Barchester Healthcare Homes Limited

Jasmine Court Independent Hospital

Inspection report

c/o Paternoster House Care Centre
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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 service was last inspected in July 2019 and was rated as requires improvement. As this was an unannounced focused inspection, we did not re-rate this location. Therefore, the previous rating remains unchanged.

We focused on specific key lines of enquiry within the safe and well-led domains.

We found:

- Staff did not always recognise or report safeguarding concerns in a timely manner.
- Staff did not always document detailed and contemporaneous care notes.
- Not all patients' risk assessments or handover notes accurately reflected current presenting risks. Therefore, staff were not fully aware of potential risks to patients and staff and how to manage them.
- Governance processes did not always ensure that managers had total oversight to ensure systems were robust and effective.
- Not all patient information was readily available in a dementia friendly way which included patients' rights and how to complain about the service.
- Staff had not ensured the "Getting to know me" booklets for patients, a dementia friendly tool to facilitate engagement with a patient, were fully completed. Therefore, the opportunity to capture the essence of each patient was missing.

However:

- The service provided safe care and treatment and the ward environments were safe and clean. The provider's adherence to COVID-19 infection prevention and control was managed very well.
- Staff minimised the use of restrictive practices.
- During this inspection we observed staff treating patients with care and compassion and knew the patients well.
- Feedback from relatives was mainly positive about the care their relatives received and they felt involved in their relative's care.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Requires Improvement 	

Summary of findings

Contents

Summary of this inspection

Background to Jasmine Court Independent Hospital

Barchester Healthcare Homes Limited is the registered provider for Jasmine Court Independent Hospital, providing 15 beds for men with a diagnosis of dementia and expressing challenging behaviour.

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

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

The current registered manager has been in post since July 2020.

The Care Quality Commission last inspected this location in July 2019 following safeguarding concerns raised by external stakeholders. Concerns at this time related to management of medicines, care plans, risk and capacity assessment documentation, physical health needs and leadership at the hospital.

What people who use the service say

- We spoke with five carers and all spoke highly of the staff and told us they were very happy with the care their relative received. All five carers said they felt their relatives were safe and staff were able to manage patients with challenging and complex needs positively.
- Three of the five carers said that their relatives were treated with dignity and respect and four carers felt there was regular communication between staff and themselves. Although one carer said sometimes, they were notified at short notice of meetings and ward rounds.
- Four carers told us they felt considered and involved in their relative's care and that management had effectively managed communication and facilitation of contact during COVID-19 restrictions.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

How we carried out this inspection

We carried out an unannounced focused inspection because of concerns raised by external stakeholders due to alleged inappropriate conduct of specific staff members and the management of some safeguarding incidents at the hospital. We visited the hospital on 21st and 28th July 2021. We focused on specific key lines of enquiry within the safe and well-led domains.

During the inspection we:

- spoke with the registered manager and clinical lead
- spoke with four staff
- spoke with five relatives
- reviewed four risk assessments and care plans for patients
- reviewed the clinic room and medicine charts for five patients
- reviewed a range of policies and procedures, data & documentation relating to the running of the service
- undertook a tour of the hospital

Summary of this inspection

- visited the wards and observed staff's interaction with patients

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a service SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The provider must ensure that staff report all relevant incidents in a timely manner. (Regulation 17(2) (b)(c).
- The provider must ensure they have appropriate assurance systems and processes in place to identify areas of concern and/or risk, and to identify when policies are not being followed (Regulation 17(2)(a).
- The provider must ensure they report all allegations of abuse or reportable safeguarding incidents to the appropriate authorities (Regulation 13(1)(2).
- The provider must ensure that patients' risk assessments are up to date and accurately reflect presenting risks which include a detailed risk management plan. (Regulation 12 (1)(2)(a)(b).

Action the service SHOULD take to improve:

- The service should ensure that relevant staff know where to locate spare keys for medicine trolleys and clinic fridges should originals keys be lost.
- The provider should ensure all patient information is available in dementia friendly format.
- The provider should ensure all patient 'getting to know you' booklets are fully completed to support care planning and person-centred care.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Requires Improvement
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Requires Improvement

Wards for older people with mental health problems

Safe	Inspected but not rated
Well-led	Inspected but not rated

Are Wards for older people with mental health problems safe?

