Arbour Lodge Independent Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

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

Summary of findings

Further information about findings in relation to the Mental Capacity Act and Mental Health Act can be found later in this report.

Overall summary

We undertook this inspection to find out whether Arbour Lodge Independent Hospital had made improvements to their service since our last comprehensive inspection July 2016.

When we last comprehensively inspected the service in July 2016, we rated the hospital as inadequate overall. We rated safe, effective and well led as inadequate, caring as good and responsive as requires improvement. Following this, we placed the service into special measures.

At this inspection in March 2017, we saw substantial improvement in this service and it has been agreed that the service can exit special measures.

A new governance structure was in place and a permanent registered manager had been appointed. At the last comprehensive inspection in July 2016, five warning notices were issued. We judged the service to have met four of them when we inspected on 17 October 2016 and we judged that the provider had met the fifth warning notice at this inspection. The improvements we had seen in October 2016 had been maintained.

At the March 2017 inspection, we rated Arbour Lodge Independent Hospital as requires improvement overall because:

- The staffing concerns identified at the previous inspection had been addressed, however at this inspection there were concerns that staff were occasionally being allocated to observations for longer than the hospital policy and observation records were not always fully completed.
- Care planning did not always provide enough detail and guidance, for example moving and handling plans and medicines administration. There were however, thorough and detailed assessments and plans for pressure care, nutritional needs and falls risks.

However:

- We received positive feedback from carers and observed positive interactions using the short observation framework tool. Staff knew patients well and had developed good relationships with patients.
- There had been improvements in the responsiveness of the service in terms of pre-admission and discharge planning.

Summary of findings

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Arbour Lodge Independent Hospital

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Wards for older people with mental health problems

Summary of this inspection

Background to Arbour Lodge Independent Hospital

Arbour Lodge Independent Hospital is run by Barchester Healthcare Homes Limited. It is a hospital that provides 24 hour support, seven days a week, for up to 13 patients with dementia and/or mental health problems. The main focus is providing support to people whose behaviour may challenge. The service is for men aged 50 years old and above. At the time of this inspection, there were nine patients living at the hospital.

The regulated activities at Arbour Lodge Independent Hospital are assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures, treatment of disease, disorder or injury, nursing care and personal care.

A registered manager had been appointed and had been in post for six months at the time of this inspection. The registered manager was also the controlled drugs accountable officer.

CQC has carried out six previous inspections at this service. We conducted a comprehensive inspection in July 2016 and the hospital was rated as inadequate with breaches to six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

Regulation 12 Safe care and treatment

Regulation 13 Safeguarding service users from abuse and improper treatment

Regulation 16 Receiving and acting on complaints

Regulation 17 Good governance

Regulation 18 Staffing

Regulation 20 Duty of candour

We served warning notices for breaches of five regulations and we issued a requirement notice for one breach of regulations.

The hospital was also placed into special measures.

The provider immediately acknowledged the seriousness of the concerns and taken steps to address the issues raised in terms of medicines management and staffing. An action plan was developed which coincided with the registered manager starting work and this was completed with support from the provider's senior management team.

We monitored progress with regular engagement meetings where the provider was open and responsive. We had issued five warning notices, four of which we followed up at an unannounced inspection in October 2016 and had been met. At this inspection, we found further improvements and that the warning notice specifically related to governance issues was met and progress noted in October 2016 had been maintained.

Our inspection team

Team leader: Andrea Tipping

The team that inspected the service comprised two inspectors.

Why we carried out this inspection

The service was placed into special measures following a comprehensive inspection in July 2016. Services placed in special measures are followed up within six months of the publication of this decision to assess progress and determine whether special measures can be lifted. The provider was given 24 hours' notice of this comprehensive inspection.

Summary of this inspection

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

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

During the inspection visit, the inspectors:

- toured the hospital and looked at the quality of the ward environment
- spoke with the hospital director and divisional director with responsibility for the service
- spoke with six staff members, including the occupational therapist
- spoke with one service user
- spoke with five carers
- undertook two short observations using the short observation framework for inspection tool
- looked at three care records of patients
- carried out a specific check of the medication management and reviewed nine prescription charts
- scrutinised five personnel records
- examined the observation prescriptions, observation records, allocations and staff duty rota
- checked complaint files and records and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with one patient and five carers during this inspection. Carers gave positive feedback about the service and the staff. Carers knew how to complain and all felt confident they could raise concerns. There was good feedback about the quality of food and flexibility around mealtimes and patient preferences. Carers were able to visit at any time during the day or evening, and whilst some would ring to arrange visits, other carers preferred to visit when they were able to. Carers said that staff were always warm and welcoming towards them. Carers also gave positive feedback about domestic staff and the cleanliness of the hospital.

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?

Requires improvement

We rated safe as **requires improvement** because:

- Agency staff checklists were not always being completed.
- Staff were being allocated to observations for longer than stated in the hospital policy.
- Observation records were not fully completed.
- Staff had not completed all mandatory training.

However:

- The clinic room was clean and tidy.
- Infection control audits were regularly completed.
- All staff had completed basic or immediate life support training.
- Risk assessments were thoroughly completed and regularly reviewed.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Moving and handling needs were not captured in care plans or assessments for all patients who required them.
- Plans for administering medication to a patient with difficulties swallowing lacked sufficient practical details.
- Out of date documentation was stored with medicine cards.
- There was insufficient oversight of Deprivation of Liberty Safeguards applications.

However:

- There was evidence of assessment of physical health at admission in all records.
- Nurses monitored nutritional needs well.
- Staff had received training in dementia awareness.
- Supervision and appraisal levels were satisfactory.

Are services caring?

Good

We rated caring as **good** because:

- All staff knew patients well, giving detailed descriptions of their lives, interests and preferences.
- We observed positive interactions using the short observation framework for inspection tool.
- Support workers showed good awareness of privacy and dignity principles.

Summary of this inspection

- We spoke with five carers who all gave positive feedback about the staff and the service.
- We saw evidence of participation in care planning where patients were able to do this.
- Patients were referred to the advocacy service at admission and the advocate visited the hospital regularly.
- Community meetings were held regularly and these were used to plan activities and discuss changes.

Are services responsive?

Requires improvement

We rated responsive as **requires improvement** because:

- There were insufficient structured activities available to patients.
- Some furniture in communal areas was ripped and needed replacing.
- Patients were not being assessed for ability to keep their own bedroom or locker keys.

However:

- Pre-admission planning involved identification of both plans for admission and proposed discharge pathway.
- There was sufficient space for activities and visits with better use being made of the space available.
- Food was of a high quality with choices available.

Are services well-led?

Good

We rated well-led as **good** because:

- A permanent registered manager had been employed.
- There was a governance structure.
- There was senior level oversight of the hospital.
- All hospital policies had been reviewed and ratified.
- Staff described morale as generally good and were able to identify improvements in the running of the hospital.
- Managers had opportunities to develop leadership and management training courses were offered within the company.

However:

- Staff were not recording observations as per the hospital policy and this had not been identified.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

All staff undertook Mental Health Act training and at the time of inspection all staff had completed this. Staff understood how the Act applied to their role.

Since the previous comprehensive inspection, all Mental Health Act policies had been reviewed and revised in line with the Code of Practice.

Forms authorising section 17 leave were in place for all patients and appropriately completed.

Consent to treatment documentation was in place for all patients who required this and copies were stored with medicines cards. Audits of consent to treatment were completed every three months. In one case, a T3 form (a certificate for someone who refuses or lacks capacity to understand treatment) was present for a patient no longer detained under the Mental Health Act. This meant there was a risk that staff may think that the patient was not able to refuse any prescribed medicine for their mental health.

Staff read patient's rights to them regularly and recorded the patient's understanding of these.

Legal files contained all original documentation and these were stored securely separate from the main clinical files. Copies of Mental Health Act paperwork were kept in clinical files.

Mental Health Act audits were completed every six months, the most recent had taken place in January 2017. This highlighted no major concerns; all documentation was present in legal files but copies of some documents were not in clinical files.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of our inspection, 95% of staff were up to date with the training.

Staff had a good understanding of the Act overall and could give examples of situations involving best interests decisions.

There was insufficient oversight of Deprivation of Liberty Safeguards applications with two patients referred with applications still pending. In essence, there were two patients deprived of their liberty without the necessary legal authority and regular reviews of this or specialist legal advice had not been sought.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Good	Requires improvement

Requires improvement

Wards for older people with mental health problems

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Good

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

The main ward area had a large lounge and dining area with two bedroom corridors which led off it. The nursing office and clinic were on one of these corridors. This layout did not allow observation of all ward areas easily. Staff mitigated this by using individual levels of observation.

There were ligature points on the ward; ligature points are places where patients intent on self harm could tie something. An audit had been undertaken in 2016 which identified all risks and staff were aware of ligature points throughout the hospital.

Staff administered medicines from a clinic room on the ward. The provider had converted a room on the ward into a clinic room which was larger than the previous room. The clinic room was clean and tidy, with room and fridge temperatures monitored daily. Resuscitation equipment was stored in grab bags in the main ward office to ensure it was available in an emergency. Nurses checked equipment on a weekly basis

All ward areas were clean and domestic staff were working throughout the inspection. Domestic staff kept comprehensive cleaning schedules showing areas which were cleaned daily and recording regular bedroom and staff areas being cleaned. Communal areas were well maintained, with suitable flooring throughout. Two couches in the communal areas had ripped covers and replacement furniture was being ordered.

The most recent local authority infection control audit was completed in October 2016. The service had scored 91%. One of the nursing staff completed local infection control audits every month and there was evidence of actions identified and the registered manager informed, for example, the ripped furniture has been highlighted as a risk and the kitchen and dining area flooring had recently been replaced having also been highlighted at a previous audit.

Staff and patients had access to call bells to summon assistance in communal areas and bedrooms.

Safe staffing

Staffing levels had been reviewed since the last comprehensive inspection and a new process had been introduced for prescribing and reviewing observations. This meant that staffing levels were sufficient for the levels of observations. There were three patients who required level four, one to one observations during the day and level two fifteen minute checks once in bed.

Staff worked 12 hour shifts. Staffing establishment levels through the day were five support staff and one qualified nurse and at night were one qualified nurse with two support workers. A support worker would work from 10am to 10pm to provide cover across both shifts. Between Monday and Friday the manager and clinical nurse were available between 9am and 5pm. Rotas reviewed for February 2017 confirmed that the hospital maintained these staffing levels.

One regular agency nurse was contracted to cover night shifts at the hospital. Regular bank or agency nurses covered day shifts on average for one to two shifts per week. An agency staff checklist had recently been introduced to ensure staff were aware of medication, moving and handling, care plans and emergency

procedures. Because these were newly introduced, they had not been completed for all agency staff working in the service. However there was only one instance of an agency member of staff not having a checklist completed and they were working with another regular qualified nurse.

At the previous comprehensive inspection, we were concerned that staff were rostered to continuous observations for periods in excess of two hours, as stipulated in the hospital policy. At this inspection, we reviewed allocation records and noted four occasions since 1 January 2017 where staff had been allocated to three hour long periods of continuous observation. The manager had taken immediate steps to identify reasons for this and ensure this did not recur. These occasions were when the nurse in charge had not realised that staff were allocated in excess of two hours rather than related to staffing levels.

The service had three full time qualified nurse vacancies and three full time support worker vacancies which they were recruiting for. There were also vacancies for a part time occupational therapy assistant and a part time Mental Health Act administrator.

A psychiatrist and a GP visited the service each week. If emergency medical assistance was required staff would contact out of hours medical services or emergency services.

All staff had completed basic or immediate life support training (including managing choking) and moving and handling training. Staff were up to date for all mandatory training with the exception of footsteps training (63%) and MI skin (57%). Footsteps training had been recently added to mandatory training and was an elearning dementia awareness course. MI skin training had been on hold as there had been discussions about this moving from being taught face to face to an elearning module so staff competencies had expired during this period.

At the previous comprehensive inspection, there were concerns about unsafe moving and handling techniques. At this inspection, we witnessed safe moving and handling practice, including staff intervening when an agency nurse attempted to move an individual unsafely.

Assessing and managing risk to patients and staff

There was no use of seclusion or long-term segregation within this service. There had been no use of rapid tranquillisation in the last six months. Since the last comprehensive inspection, all staff had received training in rapid tranquillisation and qualified nursing staff had completed immediate life support training.

There were six incidents in the last six months were restraint had been used, three of these had involved standing holds and three of these involved seated holds. These episodes involved four separate patients, with one accounting for three restraint episodes. Staff had not used prone restraint in the last six months. Staff were trained in techniques which emphasised using de-escalation strategies.

We examined three care records. Staff completed thorough risk assessments with all updated in the last three months. Staff used a recognised older adult's risk and safety risk assessment.

Patients had access to bedrooms throughout the day. The hospital allowed visiting throughout the day and evenings. There were justified blanket restrictions for safety reasons, for example, patients keeping lighters. Other restrictive practices were in place but they were being assessed and reviewed by the registered manager, for example, patients keeping their own toiletries rather than these being stored by staff.

Managers had updated all policies and procedures across the hospital in the last six months, including the observation policy. The records for observations had also been revised. Qualified nurses were responsible for allocating observations at the beginning of the shift and reviewing these at the end of the shift. We noted seven observation records from the week before the inspection where there were uncompleted boxes for observation periods, these were often at the beginning or end of the shift. There were also five general observation sheets from the last month which were undated.

All staff had attended the safeguarding vulnerable adults training. Qualified staff understood the safeguarding process and how to make a referral. Support workers showed a good understanding of safeguarding and were able to share relevant examples. We saw evidence of safeguarding notifications and meeting minutes.

There was effective medicines management practice, in terms of regular stock checks of medicines and clinic room audits. The hospital had arrangements with the GP and local chemist for prescribing and supplying medicines.

Requires improvement

Wards for older people with mental health problems

Medicines administration sheets were kept in individual files, with photographs and relevant medical information on a front sheet. There was out of date documentation in two files. In one, a T3 form (a certificate for someone who refuses or lacks capacity to understand treatment) was present for a patient no longer detained under the Mental Health Act. This meant there was a risk that staff may think that the patient was not able to refuse any prescribed medicine for their mental health. In another file, an expired deprivation of liberty authorisation was found. Medicines errors and issues were reported via incident forms with six reported in the last six months, all dealt with appropriately. All medicine administration charts were reviewed and these were completed correctly.

Qualified nurses had completed medicines competency assessments in the last 12 months, and over 70% of all staff had received additional training regarding rapid tranquillisation.

The hospital had a child visiting policy. We spoke with one carer who had been told that children were not able to visit the hospital some time previously. We raised this with the registered manager who immediately spoke with the carer to address this.

Track record on safety

In the last six months, there had been 81 incidents and accidents reported. The majority of these were falls (23) and violence to others (22). Incident forms were also completed for episodes where patients had become physically unwell and for choking incidents.

Nine incidents were related to safeguarding, although seven of these reports were linked to a service wide alert. All safeguarding incidents were notified to the local authority safeguarding team and the CQC.

Reporting incidents and learning from when things go wrong

Health and safety eLearning was a mandatory course, which 95% of nursing and support staff had completed.

All staff knew how to report an incident. The manager had developed a monitoring form in the last six months for violent incidents involving restraint. This asked for information about strategies attempted, reflections on what had and had not worked well and included a debrief section following incident. We saw four completed forms which all involved a debrief. Two also included patient debriefs following the incident, whilst the remaining two had not taken place because of agitation and short term memory problems around the incident.

We saw in staff meetings minutes and the governance meeting minutes that lessons learned were shared within the hospital and also included learning from other hospitals within the company.

Duty of candour

The provider had a policy outlining Duty of candour. We saw examples where patients and relatives had been told of incidents and where apologies had been offered, although none were at the level of serious untoward incidents. Staff described the principles of the Duty of candour and understood this.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed three care records. Nurses completed comprehensive care plans which were regularly reviewed and updated. One contained the patient's views and had been signed by the patient. The two other patients had been unable to participate in care planning due to their mental health problems.

There was evidence of assessment of physical health at admission in all records. Nursing staff ensured ongoing monitoring of physical health conditions along with the GP. Qualified nursing staff completed assessments, including pressure area assessments, falls assessments, choking assessments and completed malnutrition universal screening tools. These were being regularly reviewed and used as the basis for care plans.

Moving and handling needs were not captured in care plans or assessments for all patients who required them. The moving and handling risk assessments had a section titled 'safe system of work' to list methods to be used, number of staff, equipment and any further information, but this was often completed with a yes or no as to whether

assistance was required and then a number of staff. We saw one example that said "requires hoist" but with no further advice for staff. Another patient had recently been reassessed as non-weight bearing and a plan devised for use of a hoist, but this was not being followed by staff. When this was queried, staff explained that there were two separate plans which covered using a transfer belt and a hoist depending on the person's physical condition. However, it was unclear how support staff would know which plan to follow. Neither plan was detailed enough to ensure that staff would be able to offer assistance in different situations.

One patient was receiving medicines covertly and there was a best interest's decision and care plan in place detailing how this was to be given. One other patient had a covert medication care plan but this lacked practical detail about how medicines should be administered, for example, crushed or liquid form and whether in food or drink. On checking, it transpired that this was not covert medication, but medication consented to but which needed to be given in food or drink due to swallowing difficulties. Nursing staff addressed this during inspection.

Care records were all in paper format, with a ring binder file for each patient. Contents included admission, working in partnership, care pathways, respecting diversity, practicing ethically, identifying people's needs and strengths, control and restraint, promoting safety and positive risk taking, promoting recovery and patient centred care, developing the personal security plan and making a difference. There were photographs of patients within their files. Care records were stored in the nurse's office to which all clinical staff had access. Safeguarding alerts, Deprivation of Liberty Safeguards applications and Mental Health Act paperwork were stored in separate files.

Information relating to patients was found in different places on the ward, for example, nutritional needs were noted in a file stored in the kitchen, moving and handling assessments were found in care plans and medication administration plans were stored with medicines cards. There was no document that brought this information together in one place.

Best practice in treatment and care

Staff were aware of best practice guidance related to their work, for example National Institute for Health and Care Excellence guidance relating to dementia and guidance for managing violence, and this was used in devising care plans.

The hospital had arrangements with the GP service who referred patients to specialists when required.

Nursing staff assessed nutritional and hydration needs using malnutrition universal screening tools. Staff regularly weighed patients and took appropriate action in response to any changes. Several patients required softened or puréed diets to reduce the risk of choking and nurses ensured all staff were aware of this. Speech and language therapy reports had been ised to formulate care plans relating to swallowing difficulties and diet. Thickeners were stored in a locked cupboard in the kitchen so they were accessible for those patients requiring thickened fluids but there was no risk of them being ingested by accident.

Skilled staff to deliver care

The hospital had a contract with an NHS provider for psychiatric and occupational therapy provision. A psychiatrist attended the hospital for one day per week and an occupational therapist attended the hospital one day per week. The GP attended the hospital one day per week as part of a service level agreement.

The hospital did not have a clinical psychologist or psychology provision. Previously, the GP had accessed this by referring to primary care mental health services.

A speech and language therapist visited the service if patients were referred by the GP. A podiatrist regularly visited.

All staff received an induction at the start of employment, including four days of office-based learning including the mission and values, safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards and moving and handling. ELearning was offered in topics of health and safety, food safety and food allergies.

Staff had received additional training in dementia awareness with 80% of staff having completed this. Five staff had completed first aid training.

Requires improvement

Wards for older people with mental health problems

Staff were supervised every six to eight weeks and records confirmed this was happening. Appraisals had been completed for most staff, with an overall rate of 83% complete and the remaining reviews scheduled.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings took place weekly when the psychiatrist visited to review patients. The psychiatrist and a qualified nurse attended the reviews. Care programme approach meetings were held at intervals of approximately six months and were often attended by family and local care co-ordinators.

Qualified nurses led handovers between the two nursing shifts and written records were completed for these. Handovers also took place for visiting professionals, for example, when the occupational therapist visited.

Adherence to the MHA and the MHA Code of Practice

There was no Mental Health Act administrator in post, but recruitment was ongoing. One of the Mental Health Act hospital leads checked section papers when patients were admitted. Two Mental Health Act hospital leads covered all hospitals within the company. Mental Health Act leads were available if advice was needed.

All staff undertook mental health act training and at the time of inspection all staff had completed this. Staff understood how the act applied to their role.

Since the previous comprehensive inspection, senior managers had reviewed all Mental Health Act policies and revised these in line with the code of practice.

Forms authorising section 17 leave were in place for all patients and appropriately completed.

Ward staff told us they received a good service from the contracted independent mental health advocacy service and that all new patients, including those who lacked capacity, were referred to the advocate to explain their role. Managers told us that the advocate routinely attended ward rounds and reviews. A poster informing patients how to contact the advocate was displayed on the wall of the ward. Staff were aware of the advocacy role and how to contact them.

Consent to treatment documentation was in place for all patients who required this and copies were stored with medicines cards. Nursing staff completed audits of consent to treatment every three months with no actions required from the last audit in February 2017.

Staff read patient's rights to them regularly and recorded their understanding of these.

Legal files contained all original documentation and these were stored securely separate from the main clinical files. Copies of mental health act paperwork were kept in clinical files.

The manager and Mental Health Act lead completed Mental Health Act audits every six months, the most recent had taken place in January 2017.

An independent mental health advocate visited the hospital regularly. Patients were referred to the service when admitted and staff were aware of how to contact the advocate when needed.

Good practice in applying the MCA

All staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of inspection, 95% of staff were up to date with the training.

Staff had a good understanding of the Act overall and could give examples of situations involving best interests decisions.

Staff had completed decision specific capacity assessments and best interests decisions where these were needed. Carers and relatives were involved in these. These were reviewed as understanding and situations changed.

There had been three deprivation of liberty applications in the last six months, one approved and two still pending. The local authority had advised of a backlog in applications when contacted by the service. There had been one phone call made to check on these applications, despite them having been made two and four months ago respectively. There was not sufficient oversight of these applications. In essence, there were two patients deprived of their liberty without the necessary legal authority and regular reviews of this or specialist legal advice had not been sought.

Requires improvement

Wards for older people with mental health problems

One of these patients had care plans making clear his informal status, but the other did not, and staff referred to this person as being detained under deprivation of liberty safeguards, when only the application had been made and the urgent authorisation had expired.

Equality and human rights

We looked at staff training records. Most staff had completed equality and diversity training with 90% of staff up to date with this. Equality and diversity training was part of the mandatory training programme.

Equality and diversity had been an action for all hospitals in the previous annual quality account. The plan had been to ensure equality and diversity issues were understood and integrated into working practice, with training developed for all staff. This had been achieved but an audit of understanding was still to be undertaken.

A comprehensive equality, diversion and inclusion policy had been ratified across the hospital group.

We saw equality impact assessments used for some of the newly devised policies and when setting priorities for the next quality account.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

There was a calm, relaxed atmosphere throughout the hospital during this inspection. Staff assisted patients with their meals and drinks and provided nurturing and encouraging interactions. All staff knew patients well, giving detailed descriptions of their lives, interests and preferences.

We observed positive interactions using the short observation framework tool for inspection. Inspectors use this tool to capture the experiences of people who use services who may not be able to express this for themselves. During two half hour observation periods, 14 positive interactions with patients were observed from 15 in total. Support workers clearly knew patients well, addressed them in preferred ways and ensured that patients were comfortable, for example, initiating conversations and checking wellbeing, encouraging food intake at mealtimes and helping with drinks and snacks.

Staff described examples of how they would ensure they treated patients in a dignified way if they required assistance. Support workers were able to describe personal care provided to patients were they were aware of patient's preferences, for example when bathing. Support workers showed good awareness of privacy and dignity principles.

We spoke with one patient during this inspection who gave balanced feedback on the service and his own experiences.

We spoke with five carers who all gave positive feedback about the service and the staff. Carers knew how to complain and all felt confident they could raise concerns. There was good feedback about the quality of food and flexibility around mealtimes and patient preferences. Carers were able to visit at any time during the day or evening, and whilst some would ring to arrange visits, other carers preferred to visit when they were able to. Carers said staff were always warm and welcoming towards them. Carers also gave positive feedback about domestic staff and the cleanliness of the hospital.

The involvement of people in the care they receive

One patient told us they had received information at admission. When patients were admitted, staff spent time with them to help orientate them to the environment and routines in the hospital.

We saw evidence of participation in care planning were patients were able to do this. Carers were asked for their views and information to assist in planning individualised care for patients. We saw that relatives were involved in best interests meetings and in one case in the planning for a do not attempt cardiopulmonary resuscitation order.

Patients were referred to the advocacy service at admission and the advocate visited the hospital regularly.

Carers told us they were involved in care programme approach meetings and regular ward reviews. Carers told us they had been able to speak to the psychiatrist and the GP individually if needed.

Requires improvement

Wards for older people with mental health problems

Community meetings were held regularly and these were used to plan activities and discuss changes. Minutes of these were displayed on a noticeboard in the communal lounge.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

The service admission criteria was for men only, with a diagnosis of functional or organic mental illness and behaviour that challenged. Sources of admission were from psychiatric hospitals including secure psychiatric care. The hospital completed a pre-admission assessment and initial plan prior to admission. Bed occupancy was just below 70%. Patients were funded by commissioning groups in the north west of England.

Pre-admission planning involved identification of both plans for admission and proposed discharge pathway. Several patients had identified next placements for discharge and were awaiting a bed becoming available. We saw discharge plans in patient files and these were discussed at multidisciplinary meetings.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had one ward with an open plan lounge, kitchen and dining area in the centre of the ward and two bedroom corridors leading off.

