received and thought staff were caring.
- The provider had systems, processes and audits in place to effectively monitor the running of the service and identify any risks, themes and trends.

At this inspection all the actions we told the provider it should take had been completed as follows:

- Staff completed ligature audits with the appropriate scoring. This was in line with the provider's policy. Ligature cutters were easily accessible within the staff office. The service had implemented additional safeguards by conducting ligature training drills so staff would be prepared in the event of patient ligaturing.
- Staff updated risk assessments after incidents had occurred and they completed care records with patients. These included direct quotes and comments from the patient.
- The provider had removed some of the locked doors in the patient areas, for example, the quiet lounge. However, we found that locked doors remained on the skills kitchen, laundry room and areas not accessible to patients.
- The hospital staff communicated to patients of any changes happening to within the hospital including building work. This was facilitated through the patient meetings.

# Summary of findings

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# The Priory Hospital Dewsbury

**Services we looked at**

Long stay/rehabilitation mental health wards for working-age adults; Neurodegenerative Ward

# Summary of this inspection

## Background to The Priory Hospital Dewsbury

The Priory Hospital Dewsbury is an independent mental health hospital that provides care and treatment for up to 32 patients. The hospital has two wards.

Hartley ward is long stay rehabilitation ward for adults of working age. The ward provides care and treatment for up to 22 patients, which includes an independent living area that has 10 beds. This ward provides care and treatment for patients with complex mental health needs including multiple diagnoses. This includes mental health issues with substance misuse and mental health issues with physical health needs.

Jubilee ward provides care and treatment for up to 10 patients. This was an ageless ward specialising in dementia. This ward offers care and support for patients living with neurodegenerative conditions, such as, Huntington's disease, Parkinson's disease and Alzheimer's disease.

The Priory Dewsbury is registered with the Care Quality Commission to carry out the following regulated activities:

- Treatment of disease, disorder or injury.
- Assessment and treatment for persons detained under the Mental Health Act 1983.

We last inspected The Priory Dewsbury in November 2015. At this inspection the Jubilee ward a learning disability ward. Since that inspection Jubilee ward closed and was reopened in August 2016 to specialise in dementia care. We rated the service as overall 'Requires Improvement' after our inspection in November 2015.

## Our inspection team

**Team Leader:** Hamza Aslam, Inspector, Care Quality Commission

The team that inspected The Priory Dewsbury comprised of three people: one inspector, one pharmacist inspector and a mental health nurse specialist advisor.

## Why we carried out this inspection

We undertook this inspection to find out whether the Priory Hospital Dewsbury had made improvements to their hospital since our last comprehensive inspection in November 2015.

When we last inspected The Priory Dewsbury hospital in February 2016, we rated The Priory Dewsbury as requires improvement overall. We rated inadequate for Safe, and requires improvement for Effective, Caring, Responsive and Well-led domains.

Following that inspection we told the hospital that it must take the following actions to improve:

The provider must ensure medication administration systems are robust.

- The provider must ensure they have an accurate and up to date record of medication stored on each ward.
- The provider must ensure patients are able to have their medication when on unplanned leave
- The provider must ensure medication is administered as prescribed.
- The provider must check medication is not out of date
- The provider must ensure there are risk assessments completed for medication to be self-administered
- The provider must ensure the monitoring of the side effects of anti-psychotic medication is carried out.
- The provider must update patient records to reflect decisions made during multi-disciplinary team meetings.

# Summary of this inspection

- The provider must ensure physical health checks are carried out including blood sugar monitoring, electrocardiograms and monitoring of cholesterol levels.
- The provider must ensure patients are informed of all changes, for example refurbishment which impacts on their care, privacy and dignity.
- The provider must ensure patients are treated with dignity and respect at all times.

We also told the hospital that it should take the following actions to improve:

The provider should ensure ligature risks are assessed accurately.

- The provider should ensure where possible all ligature risks are mitigated.
- The provider should ensure ligature cutters are accessible to all staff at all times.
- The provider should ensure that rooms containing patient data are locked at all times.

- The provider should ensure risk assessments are updated after incidents occur.
- The provider should ensure patients are involved with risk assessments.
- The provider should ensure rotas reflect the actual staff on duty.
- The provider should ensure office doors are locked to ensure patient information is secure.

