Partnerships in Care Limited

Priory Hospital Arnold

Inspection report

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Date of inspection visit: 9 March 2021, 10 March 2021, 11 March 2021, 12 March 2021, 16 March 2021
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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	Inadequate
Are services safe?	Inadequate
Are services well-led?	Inadequate

Summary of findings

Overall summary

The Chief Inspector of Hospitals, Ted Baker, is placing Priory Hospital Arnold into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Priory Hospital Arnold is provided by Priory Healthcare Limited and registered with the CQC 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

• Diagnostic and screening procedures

The hospital offers two acute mental health wards for men and women on Newstead and Bestwood Wards and a psychiatric intensive care unit on Rufford Ward for women and for men on Clumber Ward. Rufford Ward opened in May 2020 and Clumber Ward opened in November 2020.

There were 16 beds on each of Bestwood and Newstead Wards which were commissioned by Nottinghamshire Healthcare NHS Foundation Trust and 10 beds on Rufford Ward. There were 10 beds on Clumber Ward, five of which were commissioned by Forward Thinking Birmingham and the other five beds could be spot purchased.

There have been 16 previous inspections to Priory Hospital Arnold. The latest was a follow up inspection in October 2020 following information of concern about Newstead and Bestwood Wards. We only looked at parts of the Safe and Well led key questions and did not rate the hospital. We last rated the hospital following our inspection in October 2019 as requires improvement overall, inadequate for safe and requires improvement for effective, caring, responsive and well led.

Before this inspection we received information of concern from anonymous contacts about Rufford and Clumber Wards and complaints raised by patients on Rufford Ward. We were told that inappropriate restraint and seclusion was used, staff were not clear about how to report safeguarding concerns and felt scared to report, the staff alarm system was not working and the maintenance and cleanliness of wards was poor.

We visited Rufford and Clumber Wards unannounced on the evening of 9 March 2021. We spoke with patients, their carers, and staff by telephone from Rufford and Clumber Wards between 10 to 12 March 2021 and visited Newstead and Bestwood Wards unannounced on 16 March 2021.

This was a focussed inspection and we inspected the Safe and Well led key questions only.

Summary of findings

We rated Safe as Inadequate and Well Led as Inadequate and Priory Hospital Arnold as Inadequate overall.

At this inspection we found:

- The wards were not safe, clean, well equipped, well-furnished or well maintained.
- The provider had not ensured all staff were confident to use the alarm system to summon help in an emergency. This meant some staff did not respond to the alarms or did not know the type of incident they were responding to.
- The service did not have enough nursing staff, who knew the patients well.
- Staff did not always follow the providers infection control procedures.
- Staff did not always assess and manage risks to patients and themselves well. The provider had not fully assessed ligature risks and taken action to reduce them.
- Leaders did not demonstrate they had the skills to perform their roles and ensure the safety of patients and staff.
- Our findings from this inspection demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not well managed.

However:

- All staff including agency staff received basic training to keep patients safe from avoidable harm.
- Staff used restraint and seclusion only after attempts at de-escalation had failed.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- Staff had access to clinical information on the providers electronic records system and verbally handed over information about patients risks between each shift.
- Staff recognised incidents and reported them appropriately.
- The majority of staff told us they could raise concerns without fear of retribution and would do so.
- Some staff told us they felt respected, supported and valued.

Following the inspection on 9 March 2021 we served an enforcement notice requiring the provider to take urgent action to keep patients safe. We required action to ensure infection control processes were in place to minimise the risks of cross infection and to assess and reduce ligature risks across the hospital.

Following the inspection on 16 March 2021 we imposed conditions to prevent admissions to the hospital and required the provider to take action to assess and reduce ligature risks. The provider responded to these within the required timescales. The provider also made a decision to close Clumber Ward temporarily which increased the staffing on the other three wards.