Activities took place in the main communal lounge, which also had an open plan dining area and kitchen area. The quiet lounge accommodated up to four people and was used for visitors but a restrictor had recently been fitted to the door so that this was open and encouraged patients to make use of the room at other times.

Managers had recently acquired tactile items placed along the corridors and around the ward, for example, a replica tool kit and matchbox cars, to encourage patients to stop at points if they were pacing and to provide prompts for conversation.

The veranda off the dining area was accessible for patients to smoke or use for fresh air. There was an additional internal courtyard with seating and plants, which was accessible to all patients. There were plans for gardening activities in the spring.

Patients were able to access their rooms whenever they wished. All rooms were en-suite and furnished appropriately. Memory boxes at the side of each bedroom door had photos and items to help orientate patients to their own rooms.

Patients could make phone calls in private with the cordless phone, which they could take to a quiet area.

Food was of a high quality with choices available. Staff served food in the dining area, which had tablecloths and condiments. We observed drinks being made for patients whenever they wished and at regular intervals otherwise. Snacks were available in the open plan kitchen area for patients to have when they wished.

Bedrooms were personalised with patients' belongings. Staff told us patients could have keys to their rooms but no one on the ward currently had a key. Lockers were available for patients to lock their belongings in however staff had to access them for patients.

Information displayed on the notice boards included posters for the advocacy service, whistleblowing, CQC and complaints information. The activity planner showed the occupational therapist was at the service on Thursdays and the GP visited on Fridays.

Resources in the communal lounge for patients to occupy themselves included films, compact discs, books and board games. There were less organised community activities occurring than on previous visits. An activity co-ordinator was in post at the last inspection but these roles had been removed from the hospitals across the company. A music therapist had previously worked one day per week in the service but had left. A part time occupational therapy post was being advertised and recruited to. Support staff engaged patients in one to one activities during observations or when opportunities arose, but there were no structured activity plans in place for the service. Similarly, there were no plans for regular leave from the hospital, despite most patients having leave authorised for this.

Requires improvement

Wards for older people with mental health problems

We observed two occupational therapy activities during this inspection, the morning session was baking which none of the patients participated in and the afternoon session was afternoon tea. There were no structured occupational therapy assessments undertaken within the service, for example assessments of functioning or activity checklists. We also observed the occupational therapist taking over observations for short periods whilst support workers assisted patients with personal care.

Meeting the needs of all people who use the service

The service provided treatment for older men with mental health problems. The majority of patients had a diagnosis of dementia but several patients had enduring mental health problems. There were difficulties in providing services for both patient groups. For example, whilst the service had implemented some features of a dementia friendly environment, this was not necessary for all patients.

Accessible and easy read information regarding medication was filed in the communal lounge for patients to access.

Information provided to patients was in English, which was appropriate to the client group at the time of inspection. A translation service was available if needed.

Photographs of all staff were displayed at the entrance to the hospital with the name and role of the member of staff.

In terms of a dementia friendly environment, symbols were used on the bathroom doors, furniture was boldly coloured and the flooring was plain which is helpful for people living with dementia. A specialist dementia advisor from within the company had recently visited to assess how to improve the environment for patients with dementia.

Listening to and learning from concerns and complaints

Patients, staff and carers told us they were aware of how to complain.

Complaints practice had improved since previous inspections. The registered manager had been overseeing complaints and we were able to review three complaints from the last six months. Complaints were being addressed in line with the hospital policy. However, these were not being uploaded onto the provider's electronic system as the manager had been unaware of this until recently.

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

Good

The managers had made significant improvements in the governance and leadership at the hospital. At the last comprehensive inspection, we had concerns about the governance and management of this hospital. This was in terms of ineffective audit, inadequate investigations and learning from incidents, poor medicines management, out of date policies and staffing levels.

The provider had immediately acknowledged the seriousness of the concerns and taken steps to address the issues raised in terms of medicines management and staffing. An action plan was developed which coincided with the registered manager starting work and this was completed with support from the provider's senior management team.

We had monitored progress with regular engagement meetings where the provider was open and responsive. We had issued five warning notices, four of which we followed up at an unannounced inspection in October 2016 and had been met. At this inspection, we found further improvements and that the warning notice specifically related to governance issues was met and progress noted in October 2016 had been maintained.

Vision and values

The company vision and values was based around the heading of "Quality First". Staff were aware of this and how it linked to the service. Staff we spoke with were aware of and demonstrated the vision of the service in terms of being person centred and providing individualised care.