Inspected but not rated

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose.

Staff made sure cleaning records were up-to-date and the premises were clean. Additional cleaning records for high touch areas in response to COVID-19 were also up to date.

Staff followed infection control policy, including handwashing. The provider supplied staff with appropriate personal protective equipment (PPE) to ensure staff and patient safety and managers undertook regular audits to ensure staff adhered to COVID-19 infection prevention procedures.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. During inspection, management told us that the medicine and fridge keys had recently been lost and they did not hold any spare keys. New medicine trolleys and a fridge were on order and as an interim measure a new lock had been placed on the medicine trolley.

Staff checked, maintained, and cleaned equipment.

Safe staffing

Requires Improvement

Wards for older people with mental health problems

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. In June 2021 the service had a vacancy for one part-time occupational therapist and 1.5 nursing vacancies. There is an ongoing drive to reduce the use of agency staffing.

Managers supported staff who needed time off for ill health.

Mandatory training

All staff had completed and kept up to date with their mandatory training and compliance was 96% at the time of inspection.

The mandatory training programme was comprehensive and met the needs of patients and staff. 94% of staff had completed dementia awareness training at levels one and two.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Assessment and management of patient risk

Staff completed risk assessments for each patient on admission using a recognised tool, and whilst these were reviewed regularly, we found one risk assessment where the date had not been updated following a significant incident.

We reviewed risk assessments for four patients and found these were not always comprehensive to reflect current risks and that information recorded was contradictory. For example, we found one risk assessment documented a patient was not at risk from others or accidents but also documented the patient was assaulted twice by other patients and had experienced twelve incidents of falls or near misses in the past. We found two risk assessments which had been reviewed but the date of review had not been amended to reflect this. The outcome measurement tool for one patient had limited information and did not accurately reflect the patient's presentation.

Use of restrictive interventions

Levels of restrictive interventions were low and were monitored in the bi-monthly clinical meetings.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. However, managers were aware that staff did not always document in detail the restrictive interventions they had undertaken. We were informed that a training workshop had been delivered to support staff and a further workshop was planned to upskill staff.

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.

Requires Improvement

Wards for older people with mental health problems

Staff followed best practice including guidance in the Mental Health Code of Practice 2007 and the Mental Capacity Act 2005. Managers regularly reviewed patients' mental health status and ensured all relevant paperwork was compliant.

Safeguarding

Staff received training on how to recognise and report abuse, appropriate for their role. 97% of all staff had completed level two safeguarding training and 80% of nurses had completed level 3 safeguarding training. However, staff were not always reporting all safeguarding incidents to the local safeguarding authority. We found one incident of an unknown injury to a patient that was only reported retrospectively following an external safeguarding review. We found a further incident where a patient had been headbutted by another patient. This was reported to the local safeguarding team four days after the incident occurred. However, the manager told us arrangements had been made for the local safeguarding authority to deliver additional training to both management and staff to ensure they felt confident to identify and report all types of safeguarding concerns when required.

Staff access to essential information

Staff had access to clinical information and used paper-based and electronic systems to maintain clinical records. However, there were several information systems that staff had to access which appeared cumbersome and some information was duplicated. For example, the service held two separate folders for safeguarding incidents, one of which documented referrals made to the local safeguarding authority and another which documented the incidents which did not meet the threshold for a safeguarding referral. Management told us they captured this information to analyse trends and assist with learning from incidents. During the inspection managers told us they were exploring options for a new database system to improve efficiency.

Records were stored securely but we found contemporaneous patient care notes were not always kept, some lacked relevant details and incidents were not always documented. We found that a serious incident involving a patient had not been recorded until several days later following the incident. Whilst the nursing handover report was a useful document, the quality of the entries was variable, and space was limited to write detailed notes. Manager's had identified that care records lacked in-depth documentation and identified this as an area for ongoing development.

Staff did not always share key information to keep patients safe when handing over to others. We found the nursing handover report for one patient did not accurately reflect the total number of incidents one of which was a serious incident. Nor did the report contain all presenting risks of the patient which included unpredictable aggression towards others. Therefore, staff did not have all relevant information to prevent or act to reduce ongoing risks to patients and staff.

