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?	Inadequate
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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.

Summary of findings

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.

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 rated Arbour Lodge Independent hospital as requires improvement because:

- Support workers who provided the majority of the care to patients and supported them on trips out had not had basic life support training. This means that support workers would not be able to respond to emergency first aid situations with the skills and competence required.
- Only two of the 15 support workers had received training in the Mental Health Act so the majority of the team providing care to patients would not understand their role in relation to the Act.
- Staff were not always following policies for the review of individual risk assessments and observations of patients.
- Staff did not have an appraisal of their performance and documented managerial supervision was not taking place regularly for staff.
- There was no evidence in the care records of physical health examination on admission because all the information in relation to physical health was stored in the GP records. There was no monitoring care plan for patients prescribed medication above the British National Formulary (BNF) limit.
- There was a divide between the nurses and support workers; they had separate team meetings and at handover, nurses did not pass on all relevant information, including changes in presentation of patients and risks.
- Staff did not always give patients copies of their care plans.
- Patients did not receive welcome information on admission or beforehand to describe the hospital environment and what to expect if they stayed there.
- There was no centralised complaints log, staff did not record concerns raised and did not follow the complaints policy.
- Some of the activities offered were not appropriate to the client group and staff did not tailored them to the needs of patients.
- There were no individual hospital objectives and the hospital director had spent months away from Arbour Lodge to provide management cover to other hospitals and care homes.
- There was a high turnover of staff.
- The hospital was not participating in any quality improvement projects or research opportunities.
- Low staff morale had been noted in the support worker team meeting minutes.

However:

Patients and their relatives reported being well cared for and the staff were very respectful. Staff were caring towards patients and we observed warm and encouraging interactions with patients. There was a high attendance at mandatory training. Staff understood the incident reporting policy and followed it. Individual risk assessments were very detailed. Care plans were in place for physical health monitoring and specific needs of patients. Staff felt that managers were approachable.

Summary of findings

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Requires improvement

Arbour Lodge Independent Hospital

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Arbour Lodge Independent Hospital

- Arbour Lodge Independent Hospital is run by Barchester Healthcare Homes Limited. A 13-bed hospital provides 24-hour support seven days a week for people with early onset dementia, mental health problems or both. The focus is providing support to people with challenging behaviours. The service is provided for men aged 50 and above.
- The regulated activities at Arbour Lodge Independent Hospital include assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures, and treatment of disease, disorder or injury.
- The service has had four previous inspections, the most recent being on 11June 2014, when the service was fully compliant with regulations.
- The hospital director was the registered manager and the controlled drugs accountable officer.

Our inspection team

Team leader: Sarah Heaton

The team comprised three CQC inspectors, a nurse with experience of managing rehabilitation services for men with mental health needs, and an expert by experience with lived mental health experience.

Why we carried out this inspection

We inspected this service as part of our ongoing comprehensive mental health inspection programme.

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 this service and the information provided by the organisation as requested as part of the inspection process.

During the inspection visit, the inspection team:

- visited Arbour Lodge and looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- observed the staff interaction and care provided to patients both within the hospital and on activities within the local community
- spoke with five relatives of patients
- spoke with nine staff members; including managers, a doctor, nurses and support workers
- attended and observed one handover meeting.
- reviewed all 13 care records of patients
- reviewed all prescription charts

Summary of this inspection

- reviewed 23 personnel files for supervision records
- 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 to four patients individually. They said that the hospital was always clean and they felt safe. Patients said that staff were caring and that they had been given information about their treatment.

However, some patients had not been involved in developing their care plan or been given a copy of it. Patients said that activities were available but that they did not always feel they were appropriate – for example, colouring in and biscuit decorating.

We spoke to five relatives of patients, who said that staff were very caring, that the environment was clean and homely, and that they felt involved in the care their relatives received. Relatives reported visiting their family members unannounced and that staff were always accommodating. One relative reported that staff arranged home visits and accompanied their family member to visit them; however, this depended on staff who could drive being on duty.

One relative said that there was a high turnover of staff and that they would like their relative to have the opportunity to go out more. An area for improvement suggested by a relative would be to have space for children to visit the hospital. They had been told that there was no facility for this, which had resulted in a patient not being able to see his grandchildren.

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?

Inadequate

We rated safe as inadequate because:

• Support workers were not trained in basic life support or trained in how to support people who may choke and have swallowing difficulties. Support workers provided the majority of the care and would not be able to respond to emergency first aid situations with the skills and competence required.

• Staff were not always following the ligature action plan of keeping the bathroom locked when not in use.

• The staff were not reviewing the individual risk assessments as frequently as the policy directed of three monthly. Three of the risk assessments had not been reviewed for over 12 months and five risk assessments had not been reviewed in over three months.

• The hospital was not following their observation policy. Support workers were completing observations of patients for longer than the policy directed of two hours. Also, they sometimes recorded observations retrospectively.

• Following a patient being found on the floor, emergency services were not contacted. Staff learning from this was to complete comprehensive notes and contact emergency services immediately.

• Nurses did not discuss risks at the handover meetings with support workers.

However:

There was a high attendance rate at mandatory training. Staff were following the incident policy and understood what an incident was and how to report them. Individual risk assessments were detailed.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

• A patient admitted at the end of July 2015 did not have a completed care plan in place from the provider.

• The hospital was not gaining consent for an individual when planning to administer injectable medication for a physical health condition in a patient's best interests.

• There was no evidence in the care records of physical health examination on admission. Staff told us that all of the information relating to physical healthcare was stored in the GP records.

Summary of this inspection

• Not all side effects were monitored for patients prescribed clozapine.

• The hospital did not have a monitoring care plan for patients prescribed antipsychotic medication above the BNF limit.

• Staff had not had an appraisal.

• Staff were not receiving regular supervision.

• Staff did not receive training in dementia.

• Nurses and support workers had separate team meetings with no joint forum for information sharing.

• Only seven out of 22 staff had attended training on the Mental Health Act.

However:

One service user prescribed clozapine had regular plasma levels undertaken when the dose had changed and when smoking status changed, which was an example of good practice. Care plans were in place for physical health monitoring and specific conditions, for example, diabetes. Care records were stored in the nurses' office to which all clinical staff had access. There were photographs of patients within their care records.

Are services caring?

Good

We rated caring as good because:

• We observed staff assisting patients in a nurturing and encouraging manner.

• Patients said staff were caring and approachable.

• Relatives reported that their loved ones were well cared for, staff always made them welcome when they visited and their loved ones had improved in the time they were at Arbour Lodge.

• Patients reported being involved in their care plans.

• Staff facilitated community meetings with patients monthly.

• Activities took place in the local community which patients were supported to attend.

However:

Patients were not given copies of their care plans. There was no current welcome information for patients prior to or at admission to orientate them to the hospital environment.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

Summary of this inspection

• There was no centralised complaints log in place, concerns raised by patients had not been recorded and the complaints policy not followed.

• Staff did not always tailor the activities to the needs of patients and patients felt they were inappropriate.

However:

There was very positive feedback and observation of the music sessions and the planned community leave.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

• There were no individual hospital aims and objectives.

• The hospital director had spent months away from Arbour Lodge to provide management cover to other hospitals and care homes. Resulting in a lack of progress with the development of the service and training and management support to staff.

• Staff did not complete the actions from the infection control audits.

• There was a high turnover of staff.

• There was a divide between nursing and support worker staff, with information relating to risk not being shared.

• The hospital was not participating in any quality improvement projects.

• Low staff morale had been noted within the support worker team meeting minutes.

• Staff were not receiving appraisal or regular supervision.

• Staff were not always aware of policies and procedures and these were not being followed.

• In relation to a safeguarding incident, we noted that there was no clear report structure for investigating incidents.

• The plans from a safeguarding meeting in relation to the GP contract had not been completed.

However:

Staff reported the hospital director, now back full time at the hospital and clinical lead were approachable and felt able to raise concerns with them. The hospital director was aware that his prolonged absence from the service had caused problems in the leadership and oversight of the hospital.

Detailed findings from this inspection

Mental Health Act responsibilities

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

There were five patients detained under the MHA.

Information provided by the trust showed that seven out of 22 staff had attended training in the MHA. The hospital director advised that an informal training session had been provided to the staff team. However, there were no records available to verify this. Four of the ten staff interviewed could not explain the guiding principles of the Act or the code of practice and their role in relation to the MHA.

Copies of T2 and T3 forms recording consent to or authorisation of treatment were available with medication charts.

We saw evidence in care records that the patients' rights were read to them monthly in line with section132 of the Act.

Independent Mental Health Advocacy services were provided by a local organisation. Information explaining how to access this service was displayed on the noticeboard.

There was a file to store documentation for patients relating to the MHA. We found one patient who was subject to Ministry of Justice restrictions did not have section papers or authorisation relating to leave in his care records, although this information was located from the archives when requested.