A quality account for 2016/2017 had been published by the company, with targets for the hospitals in the group. These included discharge planning, targeted health interventions, improving patient involvement and standardising care documentation.

Good governance

Across the company's hospital provision, a new governance structure had been created. The divisional director had been able to recruit two senior posts to support improving

quality across the hospitals. The divisional director had ensured that policies had been reviewed and ratified and were in date at this inspection, including policies relating to the Mental Health Act.

The governance structure was of local governance meetings, which then fed into divisional governance meetings, which were then fed up to board level governance within the company. Information would then similarly be cascaded down from board to divisional to local level. Meeting minutes were available for staff to read and were fed back at staff meetings. Lessons learnt and improvements could be more readily shared across the hospitals.

A new format had also been devised for risk registers and was being used across the hospitals. We noted that this did not record the length of time risks had been on the register, and this was changed during this inspection.

Since the last inspection, a permanent registered manager had been appointed. Staff told us they felt there had been improved structure to the hospital since and that improvement had been driven by the manager. There had been clear improvements in terms of serious incident reporting, audits, medicines management and staffing levels.

The registered manager had received support from the divisional director and their team to take actions that were necessary for the hospital and to address concerns raised at the previous inspection.

The ratification and introduction of all the hospital policies had been managed adequately, with three policies being released each week and staff given protected time to familiarise themselves with these and sign to say they had read them.

The issues raised at this inspection in terms of activity provision were already identified by the managers and plans were in place for recruitment of an occupational therapy assistant. A review of the current occupational therapy service was underway. Similarly, a Mental Health Act administrator post was also being recruited to.

Leadership, morale and staff engagement

At this inspection, there had been improvement in leadership both within the hospital and at a senior level. Sickness and absence rates were monitored and there was one employee on long term sick leave at the time of this inspection. There were no bullying or harassment cases. We reviewed five personnel files and found they were in good order, with evidence of disclosure and barring checks and references sought prior to employment.

Staff knew what the whistle blowing process was. All staff felt confident they could raise concerns.

Staff described morale as generally good and were able to identify improvements in the running of the hospital. Teams worked well together and staff described feeling supported by colleagues and managers. Staff told us they were involved in audits within the hospital, for example, ligature and infection control audits. Staff also felt they could feedback on the service and that areas for improvement would be considered.

Managers had opportunities to develop leadership and management training courses were offered within the company.

Staff supervision had improved and an appraisal cycle was underway.

Staff were offered protected time for completing elearning and familiarising themselves with new policies.

An employee of the month scheme was in operation where individuals were nominated with gift vouchers awarded to the recipient each month.

Commitment to quality improvement and innovation

The provider does not participate in any national quality improvement programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff complete all mandatory training.
- The provider must ensure damaged furniture is replaced promptly .
- The provider must ensure that staff complete written observation records.
- The provider must continue to review observation allocation sheets to ensure staff are not allocated to more than two hours observations as per the policy
- The provider must ensure that moving and handling plans are detailed and provide adequate guidance to staff.
- The provider must ensure that care plans relating to medication administration are detailed and provide guidance to staff, for example, when administration in food or fluids is required.
- The provider must ensure that patients deprived of their liberty without appropriate legal authority have their situation regularly reviewed, including seeking legal advice.
- The provider must ensure that meaningful activity and leave takes place.

Action the provider SHOULD take to improve

- The provider should ensure that agency staff checklists are being completed.
- The provider should assess individual's ability to have their own room and locker keys.
- The provider should ensure that all patient records accurately reflects the patient's current legal status.
- The provider should ensure that the child visiting policy is followed.
- The provider should review occupational therapy provision.
- The provider should consider the use of one page profiles or similar to draw together essential information.

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 9 HSCA (RA) Regulations 2014 Person-centred care How the regulation was not being met: Staff did not complete sufficiently detailed moving and handling plans. Care plans for administration of medication lacked sufficient detail. This was a breach of regulation 9 (3)

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 How the regulation was not being met: Two patients were referred for deprivation of liberty authorisations but there had been insufficient oversight and care review whilst these applications were pending. This was a breach of regulation 13 (5)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	How the regulation was not being met: Staff were not completing observation records correctly. Staff were allocated observations in excess of two hours. This was a breach of 17 (1)

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 How the regulation was not being met: Staff had not completed all mandatory training. This was a breach of 18 (1) & (2)