Partnerships in Care Limited

Priory Hospital Arnold

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

This was a focussed inspection and we inspected the Safe and Well led key questions only. We did not re rate Priory Hospital Arnold at this inspection.

We found an identified ligature risk had not been reduced despite the provider telling us they had, and others did not have a timescale set to reduce.

Staff did not always assess and manage risks to patients and themselves well.

Some furniture and equipment had not been repaired or replaced.

Leaders did not always 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:

The provider had trained all staff in ligature risks and assessed their competency in this since our previous inspection.

The service had enough nursing staff who knew the patients well although there were only two wards open and ten patients.

The wards were clean and maintenance staff had redecorated and removed the graffiti.

The provider had improved the alarm system although some staff said there were still false alarms which meant they did not always respond.

Staff followed the providers infection control procedures.

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** 	• There were some outstanding ligature risks and others that the provider had identified did not have a timescale set to reduce but they had locked the room, for example, communal bathroom. • Staff did not always assess and manage risks to patients and themselves well. • The provider had improved the alarm system although some staff said there were too many false alarms which meant they did not always respond quickly. • Some furniture and equipment had not been repaired or replaced and there was not always a timescale set to do this. • Leaders did not always demonstrate they had the skills and knowledge to perform their roles and ensure the safety of patients and staff. • Governance processes did not operate effectively at ward level and performance and risk were not well managed. However: • The cleanliness of the wards had improved since our previous inspection. • Staff followed the providers infection control procedures. • Since our previous inspection the provider had trained all staff in reducing ligature risks and had assessed their competency with this. • There were enough nursing staff who knew the patients well.

Summary of findings

Contents

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:

• 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. Since our previous inspection in March 2021 the provider has closed Newstead and Clumber Wards.

There were 16 beds on Bestwood Ward and eight beds on Rufford Ward which were commissioned by Nottinghamshire Healthcare NHS Foundation Trust.

There have been 17 previous inspections to Priory Hospital Arnold. The latest was a follow up inspection in March 2021 following information of concern about Rufford and Clumber Wards. We only looked at parts of the Safe and Well led key questions across all four wards and issued a notice of decision to impose conditions. We placed the hospital into Special Measures following this inspection. We rated Safe as Inadequate and Well Led as Inadequate and Priory Hospital Arnold as Inadequate overall. The conditions imposed included preventing patient admissions.

Before this inspection we received information of concern from anonymous contacts and from a relative and the ambulance service about incidents that happened on the wards and the management of patient risk.

We visited Bestwood and Rufford Wards unannounced on the evening of 15 June 2021 and during the day of 16 June 2021. This was a focussed inspection and we inspected parts of the Safe and Well led key questions only. We did not rate the hospital at this inspection.

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. We only visited Rufford and Bestwood Wards at this inspection and looked at the seclusion room and de-escalation room on Clumber Ward which was closed at the time of this inspection.

Two CQC inspectors and one inspection manager visited Rufford and Bestwood Wards unannounced on the evening of 15 June 2021 and during the day of 16 June 2021.

The inspection team:

- spoke with two patients who were using the hospital.
- observed staff interacting with patients.

Summary of this inspection

- observed the handover from the day staff to the night staff for both wards on 15 June 2021.
- spoke with 15 staff members including nurses, support workers, ward managers and the hospital director.
- looked at the quality of the hospital environment.
- looked at six patient care and treatment records.
- looked at a range of documents relating to the running of the hospital.

Areas for improvement

- The provider must reduce all ligature risks.
- The provider must ensure that all equipment is 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	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

Following our previous inspection, we served a Notice of Decision to impose conditions on the provider which required them to reduce ligature risks at Priory Hospital Arnold. In response to this the provider had completed a comprehensive assessment of ligature risks throughout the hospital and had undertaken works to reduce most of the risks identified. However, at our previous inspection we identified a ligature risk in a bedroom on Bestwood Ward. At this inspection we saw that this had not been removed. The maintenance staff immediately removed this however the provider had given us written assurance weekly since 18 March 2021 that this had been done. We also found a further ligature risk in another bedroom on Bestwood Ward that maintenance staff immediately addressed. We found a further outstanding action on Bestwood Ward where the provider had identified a risk but had not acted to reduce this risk. Staff told us how they used observation to reduce this risk. We saw ligature anchor points which staff said there were plans to reduce but there was not a timescale to do this. Maintenance staff had locked off two communal toilets and the communal bathroom on Rufford Ward due to ligature risks. Staff did not know when this work would be completed. Patients had an ensuite shower and toilet, but this meant they did not have access to a bath which for some patients could be a therapeutic activity.