We issued the location with two requirement notices. These related to:

- Regulation 12 of the Health and Social Care Act (Regulated Activity) Regulations 2014, 'Safe Care and Treatment' 12 (2) (a) (g),
- Regulation 10 of the Health and Social Care Act (Regulated Activity) Regulations 2014 'Dignity and Respect' 10 (1).

During this inspection we found that the provider had taken action required to address these concerns.

## How we carried out this inspection

On this inspection, we assessed whether the hospital had made improvements to the specific concerns we identified during our last inspection. We did not re-rate the hospital because this inspection was over six months since the publication of the last inspection report. In addition the service we inspected was different to the service inspected in November 2015, since our last inspection there was an addition of a dementia ward, and the closure of one of the rehabilitation wards.

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- spoke to four patients using the service
- spoke to one carer
- reviewed five patients' care and treatment records
- interviewed the registered manager
- spoke to six other members of staff including a nurse, health care assistant and doctor.
- carried out a specific check of medication management and reviewed ten medication charts
- looked at the quality of the physical environment and observed interactions between staff and patients
- looked at a range of policies, procedures, audits and other documents relating to the running of the service.

## What people who use the service say

We spoke to four patients during our inspection. All patients provided positive feedback about the care and treatment that they received. They told us they looked

forward to having leave from the hospital to access the community. They also told us that staff were caring. One patient described his treatment at the hospital as "good" and another said it was "happy days".

# 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?

We found the following areas of good practice :

- Medicines charts were up-to-date and clearly presented to show the treatment people had received. Records contained the relevant legal authorities for treatment and nursing staff completed regular monitoring.
- Staff stored medicines safely. Wards had emergency medicines available for use if needed.

### Are services effective?

We found the following areas of good practice :

- Staff were routinely completing physical health checks for all patients, and they were clearly documented on the patients care records.
- All patients who were on anti-psychotic medication completed a side effect monitoring tool to see if they reported any adverse effects from medication.

### Are services caring?

We found the following areas of good practice :

- We observed staff delivered kind and compassionate care to patients. Staff had developed positive relationships with patients and this was evident in their interactions.
- Patients gave positive feedback about their care and treatment at the hospital. They told us they were happy with how staff treated them and they looked forward to having leave.

### Are services well-led?

We found the following areas of good practice :

- The hospital had systems and processes in place to effectively monitor staff performance. Senior management had oversight on key performance indicators, themes and trends of incidents, supervisions, appraisals and training.
- The hospital had a local risk register which staff could input areas of risk, this fed into a wider organisational risk register. Staff reviewed the risk register at governance meetings.

# 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.

## Mental Capacity Act and Deprivation of Liberty Safeguards

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



# Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Well-led	

## Are long stay/rehabilitation mental health wards for working-age adults safe?

### Safe and clean environment

The Priory Hospital Dewsbury had two locked wards. These were accessed through a main entrance and then via a courtyard and garden area. Entry to the wards was controlled by a key fob entry system. There was clear signs at the exit of each ward for patients who were able to access unescorted leave on how they could do this.

We looked at the facilities on both wards and found they were clean and well maintained. We looked at the cleaning records for October 2016 and we saw that domiciliary staff updated the cleaning records daily. The main lounge area was the central point of each ward and each ward had one wing where the patient bedrooms were situated. On Hartley ward, there was an additional wing for up to 10 patients who could live more independently, this area had its own lounge and skills kitchen. All the bedrooms were en-suite. There were blind spot risks in some areas of the main ward however, these were mitigated due to the number of staff and staff completed regular observations in communal areas. The activity rooms and telephone room had large windows that staff could look into. Patients could only access the clinic room with a member of staff present.

At our inspection in November 2015 we found the service had not assessed potential ligatures risks in line with the provider's policy. A ligature point is anything which could be used to attach a cord, rope or material for the purpose of hanging or strangulation.