We reviewed five "Getting to know me" booklets for patients, which is a dementia friendly tool to facilitate engagement with a patient. We found minimum information within the booklets, therefore the opportunity to capture the essence of each patient was missing and was a barrier to patient engagement and person-centred care planning.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Requires Improvement

Wards for older people with mental health problems

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely and we saw evidence that clinical audits had been in place since January 2021 and action taken when an error had occurred.

Track record on safety

Reporting incidents and learning from when things go wrong

The service generally managed patient safety incidents well but staff did not always know what incidents to report and how to report them. We found one incident where there was a delay of 36 days before a staff member reported to management an alleged inappropriate restraint of a patient by another staff member. Once management were made aware of the incident, they immediately alerted the local safeguarding authority. Managers told us this incident was being investigated. There was a further incident when a staff member failed to report an allegation of assault by a patient. This placed both patients and staff at risk as not all presenting risks of the patient were reported in a timely manner.

Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Managers shared learning about never events with their staff and staff understood the duty of candour and gave patients and families a full explanation when things went wrong.

Managers investigated incidents, gave feedback to staff and shared feedback from incidents outside the service.

There was evidence that changes had been made as a result of feedback. For example, the provider was working closely with the local safeguarding authority to improve their awareness to safeguarding concerns and when to make appropriate referrals.

Managers debriefed and supported staff after any serious incident

Are Wards for older people with mental health problems well-led?

Inspected but not rated

Leadership

The registered manager and clinical lead had a good understanding of the service they managed and were visible and approachable for patients and staff. Leadership at the hospital had been consistent since July 2020 when the new manager joined the service and the clinical lead moved into their current role in August 2020.

Requires Improvement

Wards for older people with mental health problems

Staff we spoke with told us that management were supportive and felt comfortable approaching them to raise any concerns. All were aware of the provider's whistleblowing policy and felt confident to use it.

The management demonstrated the providers core values and commitment to improving the quality of patient care and were keen to engage in further learning opportunities with both internal and external stakeholders.

Culture

All staff we spoke with told us that most colleagues were supportive of one another, although some told us there were tensions amongst some team members. Management were aware of these issues and were looking at ways to address these through supervisions, appraisals and staff meetings.

One staff member told us they had been with the organisation for ten years and enjoyed working at the hospital. They had been supported to access development opportunities related to their role enabling them to obtain an academic qualification.

The provider had a staff notice board promoting the "We Care" programme which was available to all staff and offered a wide range of health and wellness support services including support for staff who had experienced assault, although management were also available to offer support and offered de-briefs. However, we found patient factsheets were not dementia friendly and therefore unlikely to be utilised by patients.

The provider had a staff recognition scheme in place whereby a staff member was nominated "employee of the month".

Governance

Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well. The provider demonstrated attempts to improve their governance systems, however, these did not appear robust enough to ensure sustainable improvements could be demonstrated and embedded into practice. Further improvements were required to ensure managers had total oversight and that all systems were robust and effective particularly in relation to case recording, incident reporting and awareness to safeguarding.

As part of the provider's clinical governance procedures, managers completed regular audits which included COVID-19 risk management, care records, capacity, consent and patients' rights, emergency equipment checks, medicine management, nutrition and infection and prevention and control. We reviewed the clinical governance minutes for April and May 2021 which demonstrated managers had identified that care records lacked in-depth documentation of events or activities, incidents, de-escalation interventions and social leave facilitation. The managers were aware this was an area for ongoing development and had plans for further skills workshops for staff.

Managers had implemented an action plan to address improvements in the quality of care record documentation and improving staff's awareness to safeguarding referrals. However, as this was newly introduced, its effectiveness was not yet known.

Management of risk, issues and performance

Requires Improvement

Wards for older people with mental health problems

Managers had not ensured staff consistently had access to the information they needed to provide safe and effective care. Local audits did not capture all areas to provide assurance. The manager was developing a more robust tool to capture a broader range of indicators, including the identification and management of safeguarding referrals.

Information management

Staff engaged actively in local and national quality improvement activities.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment