The Priory Hospital Heathfield

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

Overall summary

We carried out an unannounced focussed inspection at the Priory Hospital Heathfield, to look at the improvements made to the service following our previous inspection visits on 12 June and 14 July 2020. Following our visit in July 2020, we served the provider an urgent notice of decision under Section 31 of the Health and Social Care Act 2008, which imposed conditions on their registration. Section 31 of the Health and Social Care Act 2008 is an urgent procedure whereby the Care Quality Commission can vary any condition on a provider's registration in response to serious concerns. We took this urgent action as we believed that a person would or may have been exposed to the risk of harm if we did not do so.

During this inspection we identified that the service had taken a number of positive steps since our inspection visits in June and July 2020. However, we were concerned that the provider had not appropriately reviewed and monitored the patients' records, in accordance with the conditions we imposed on their registration. Following our inspection visit we served the provider on 4 September 2020 an urgent notice of decision to impose new conditions on their registration under Section 31 of the Health and Social Care Act 2008. We took this urgent action as we believed that a person would or may be exposed to the risk of harm if we did not do so. We have imposed conditions on the provider to ensure that they address the concerns we found following our inspection.

We found:

- The provider had not ensured that a suitably qualified professional had reviewed patients' records in line with the conditions applied to the provider's registration under the urgent notice of decision we served on 15 July 2020.
- The service did not ensure that patients were protected from skin tissue breakdown. Staff had not completed the skin integrity risk assessments correctly and had not reviewed these within the timeframe set in the urgent notice of decision served on 15 July 2020. This put patients at an increased risk of developing pressure ulcers.
- Staff did not evaluate the quality of care provided. All patients remained on food and fluid charts without an identified clinical reason. Information recorded on the

Summary of findings

food charts regarding the consistency of the food for some patients was different to the information recorded on the handover forms. This could increase the risk of patients chocking.

- Staff did not accurately complete patients' food and fluid charts.
- Staff did not understand the individual needs of patients. The inspection team did not witness any staff supporting patients with communication difficulties to use their communication aids. We did not see any evidence that appropriate assessments had been carried out to determine the communication needs of the patients. This meant that patients may still not be able to communicate their needs to staff.
- The leadership team at the hospital had not identified the new concerns found during the inspection and had not addressed some of the actions required by the urgent notice of decision served on 15 July 2020.

However:

- Staff had reviewed all patients' ability to summon assistance. Call bells had been put in place where appropriate and patients observation levels had been reviewed.
- The hospital was clean and tidy and the wards were calm.
- Patients were not left alone for long periods of time as we found at our last inspection.
- There were enough nursing staff on both wards and they were spending time with the patients.

Summary of findings

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Background to The Priory Hospital Heathfield

The Priory Hospital Heathfield is a specialist neurorehabilitation service that provides post-acute neurobehavioral rehabilitation for people with an acquired brain injury as well as offering long term care and support to people with complex needs relating to progressive neurological conditions. The service has two wards, Boyce unit provides care and support for people with progressive neurological conditions such as Huntington's disease, stroke, acquired brain injury and mental health problems. Holman unit is focused on providing post-acute neurobehavioral rehabilitation. Boyce ward has 15 beds and Holman has nine. At the time of writing there were six patients on Holman ward and nine patients on Boyce ward. The Priory Hospital Heathfield is registered to provide the following regulated activities:

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

At the time of the inspection there was no registered manager in post, however the service was in the process of recruiting a new registered manager. The previous manager had left on 22 May 2020. The Priory group had ensured that an interim hospital director was covering the post, supported by an interim director of clinical services and a Priory operations director. The service had also recently recruited a locum ward manager.

Prior to the unannounced focussed inspections we undertook on 12 June 2020, 14 July 2020 and 2 September 2020, the Priory Hospital Heathfield was inspected in June 2018. At that time the hospital was registered as a care home, therefore it was inspected using our adult social care methodology. During the inspection in 2018, Priory Heathfield was rated good overall and good in all five domains. Since that inspection the provider has redesigned the service and is now operating it as a hospital. These ratings were suspended following the inspection we undertook on 14 July 2020, because the service was inspected under a different inspection methodology and were not a true reflection of the current quality of care.

Following the inspection in June 2020, we wrote to the provider under Section 31 of the Health and Social Care Act 2008 about our serious concerns about the safety and patient care at the Priory Hospital Heathfield. The provider responded to our letter with an action plan that told us what action they were taking to address the concerns raised.

We returned to the service in July 2020 to review progress against the actions the provider told us they were taking to address the concerns in the Section 31 letter of intent. On 15 July 2020, following our second visit, we served the provider an urgent notice of decision to impose conditions on their registration under Section 31 of the Health and Social Care Act 2008. The following conditions were imposed:

1. The registered provider must:

a) By 2pm on 17 July 2020 (at our regular weekly meeting), followed up by confirmation in writing, inform the Care Quality Commission of what steps they intend to take and implement to significantly strengthen the clinical leadership and oversight arrangements on every shift on both Boyce ward and Holman ward at Priory Hospital Heathfield, Tottingworth Park, Broad Oak, Heathfield, East Sussex, TN21 8UN.

b) Provide the Care Quality Commission on every Friday, starting from Friday 24 July 2020, evidence of the steps taken in relation to (a) above including any monitoring data or audits undertaken in connection with the arrangements implemented.

2. The registered provider must:

a. By 2pm on 24 July 2020 ensure that patient records are reviewed by a suitably qualified and competent clinical professional including review of records for all patients who are unable to summon assistance (should they need it) to ensure that the current level of observation being provided is suitable for their needs;

i. review of records for all patients with continence management needs to ensure they prescribe how often they should be checked;

Summary of this inspection

ii. review of records for all patients with communication needs to ensure that there are suitable systems in place to ensure that staff and patients can effectively communicate including patients being able to summon assistance should they need it;

iii. review of records for all patients that require repositioning to relieve pressure to ensure it clear how often patients should be repositioned and ensure this is effectively communicated to staff involved in their care;

iv. review all skin integrity risk assessments and ensure they are correctly completed and risks are integrated into care planning;

v. review all food and fluid charts and ensure that where necessary they are completed accurately and fully including recording the clinical rationale, the amount of food being consumed and details regarding the food being consumed.

b. ensure that after patient care records are reviewed in accordance with (a) above, they are monitored by a suitably qualified, experienced and competent clinical professional starting 17 August 2020.

c. by 17 August 2020, provide the Care Quality Commission with written confirmation and evidence to corroborate that those reviews have been carried out and thereafter on a monthly basis.

Our inspection team

The team that inspected this service comprised of two inspectors and one specialist adviser with experience of working in this clinical area.

Why we carried out this inspection

We undertook an unannounced focussed inspection at The Priory Hospital Heathfield, to look at the improvements that had been made against the conditions imposed on the provider's registration on 15 July 2020.

How we carried out this inspection

As this was a focussed inspection, we did not re-rate the service as we only looked at some of the key lines of enquiry across each domain. Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with two patients who were using the service;
- spoke with two registered nurses, the ward manager, the interim hospital director and the operations director;
- looked at all the physical health and basic care monitoring forms and charts which were kept on the wards;
- looked at seven electronic care and treatment records of patients;
- looked at a range of documents relating to the running of the service;
- attended the morning multidisciplinary team meeting.

Summary of this inspection

What people who use the service say

We had mixed reports from people who used the service.

One patient told us that the hospital felt like a prison, they did not get to access the community often and they would like more activities to be organised.

Another patient told us that they like the hospital and they had been involved in personalising their bedroom and the ward.

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?