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	Inadequate 	• The wards were not safe, clean, well equipped, well-furnished or well maintained. The provider did not assess and manage risks to the environment and equipment. Repairs to equipment and the environment were not made in a timely manner. • The provider had not ensured all staff were confident to use the alarm system. This meant some staff did not respond to the alarms or did not know the type of incident they were responding to. • The service did not have enough nursing staff, who knew the patients well. • Staff did not always follow the providers infection control procedures and anti-bacterial gels and wipes were not always available. • Staff did not always assess and manage risks to patients and themselves well. The provider had not fully assessed ligature risks and taken action to reduce them. • Leaders did not demonstrate they had the skills to perform their roles and ensure the safety of patients and staff. • Our findings from this inspection demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well. However: • All staff including agency staff received basic training to keep patients safe from avoidable harm. • Staff used restraint and seclusion only after attempts at de-escalation had failed. • Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. • Staff had access to clinical information on the providers electronic records system and verbally handed over information about patients risks between each shift.

Summary of findings

- Staff recognised incidents and reported them appropriately.
- The majority of staff told us they could raise concerns without fear of retribution and would do so.
- Some staff told us they felt respected, supported and valued.

Summary of findings

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Summary of this inspection

Background to Priory Hospital Arnold

Priory Hospital Arnold is provided by Priory Healthcare Limited and registered with the CQC to provide the following regulated activities:

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There have been 16 previous inspections to Priory Hospital Arnold. The latest was a follow up inspection in October 2020 following information of concern about Newstead and Bestwood Wards. We only looked at parts of the Safe and Well led key questions and did not rate the hospital. We last rated the hospital following our inspection in October 2019 as requires improvement overall, inadequate for safe and requires improvement for effective, caring, responsive and well led.

Before this inspection we received information of concern from anonymous contacts about Rufford and Clumber Wards and complaints raised by patients on Rufford Ward. We were told that inappropriate restraint and seclusion was used, staff were not clear about how to report safeguarding concerns and felt scared to report, the alarm system was not working and the maintenance and cleanliness of wards was poor.

How we carried out this inspection

This was a focussed inspection and therefore our inspection activity focussed on the Safe and Well led key questions.

Due to the Covid-19 pandemic, we conducted patient, carer and staff interviews by telephone. A small inspection team visited Rufford and Clumber Wards unannounced on the evening of 9 March 2021. Two inspectors visited Newstead and Bestwood Wards unannounced for one day on 16 March 2021 to look at areas that could not be inspected remotely. In total four CQC inspectors, one CQC inspection manager, an Expert by Experience with experience of using mental health services and one specialist professional advisor, a nurse with experience of working on psychiatric intensive care units, contributed to this inspection.

During the remote part of this inspection we completed telephone interviews with patients, staff and family/carers and reviewed a range of policies, procedures and other documents relating to the running of the hospital. During the site visit we visited all four wards to look at the environment and reviewed the care and treatment records of patients.

Summary of this inspection

During this inspection, the inspection team:

• spoke with 12 patients who were using the hospital.

• completed telephone interviews with five family members/carers.

• completed telephone and face to face interviews with 22 staff members including nurses, support workers, psychologist, and occupational therapist.

• looked at the quality of the hospital environment.

• looked at three patient care and treatment records.

• looked at a range of policies, procedures and other documents relating to the running of the hospital.

• received three completed comment cards from patients and five from staff members.

Areas for improvement

- The provider must assess all ligature risks and mitigate the risks.
- The provider must train all staff in ligature risk management.
- The provider must ensure that all staff follow infection control procedures at all times and anti bacterial gel and wipes are provided.
- The provider must ensure that all staff are trained in how to care for patients admitted to psychiatric intensive care units.
- The provider must ensure that safe staffing levels are maintained on all wards at all times.
- The provider must ensure that all wards and equipment are clean, safely maintained and in good working order.
- The provider must ensure that audits and governance systems fully assess and identify risks to patients and staff and improvements are made as a result.

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	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate
Overall	Inadequate	Not inspected	Not inspected	Not inspected	Inadequate	Inadequate

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

Inadequate

Safe	Inadequate
Well-led	Inadequate

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

Inadequate

The wards were not safe. At our first inspection on 9 March 2021 on Rufford and Clumber Wards we saw that wards were dirty. The bath on Clumber Ward appeared to not have been cleaned since its last use. We saw toilets had not been cleaned and were full of urine and faeces. On Rufford Ward we found ants on the entrance into the seclusion room. We found all three seclusion rooms were dirty and had what appeared to be blood, faeces and dried food and sputum on the floors and walls. Patients told us the seclusion rooms were dirty. Patients said that cleaners cleaned their bedrooms weekly and their bedrooms were often dirty. Three staff told us that cleaners were on the ward daily and then other staff did more cleaning at night but there was not always time to do this. We saw that there was graffiti on walls and furniture in both Rufford and Clumber Wards as well as in the shared seclusion room. Six patients told us there was graffiti everywhere. We found a bag of what appeared to be urine in the bathroom on Clumber Ward, no staff knew who it belonged to, how long it had been there or why it was there. Following our inspection, the registered manager told us that this bag had been handed to ward staff by ambulance staff for disposal as a patient had needed to pass urine on their way to the hospital the weekend before. Staff had forgotten to dispose of it and staff had not seen it on the daily health and safety checks. In Clumber Ward seclusion room, we found 'strong wear' (clothing provided to prevent a person from using clothing to tie a ligature) in a heap in a cupboard in the staff observation area. It was not clear if this had been worn by a patient and so could put patients at risk of cross infection. Following our inspection on 9 March 2021 the provider employed contract cleaners to deep clean all wards. We observed that the wards were cleaner during our inspection on 16 March 2021 and the contract cleaners were deep cleaning some bedrooms.

Staff did not always follow the providers infection control procedures. At our inspection on 9 March 2021, we found the hand gel dispenser on the entrance to Rufford Ward was empty. On both wards, we observed 10 to 12 staff attending the handover meeting between shifts within one room. Staff were not able to socially distance due to limited space, this meant there was an increased risk of cross infection. On 16 March 2021 we saw that there were notices on each door to indicate the maximum amount of people allowed. Staff told us that handovers were split into two meetings as only six people could be in the rooms at a time. On 9 March 2021, we observed on both wards that no staff were carrying hand gel, hand gel was available only in the nurse's office. We observed that no staff wiped computer keyboards or phones after use and there were no antibacterial wipes available to do this to prevent cross infection. The bins containing soiled personal protective equipment that staff disposed of following care of a patient who tested positive for COVID-19 were overflowing, and there were gloves and masks on the floor. The provider had addressed these issues at our inspection on 16 March 2021.

The wards and equipment provided were not well maintained. Ten staff we spoke with told us about problems with the staff alarm system. Staff said there was a 30 second delay from pulling their alarm to it sounding. The alarm did not detail the type of incident and response required, for example, assistance with restraint or life support. Staff said they use the radios as back up to inform staff responding as to the type of incident. Staff told us that there were many false

alarms, so staff sometimes ignored the alarms. Staff sometimes forgot to reset it and therefore it became a familiar background noise that staff did not always respond to when required. At the time of our inspection the provider was retraining staff in how to use the alarm system. On 16 March 2021 engineers were on site installing panels so that staff could clearly see which ward the alarm was on.

On Clumber Ward on 9 March 2021 the washing machine in the laundry room was broken. The provider replaced the washing machine the following day. We found red bags (soiled items) piled to the top of the laundry container within the room. Staff told us that they took the laundry through the hospital to the main laundry including the soiled items from the patient who had tested positive for COVID-19. On 16 March 2021 on Newstead Ward staff and a patient told us that the tumble dryer had not worked for several months and they had to take drying to other wards or the main laundry. In the clinic room in Clumber Ward we found the weighing scales were broken and the electronic thermometer, blood pressure machine and pulse oximeter had not been calibrated. This could mean there were false readings of patients' physical health observations. On Rufford Ward patients had taken pictures off walls and these had not been replaced. The provider had started to repaint the walls but doors that had been removed on the dining room and de-escalation room had not yet been replaced. A screen was used to provide privacy when patients used the de-escalation room.