During this inspection, we found the service had re-assessed the ligatures appropriately. In addition the service had taken action to increase staff confidence in responding to incidents regarding ligaturing. The service had regular training timed drills where a life size dummy was placed in a simulated ligature incident and staff were

assessed in their response. The response was captured by assessors and staff received a debrief, learning was shared of how staff could improve. In the last debrief staff identified the weight of the dummy was not life like and too light. There were discussions on how to make the scenarios more realistic. Ligature cutters were available and clearly signposted in the staff office.

All staff carried alarms on their person; there were locator boxes placed throughout the wards. This meant if an alarm was sounded staff knew where in the hospital to respond. During the inspection a member of staff called for assistance by using their alarm and we saw a prompt response from staff from different parts of the hospital attending to assist.

During our last inspection we found the provider did not adhere to safe medication management in line with best practice. However, on this inspection we found medicines were kept securely and only accessible to staff authorised to handle medicines. There was a comprehensive checklist completed by a qualified nurse. This included stock levels, consent to treatment documentation and clinic room checks. Where audits identified concerns, we saw that staff took action to address them. We saw that the temperature of the medicines refrigerator and room were regularly monitored. Appropriate facilities were in place for the safe disposal of medicines. Staff completed checks of emergency medicines to ensure they were available if needed. There were appropriate arrangements for the management of controlled drugs. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

### Assessing and managing risk to patients and staff

Between May and October 2016 The hospital reported 135 reported incidents, of these, 32 were incidents of physical restraints. This meant that staff were successfully able to

# Long stay/rehabilitation mental health wards for working age adults

manage 77% (103) incidents through verbal de-escalation. The most common incidents were patients verbally abusing each other, or attempting to physically abuse each other.

The hospital did not use prone restraints. Prone restraints also known as 'face down restraints' can result in compression of the chest and airways and put the person being restrained at risk. The hospital does not have seclusion facilities. There were no reported episodes of seclusion.

We reviewed five patients' risk assessments and found they were comprehensive. Patients had individual risk assessments attributing to different parts of their care, for example, one patient had a risk assessment for his diabetes. This outlined his condition, allergies to medication, it outlined how regular physical observations were required, foods recommended, and foods they should avoid. All patients who were self-medicated had risk assessments which outlined what stage of self-medication they were at and how they administered their medication. At the bottom of each risk assessment staff documented which best practice or guidance was being used to inform decisions.

During our last inspection we found concerns relating to medication management within the hospital. The hospital have improved their medication management and now met the regulation they previously were in breach.

Staff had a detailed understanding of safe medicines management and training for staff had been provided since our last visit. The provider had reviewed medicines policies. These included local medicines arrangements and covered all aspects of medicine management.

We reviewed 10 patients' prescription charts. We found that staff completed these records accurately. The prescription charts were up-to-date and clearly presented to show the treatment people had received. Some patients in the service were receiving antipsychotic treatment above British National Formulary limits. This can increase risks for the patient as it is above the recommended guidance limits. We found that these risks were monitored through additional physical health monitoring. The hospital completed physical health monitoring regularly. Where required, the relevant legal authorities for treatment were in place and nurses checked these when administering medicines.

Therapeutic drug monitoring was completed and recorded for patients receiving medication such as Clozapine that requires close monitoring. Monitoring is important to ensure people are physically well and that they receive the most benefit from their medicines.

Where staff prescribed medicines for patients 'as and when required', we saw that they were fully listed on the prescription chart. Information was available on the medical condition for which the medicine was prescribed. However, for two people on Jubilee ward this guidance was not person centred and the interval between doses was not specified. We brought this to the attention of the doctor at our visit who took immediate action to rectify this.

Where patients had medicines administered covertly (hidden) we saw that appropriate assessments were completed. A best interests decision had been made for the patient, this had been done with all the involvement of family and the professionals involved in the patients care. We found the staff did not document clearly how the medication would be administered. This information would help to ensure people were given their medicines safely and consistently. Staff clarified the care records after we brought it to their attention.

Some patients managed their own medications under the supervision of a nurse, staff discussed patients' progress at multi-disciplinary team meetings, and a risk assessment was in place. Since our last inspection, the provider had implemented a system for supplying medicines for unplanned leave. This meant that patients' medicines needs were met whilst away from the hospital.

Staff were aware of their responsibilities of safeguarding adults and children. This was embedded as part of their mandatory training. If staff were unclear on how to deal with concerns they told us that they felt comfortable to go to senior staff to discuss their options. We saw that there were safeguarding posters around the hospital with flow diagrams on what actions to take.

**Are long stay/rehabilitation mental health wards for working-age adults effective?**  
(for example, treatment is effective)

**Assessment of needs and planning care**

# Long stay/rehabilitation mental health wards for working age adults

We looked at five patients' care and treatment records and found staff completed comprehensive and timely assessments after admission. All patient records were held electronically and were securely stored on an electronic patient record system. Staff had unique login and passwords to access records. The care records held individualised information to enable staff to provide patients with personalised care. Care plans were holistic, person centred and detailed. Patient records were regularly updated after multi-disciplinary meetings and reflected patient comments.

During our last inspection we found there were inconsistencies in physical health monitoring and that anti-psychotic side effect monitoring was not completed. During this inspection, we found that patients were now receiving regular monthly physical health checks. This included the monitoring of bloods, blood pressure, height and weight. This meant the hospital increased their monitoring of the patients' physical health and could respond to concerns in a timely manner. Staff updated care records appropriately to reflect if patients refused to have physical observations undertaken.

Staff completed a side effect monitoring tool with all patients who were prescribed anti-psychotic medication. This meant staff could monitor if patients reported to experience any symptoms or side effects of taking anti-psychotic medication and appropriate changes to dosage could be made. The hospital used a side effect tool developed by a local pharmacy who works in partnership with the hospital. Although it was an unrecognised tool, the hospital director told us it had been modified using the Liverpool University Neuroleptic Side Effect Rating Scale (LUNSARS). The LUNSARS is a nationally recognised tool to monitor side effects of anti-psychotic medication. She said the new tool was simplified and staff found patients understood and engaged with the tool more effectively.

## Are long stay/rehabilitation mental health wards for working-age adults caring?

### Kindness, Dignity, Respect and Support

During our last inspection we found staff did not always treat patients with kindness, dignity and respect. However, during this inspection we observed staff delivering kind

and compassionate care. Staff were attentive to patients and engaged in activities. We saw one example of a member of staff supporting a patient to read a newspaper by reading articles alongside the patient and discussing the content. It was evident staff had built positive relationships with patients and was reflected within the interaction. Staff were very motivated during their interviews and were keen to tell us how the hospital had embedded person centred care at the heart of daily practice.

We spoke to four patients in the hospital all of whom spoke positively about the care and treatment they received. They said they received regular leave and they looked forward to it. One patient said they were "happy" at the hospital and another patient said they liked the staff that were involved in their care, in particular their doctor.

## Are long stay/rehabilitation mental health wards for working-age adults well-led?

### Good Governance

The hospital had systems and processes in place to effectively monitor staff performance. Senior management had oversight on key performance indicators, themes and trends of incidents, supervisions, appraisals and training. During our last inspection we found the hospital did not have audit procedures in place to manage medication effectively. The hospital now had systems in place to assure themselves that medicines were being managed safely. The hospital had a contractual arrangement with an external pharmacy to provide medicines for all patients. A pharmacist did not work onsite. However, the service received support from pharmacy staff who undertook audits of medicine cards across the hospital. Audits showed the hospital complied with proper and safe management of medicines. Where there were issues identified in the audits, these were addressed through actions taken. For example, one audit highlighted that allergy information for one patient on one ward was missing from the medicines chart; staff addressed this once we brought it to their attention. The pharmacist also provided support and advice and attended the monthly medication management meeting.

There were regular meetings for staff and patients to feedback about the service and things they would like to

# Long stay/rehabilitation mental health wards for working age adults

see different. Staff had a board in their staff room where they could make suggestions, and had regular lunch meetings with the hospital director where staff could discuss issues informally. Patients had monthly 'patient meetings' to explore how care was being delivered to them

and how things could be improved. We saw one example where the chef arranged a meeting to discuss what types of food patients would like. The outcome of the meeting showed patients would like more variety in their cuisine.

There was a local risk register which staff could input areas of risk, this fed into a wider organisational risk register. These were reviewed at governance meetings.