- Staff had not completed the skin integrity risk assessments correctly. The assessments had not been reviewed within the timeframe set in the urgent notice of decision we served on 15 July 2020. Patients' physical health conditions were not taken into consideration when carrying out these risk assessments.
- Some information on the wards about patients was wrong. For example, information recorded on the food charts was different to the information recorded on the handover forms.
- Staff did not have easy access to clinical information. It was not easy for them to maintain high quality clinical records, because records were stored in various places and in different formats both paper and electronic.

However:

- All patients had received a review of their ability to summon assistance. Call bells had been put in place where appropriate and patients observation levels had been reviewed.
- The service had enough nursing and support staff to keep patients safe.
- All wards were safe, clean, well equipped, well-furnished and fit for purpose.

Are services effective?

- Staff did not assess patients' continence management needs on an individual basis. This meant that all patients who required support in changing their continence pads had them changed every two hours and throughout the night. There was no clinical rationale for the frequency of this intervention.
- Managers did not make sure that they had staff with the range of skills needed to provide high quality care. Staff did not record information in an accurate and meaningful way. Staff did not understand how to complete forms and charts correctly so that they provided the information needed to meet patients' care needs. For example, they did not know how to complete food and fluid charts accurately. Staff did not record on some of them the consistency and the quantity of the food consumed by the patients.
- Staff did not effectively evaluate the quality of care provided. For example, all patients remained on food and fluid charts without identified clinical reasons.

Summary of this inspection

- Staff could not demonstrate that patients' clinical records were reviewed and monitored in line with the conditions on the providers registration certificate.

Are services caring?

- We observed that staff were spending more time with the patients and they were supporting patients with some tasks. Patients were no longer left on their own for long periods of time in their bedrooms.

Are services responsive?

- No appropriate assessments have been carried out to determine the communication needs of the patients. This meant that patients may still not be able to communicate their needs to staff as this had not been sufficiently assessed.
- Staff were not using communication aids with patients who had challenges with communicating their needs. Staff had developed communication cards for patients but on the day of the inspection they were not using them.

Are services well-led?

- Leaders did not demonstrate that they had a good understanding of the services they managed and the improvement needed.
- Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level. We found that there were no effective systems in place to identify that staff were incorrectly completing paper work, such as food and fluid charts and skin integrity risk assessments.

Long stay or rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

All wards were clean and tidy; we saw staff cleaning the ward areas during our visit and carrying out maintenance tasks. The wards were well organised and calmer since our last inspection visits. The gardens looked tidy and patients were able to access them. The empty bedroom in the apartment area on Holman ward had been cleared of the storage items and we were told that staff were planning to do the same for the adjoining kitchen. On Boyce ward, the damage to the ceiling had been repaired but still required painting. Ward staff told us that this was on a maintenance plan and would be completed soon. We saw two new 'you said, we did' boards in the hospital's entrance hall and in the dining area on Holman ward, but only the one in the entrance hall included information.

Safe staffing

The provider had enough clinical and support staff to support patients. On Holman ward for example, there were six rehabilitation assistants to support six patients. There was also a registered nurse in each ward, a recently recruited locum ward manager and other clinical staff, such as a psychologist and a physiotherapist.

Assessing and managing risk to patients

Staff had not correctly completed and had not reviewed within the timeframe set in the urgent notice of decision we served on 15 July 2020 patients' skin integrity risk assessments. We found that staff had not considered the patients' physical health condition when carrying out these risk assessments. For example, a patient's diabetes and another patient's broken skin were not considered when staff completed these risk assessments. Staff reviewed the risk assessments on the day of the inspection, however the documents produced were also completed incorrectly. This meant that the patients were at risk of developing pressure ulcers because staff did not understand how to accurately assess the level of risk and therefore mitigate against it within care plans.

During our inspection in June and July 2020 we found that all patients were on food and fluid charts without an identified clinical reason. During this inspection we found that all patients continued to be on food and fluid charts with no clinical reasons identified. Staff had recorded a daily fluid target for some patients in a general folder. However, staff had not recorded this target on the recording charts and there was no indication of what action staff would take if the patient did not consume the target amount of fluid.