The service had enough nursing and medical staff but some of the nursing staff did not know the patients as they were agency staff. The provider told us on 30 March 2021 there were vacancies for 18 registered nurses but two of these posts had been recruited to. There were 17.5 healthcare support worker vacancies but 13 of these posts had been recruited to. The provider said all agency staff had received an induction and training. Staff told us that agency staff often cancelled their shifts therefore leaving shifts short of staff. However, the introduction of a senior manager from 6am across the hospital had improved the staffing numbers as they were able to authorise cover for shifts cancelled. The provider told us in February 2021 there were 55 shifts that were not filled, this was a decrease from 74 in December 2020 and 64 in January 2021. Patients told us that there were too many agency staff who did not know them well although there was always staff to help. However, one patient said that when there were incidents happening on the ward there were no staff available to talk with which made them feel unsafe. Six staff members told us that they often missed their breaks due to staff shortages and would spend over five hours at a time observing patients without a break. This meant that they may lose concentration and miss risks that patients posed such as attempting to self-harm. In one patient's seclusion records on 6 March 2021 on Clumber Ward staff had recorded that they were unable to check the patient's physical health observations due to "low staffing levels."

There were only two occupational therapists for four wards as one therapist was on maternity leave and had not been replaced. There were three wellbeing staff for four wards as there was one vacancy. They organised activities for patients and we saw them playing badminton with patients and supporting them to go to the hospital shop. Patients and their relatives told us that activities were limited which meant they were often bored.

Staff did not assess and manage risks to patients and themselves well and had not identified and taken action to reduce ligature risks. On 9 March 2021 we found corners on bathroom doors and bathroom panelling, gaps in beading on storage units and gaps in the windowsills in the seclusion room which could be used as ligature anchor points. On 16 March 2021 we found the provider had not addressed these and we also saw a wardrobe door in a bedroom on Bestwood Ward. Managers were not aware of this door and this had not been highlighted as a ligature risk in previous ligature audits. In one patient's seclusion records we saw that the patient was able to try to tie a ligature with his underwear during the seclusion and staff did not offer him "strong wear" to reduce this risk. The patient also had a button which they tried to put in their mouth and staff had not removed this prior to the patient being secluded.

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

Inadequate

The provider previously notified us of the death of a patient on Newstead Ward last year after tying a ligature. Following this death, the provider identified a risk from the ensuite doors on Newstead and Bestwood Wards and replaced these. However, our findings from this inspection show that they have not fully assessed all ligature risks and taken action to reduce these as learning from this incident.

Staff received basic training to keep patients safe from avoidable harm but not all staff had experience of working with patients on psychiatric intensive care units. Staff told us that they had two weeks of training before working on the psychiatric intensive care units and the provider confirmed this. However, staff said this had not fully prepared them to meet the needs of patients if they had not had previous experience. They said they did not have opportunities in supervision with their manager to raise the concerns they had about their lack of experience.

Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff and patients told us that restraint was only used when verbal de-escalation had failed and was for the minimum amount of time. The provider told us that over the last six months there has been a decrease in the number of restraints on Bestwood, Clumber and Newstead Wards. In February 2021 there were 19 incidents on Bestwood Ward, seven on Clumber Ward and one on Newstead Ward where restraint was used. However, there were 75 incidents on Rufford Ward. This was due to an increase in incidents where patients had self-harmed so staff had intervened to try to prevent this.

Staff and patients told us that oral medication was offered to patients and rapid tranquilisation was only used as a last resort. We observed this during our inspection on Rufford Ward. Staff spent time with a patient talking with them and trying to offer them alternatives to rapid tranquilisation. The provider told us there has been a general increase in the use of rapid tranquilisation over the last six months due to the change in acuity at the hospital.

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff told us there were Safeguarding Champions on each ward. These were staff who had received further training in safeguarding and advised other staff on what and when to report to the local authority. The provider had monthly meetings with the local authority safeguarding team to discuss incidents involving patients and what action was needed to safeguard patients from harm.