The ligature risk assessment dated February 2021 detailed the actions to be taken but nowhere to record the due or completed date. The provider planned to review the ligature risk assessments by the end of June 2021. We advised that this should be done urgently to ensure there were no further oversights in their assurance.

Since our previous inspection the provider had trained all permanent staff in reducing ligature risks via video and all, but one bank staff member had completed a competency assessment. All staff had been given an additional workbook on ligature risks to complete in the few weeks before this inspection. We found that staff had a good knowledge and awareness of the risks. Staff knew where the ligature knives were kept and there were pictures on the doors to guide staff to where ligature knives were kept.

Staff had access to alarms which they checked daily to ensure they were working. Since our previous inspection staff said the provider had improved the sound of the alarm so it could be easily heard. They had also installed screens on the ward office windows and in the main corridors which alerted staff to where the alarm was. However, staff said they still needed to use the radio to detail what type of assistance was needed, for example, all male staff to deal with an incident. We observed there were some false alarms where staff had forgotten to reset the alarm, or their alarm had fallen off their belt. Staff said there were still times when they did not respond as they thought it was another false alarm. This could put staff and patients at risk of harm.

Since our previous inspection the cleanliness of the wards had improved. A staff member was allocated every hour to clean touch points on the wards and we observed staff cleaning during the inspection. However, staff did not always

record this, on Bestwood Ward staff had only completed 52% of records for the last six weeks. On Rufford Ward we found gaps in three days in the week before this inspection where staff had not recorded to show they had completed this. On Bestwood Ward the bin in dining room was open with food waste on 15 June. The provider replaced this with a closed bin by the next morning.

The environment had improved since our previous inspection. The provider had redecorated and removed graffiti from the walls. The provider had replaced the de-escalation room doors on Rufford Ward. However, they had not replaced the dining room doors, staff said these had been ordered but they did not know the timescale for fitting. Maintenance staff had closed off the hot tap for patients to make hot drinks in the dining room on Rufford Ward as it was not regulating the temperature so was unsafe, staff did not know when this would be repaired. The computer that patients used was not working on Rufford Ward and staff said they did not know when it would be repaired.

Staff followed the infection control policy, including handwashing. All staff respected social distancing guidance and wore appropriate personal protective equipment (face masks) and were bare below the elbow before coming on shift. There were notices on rooms and offices stating how many people could use the room at any time to follow COVID-19 guidance. The rooms where handover between shifts were held had changed since our previous inspection so that staff could safely distance from each other. The provider had supplied hand sanitiser and wipes so that staff could clean computers after use to reduce risks of cross infection. All staff had twice weekly lateral flow tests which they had to report on the Priory system to show they had tested negative for COVID-19.

The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. We looked at the seclusion rooms on Rufford and Clumber Wards and the shared seclusion room between these two wards. Staff said the seclusion rooms had not been used for several weeks. We saw that the rooms had been deep cleaned since our previous inspection. However, there were red marks on the flooring on Clumber Ward which the cleaning had not removed.

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Records on Bestwood Ward showed that staff checked, maintained, and cleaned equipment. On both wards the clinic rooms were clean with stickers in place to show what staff had cleaned and when.

The service had enough nursing and support staff for the two wards open to keep patients safe. The provider rarely used agency or bank staff as only two wards were open. The provider was recruiting registered nurses and activity coordinators for each ward to be able to safely open Newstead and Clumber Wards and there was a vacancy for a lead psychologist.