We reviewed all patients' food and fluid charts and found that staff did not record on some of them the consistency of the food consumed by the patients. This meant that staff may not be aware of patients' individual needs and risks associated with nutrition and hydration and it would be difficult to know when to escalate concerns because information was not being recorded appropriately. A registered nurse told us that they discussed with hospital management about all patients having food and fluid charts completed without a clinical reason, however the hospital management informed them that these charts should be completed for all patients.

Staff access to essential information

It was difficult for staff to make sure patients' records were up to date and accurate, because staff kept information about patients in various places. For example, recording charts were sometimes kept on clip boards, in individual files, or a monitoring folder. We found that some of the recorded information on these forms was inaccurate and

on occasions staff had contradictory information about patient care. For example, we found that information recorded on the food chart of a patient was different to the information recorded on the handover form. The food chart indicated that the patient was on 'soft' diet, but the handover document indicated that the patient needed to be on 'pureed' diet. This could increase the risk of patients chocking. We also found that staff had changed the observation levels of a patient during August 2020, but this was not reflected on the handover document. This meant that staff did not provide the correct level of support to the patient.

Medicines management

A patient was being administered a laxative medication on an as and when needed basis, however the medication chart indicated that it was a regular medication. We checked the patient's electronic records and we did not find any relevant instructions issued by a clinician, or any other related records to explain this. This was raised with the provider who informed us that this will be investigated, the incident will be entered on the hospital's incident reporting system and a medication competency check will be completed with the nurse on duty.

Reporting incidents and learning from when things go wrong

Overall the service had improved the way staff completed body maps and monitored injuries. However, we found that a wheelchair injury sustained by a patient had not been followed up. We also found that there were no corresponding records about this injury on the patient's electronic file. This was raised with the provider who informed us that this will be reviewed and an incident report will be created.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Assessment of needs and planning of care

Staff could not demonstrate that they reviewed and monitored patients' clinical records in line with the conditions on the providers registration certificate. We checked the electronic records for seven patients and found that the patients' care records were not reviewed and monitored in line with the conditions under the urgent notice of decision we served the provider.

Best practice in treatment and care

We found that the provider had introduced some new paperwork since our last inspection, such as 'repositioning charts' and 'incontinence/pad changing charts', however there was not an identified clinical reason for the use of these. For example, we reviewed seven repositioning charts and found that all patients were repositioned every two hours, however there was not any clinical reason available to justify this. Also, it was not clear that patients' individual needs had been taken into account in coming to this determination. This meant that the provider was not taking account of patients' particular risk factors. For example, some patients may need to be repositioned less regularly if they were more mobile which would be less intrusive for the patient.

Skilled staff to deliver care

We found that the provider had introduced a 'register of staff understanding of what is required'. Staff were asked to sign and date this form to confirm that they had understood of what was required with regards to the patients' repositioning needs, food and fluid charts, continence charts, body maps and elimination charts. However, there was no standardised training or competency assessment associated to this document. We were told that the registered nurses were just verbally explaining to each staff member what they needed to know. There was little evidence that this system was effective. For example, staff were not completing food and fluid charts correctly.

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

Kindness, privacy, dignity, respect, compassion and support

Patients' needs were not being met in an individualised basis. For example, all patients had food and fluid charts

Long stay or rehabilitation mental health wards for working age adults

completed without an identified clinical reason. Also, some patients were repositioned every two hours, however it was not clear whether patients' individual needs had been taken into account in coming to this determination.

During our inspection visit in June 2020, we did not observe staff engaging with patients in a meaningful way. Patients were spending long periods of time in bed without interaction

from staff. During this inspection we found that staff were interacting more with patients. We did not see any patients spending long periods of time in their bedrooms by themselves. For example, we observed a staff member on Holman ward supporting a patient with personal care tasks. The atmosphere on the wards felt more relaxed this time and we observed staff and patients laughing in the lounge.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Meeting the needs of all people who use the service

Staff did not use communication aids to support patients who had challenges to express their needs.

A patient on Boyce ward did not have their pack of symbols on their wheelchair as it should have been; this was instead left in their bedroom. On Holman ward there was a printed menu on the wall in the dining area. However, there were no symbols or pictures, other than a picture of the main meal for the day on the planning board in the lounge. This meant that patients may not be able to communicate their needs to staff and to effectively express their wishes.

The service had recently introduced communication aids for some patients and individual boards had been placed in their bedrooms, however, these had not yet been embedded yet in staff practices. On Holman ward we saw some symbols on a patient's board. We also found that the service had introduced a 'hear my voice' communication folder which was kept in the lounge. This folder contained symbols for patients to use to make choices about their day to day care and to better express their feelings and emotions. However, despite their improved accessibility these aids were not in use during our visit.

No appropriate assessments have been carried out to determine the communication needs of the patients. This meant that patients may still not be able to communicate their needs to staff as this had not been sufficiently assessed.

Staff told us that patients had individualised printed timetables displayed in their bedrooms, but we did not see any when patients invited us to see their bedrooms. However, we saw a planning board in the lounge with some generic information regarding activities. Some patients told us that there were not enough activities and they were often bored. They also said they had very limited opportunities to access the community. However, during the inspection we observed two patients from Boyce ward accessing the community.

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

Leadership

Leaders were not aware of all the concerns we found during the inspection. They had not identified that the service was not compliant with the urgent notice of decision served on 15 July 2020. Whilst improvements had been made since our last inspections, they had not been effectively implemented. Leaders had designed changes, but frequent changes in leadership due to the absence of a Registered Manager may have had an impact on the oversight of these.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate effectively at ward level. We found that there were no effective systems in place to identify that staff were incorrectly completing paper work. For example, we found that the mistakes on the skin integrity risk assessments and the frequency of patients being repositioned recorded on the charts, had not been identified and no action had been taken to correct these. Quality ward rounds were taking place, however they did not identify these issues of concern.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider MUST ensure that there are enough staff on duty who have the knowledge, skills and competence to meet the needs of all patients admitted to the hospital.
- The provider MUST ensure that all staff know how to complete accurate and meaningful records and why they are important.
- The provider MUST ensure that the patients' continence management needs are reviewed to ensure that they are individualised and based on appropriate assessments.
- The provider MUST ensure that the patients' skin integrity risk assessments are correctly completed, take into account individual factors and risks are integrated into care planning.
- The provider MUST ensure that staff are aware of patients' communication needs and use any tools needed to aid communication with patients.
- The provider MUST ensure that patients' repositioning needs are reviewed to ensure that they are individualised and based on appropriate assessments.
- The provider MUST ensure that all patients' fluid and food charts are reviewed to ensure that they are individualised and based on appropriate assessments.
- The provider MUST ensure that patient records are accurate and better integrated to reduce the risk of inconsistency.

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 9 HSCA (RA) Regulations 2014 Person-centred care Patients with communication needs were not always supported to use communication aids to communicate their needs. This was a breach of regulation 9(1)(a)(b)(c)

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 always have the skills, knowledge and competence to meet patients' needs. Staff did not know how to complete paperwork correctly. Patients were not protected from tissue breakdown. Patients' individual needs and risk factors were not always taken into account and integrated into care planning. This was a breach of regulation 12(1)(2)(c)

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

This section is primarily information for the provider

Enforcement actions

The provider's governance systems had not recognised the concerns identified in this report, nor had they identified that the service was not compliant with the urgent notice of decision served on 15 July 2020.

Accurate patient records were not maintained.

This is a breach of regulation 17(1)