Staff had access to clinical information about patients. Staff told us they could access patient electronic records and patients' risks were handed over in shift handover sessions. We observed this on the handover from the day to night shifts on Clumber and Rufford Wards.

We did not look at the systems and processes to prescribe, administer, record and store medicines at this inspection.

Staff told us they knew how to report incidents and reported them appropriately. They said that managers shared lessons learned with the whole team and the wider service. Three staff members told us they always had a debrief following an incident and three staff members told us they did not have debriefs. Staff who said they had debriefs said these were verbal and not formally recorded.

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

Inadequate

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

Inadequate

Leaders did not demonstrate they had the skills, knowledge and experience to perform their roles. Our findings from this inspection showed that managers had not taken action to ensure the environment was safe for the patients.

Some staff told us that the registered manager and director of clinical services were visible in the service and approachable for patients and staff. Ten staff members told us that the registered manager held weekly breakfast sessions which they attended and found useful. Three staff members told us the registered manager chaired the 'Your say' forum which was a good way of getting their views heard. They said that during the COVID-19 pandemic this had been via a video call which had made it easier to attend and accessible to more staff. Some staff told us that senior managers only visited the ward if there was a serious incident which confirmed what whistle blowers had told us prior to this inspection.

Six staff told us they felt respected, supported and valued and that staff on the ward worked well as a team. Staff said that the senior management team support them and have their best interests at heart. However, other staff told us they were not listened to and several staff had left because of this.

Fourteen staff said they felt able to raise concerns without fear of retribution and knew how to do this. This did not confirm what the whistle blowers told us prior to this inspection and only three staff members said they were not confident to whistle blow. Other staff said they had not raised concerns because they did not need to.

Our findings from this inspection demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not managed well. We found that audits had not identified risks to patients and staff. Ligature risks had not been fully assessed and action had not been taken to reduce those risks until our inspection. We found that environmental audits had not identified that the wards were not clean. During our inspection patients told us that the wards were dirty and we observed this to be the case. We looked at 'Quality Walk Arounds' (audits) completed in January and February 2021. On Clumber Ward on 3 February 2021 the audit completed by the ward manager identified the washing machine was broken. No action was stated on the audit form and the provider did not replace this until after we found this on our inspection on 9 March 2021. On Rufford Ward patients said on 29 January 2021 they would like their bedrooms cleaned more often than weekly; the audit stated that housekeepers would be informed of this. At this inspection patients said they would like their bedrooms cleaned more often. The audit also stated there was graffiti on walls and furniture. Staff and patients told us that there had been graffiti on walls of the seclusion rooms for over three months and managers were aware of this. The provider did not take action to remove this until after our inspection on 9 March 2021.

Ward teams had access to the information they needed to provide safe care through handovers and the providers electronic records system. However, staff told us that handovers were not recorded, and they did not have the opportunity to attend staff meetings regularly.

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 15 HSCA (RA) Regulations 2014 Premises and equipment The wards were dirty and had not been cleaned regularly. Equipment was not maintained and repairs and redecoration were not completed in a timely manner. Staff did not have confidence in the alarm system to alert them where and what type of incident was occurring.

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 There were not always enough staff on each shift to keep patients safe from harm.

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 Our findings from this inspection demonstrated that governance processes did not operate effectively at ward level and performance and risk were not managed well. The provider had not assessed, identified and managed risks to the safety of patients and staff. Outcomes from audits did not improve the service and action was not taken when staff identified risks.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The provider did not support staff who did not have experience of working in psychiatric intensive care units to improve their skills and knowledge.**

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 **Staff did not follow the providers infection control procedures and sufficient anti-bacterial gel and wipes were not available.** **The provider had not assessed all ligature risks and taken action to reduce these. We found ligature risks on the female bedroom corridor on Bestwood Ward, in the de-escalation room on Clumber Ward and the seclusion rooms on Clumber and Rufford Wards that had not been reduced.**