The ward manager could adjust staffing levels according to the needs of the patients. Patients rarely had their escorted leave or activities cancelled. The service had enough staff on each shift to carry out any physical interventions safely.

Staff had completed and kept up to date with their mandatory training. Managers monitored mandatory training and alerted staff when they needed to update their training. Staff also told us they had completed training in autism which helped them to understand how to support some of the patients.

Staff did not always assess and manage risks to patients well. Records showed that staff completed risk assessments for each patient on admission and reviewed this regularly. However, before this inspection we were informed of an incident where a patient self-harmed that showed staff did not manage well the risks to the patient. Staff told us there was a blanket approach to managing patient risks at mealtimes which was not always dependent on individual patient risks. Following this inspection, the provider planned to train all staff on relational security and the role of the safety nurse.

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

Inspected but not rated

We observed the handover for each ward from the day to the night staff. There was a detailed handover of each patient's risk. The manager had identified that handovers needed to be more focused on patients' risk assessments and care plans. They had tasked a ward manager to put together a plan to address this and other areas they had identified needed to improve.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff kept up to date with their safeguarding training. Staff told us they had completed training in safeguarding children and adults. However, some staff had a limited understanding of how to identify abuse. The manager had identified that staff had not reported all safeguarding occurrences but left it for senior managers to report often several days after event. This could put patients at risk of harm. The manager was addressing this.

We did not look at the medicine management systems and processes at this inspection.

The service did not have a good track record on safety. The provider notified us of the death of a patient in September 2020 after tying a ligature. Following this death, the provider identified a risk from the ensuite doors on Newstead and Bestwood Wards and replaced these. Following our previous inspection, we served a Notice of Decision to impose conditions which required the provider to assess and reduce all ligature risks. However, we found at this inspection two ligature risks although maintenance staff removed these immediately. The provider needs to assure themselves that all ligature risks have been reduced.

The service did not always manage patient safety incidents well. Staff did not always know how to report them but said they would inform the nurse in charge. However, the manager had identified that nurses did not always know when to escalate incidents and did not fully report and record these well.

Staff said they did not always have a debrief following an incident. The manager had identified that post incident debriefs were not held and lessons learned were not shared effectively.

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

Inspected but not rated

Leaders did not always have the skills, knowledge and experience to perform their roles. However, staff told us this was improving. Staff said that the new manager and new ward manager for Bestwood Ward were more supportive, proactive and visible on the wards.

Staff did not always feel respected, supported and valued. Some staff told us staff morale was low. Staff said there was a problem with communication and consistency and not handing over essential information or working as a team. However, they said the new manager was trying to change the culture and staff worked better as a team now less agency staff worked there.

Staff were aware of how to use the whistle blowing process and said they would raise concerns if they needed to.

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

Inspected but not rated

Our findings from this inspection demonstrated that governance processes did not operate effectively at ward level and that performance and risk were not always managed well. However, the manager had identified this and had started to address this.

The provider had told us since 18 March 2021 that all ligature risks identified at the previous inspection had been removed but we found an outstanding risk in a patient bedroom on Bestwood Ward. Following our previous inspection, the provider completed a ligature assessment of all wards and put together a plan of works to reduce these. However, there were no dates on this to say when the works were completed or would be done.

The manager had identified gaps in records of patient observations, medicine fridge temperatures and security/safety nurse checks. They sent a memo to all staff on 16 June 2021 to say staff had to check all records at the end of each shift and no staff could go home until done. We found gaps in one patient's daily physical health observation records and in cleaning records. These had not been identified by the charge nurse or the ward manager.

Ward teams did not have access to the information they needed to provide safe and effective care and did not use that information to good effect. The manager had allocated a ward manager to write a project plan to address this with timescales for completion and told us they would oversee this. This included more robust audits, nurses being more aware of their roles, reducing medicine errors and improvement of care plans and handovers.

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
Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Staff did not have full confidence in the alarm system to alert them where and what type of incident was occurring.

Regulated activity	Regulation
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.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found an identified ligature risk that had not been reduced, although immediate action was taken to rectify this. Staff did not know the timescales to complete the work on reducing ligature risks.

Inactive