Mental Capacity Act and Deprivation of Liberty Safeguards

Three of the 13 patients were subject to deprivation of liberty safeguards (DoLS). These are rules on how someone's freedom may be restricted in their best interests to enable essential care or treatment to be provided to them. The safeguards ensure that the least restrictive option that can be identified to meet a specific need is applied. Two further patients had an urgent application submitted. The full applications were still being assessed. Of the three patients subject to safeguards, only one had the authorisation of restrictions recorded in their care records.

Staff told us that patients subject to restrictions on their freedom were regularly assessed to see if they were capable of consenting to treatment. However we could not find this within the records.

Mental Capacity Act (MCA) training was provided to staff, with 100% attendance.

The hospital had a mental capacity checklist in place with 10 forms completed in detail for patients.

Staff we spoke with had an understanding of the MCA and how to promote the best interests of patients without the capacity to make decisions for themselves.

There was a MCA policy in place dated July 2013. A list at the back of the policy should have been signed by staff to show they had read the policy. However, there were no completed policy checklists for us to view on the inspection. Therefore, it was difficult to know if staff had read the policy.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Overall	Inadequate	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Inadequate

Safe and clean environment

Staff checked the hospital for ligature points, which are places where patients intent on harming themselves could tie something to hang or strangle themselves. The hospital had an audit report of the risks and an action plan to mitigate them, dated 8 July 2015. An example of action being taken was that wall lights in the corridors were being replaced with an anti-ligature design during the inspection.

Door handles and locks on the inside of bedroom doors were anti-ligature in design and each bedroom door was fitted with a glazed privacy panel. This enabled staff to conduct observations without disturbing patients. The beds were profile beds that could be raised and lowered. These posed a potential risk as they could be lowered to the floor, trapping a person underneath. This had not been highlighted as a potential risk.

In the assisted bathroom, taps, the showerhead and bath hoist presented a ligature risk along with a wall cabinet and wooden display unit. The plan to mitigate the risk was for patients to be supervised when using the facility and for the bathroom to be kept secure at all other times. There was one occasion during the inspection when the bathroom was not locked when not in use.

The clinic room was small and could not be used to discuss medicines privately or allow dispensing to the patient in the clinic. Medicines were dispensed and then taken by the nurse to each patient individually. There was no room for an examination couch and physical observations were undertaken in patients' bedrooms. Clinical equipment (for example, weighing scales) was stored in inappropriate areas, the staff toilet due to lack of space. Resuscitation equipment was stored in the nursing office. Records confirmed good practice of staff checking fridge temperatures daily and resuscitation equipment was weekly.

The hospital was visibly clean and presented to a high standard. Relatives and patients confirmed this, when they visited which on occasion was unannounced.

Staff completed the laundry in the care home next door, which was owned by the same provider.

There was anti-bacterial hand sanitizer in the reception area for visitors to use. Support workers wore short-sleeved uniform tops so they were bare below the elbow. Staff had minimal jewellery on and adhered to infection control principles. Staff had not completed the actions from the infection control audits within the timescale. Actions identified on 7 July 2015 with a month completion date included a bed and mattress-cleaning regime, removing inappropriate items from the sluice and storing sauces and preserves in the fridge. These actions had not been completed at the infection control audit on 3 August 2015, or the inspection at mid-August.

All staff had alarms and the hospital provided the inspection team with them.

Safe staffing

- Total establishment levels qualified nurses (WTE) 7
- Total establishment levels nursing assistants (support workers)(WTE) 21

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Total number of WTE vacancies qualified nurses 2
- Total number of WTE vacancies nursing assistants (support workers) 9
- Number of shifts filled by bank or agency staff to cover sickness, absence or vacancies 123
- There were no shifts that had NOT been filled by bank or agency staff where there is sickness, absence or vacancies
- Number of substantive staff leavers in the last 12 months 7
- Total % turnover of ALL substantive staff leavers in last 12 months 25%
- Total % vacancies (excluding seconded staff) 39%
- Total % permanent staff sickness overall 4%

Of the 21 support worker posts, there were vacancies of 39%. As a result 123 shifts were covered by bank and agency staff from 1 April 2015 to 3 July 2015.

Shifts comprised one qualified nurse and three or four support workers, dependent on need, during the day. At night, the shift was one qualified and two support workers. Rotas reviewed from the beginning of May to the end of July 2015 confirmed that these staffing levels were maintained and sometimes exceeded, with one qualified nurse and five or six support workers on occasions.

In addition to regular contracted staff, the hospital had three regular bank support workers and one regular agency nurse who covered shifts. This enabled patients to have support from familiar staff.

We observed, and patients confirmed, that the qualified nurses spent significant parts of the day in the office. Support workers were providing the majority of care and support to patients.

Patients reported going out on leave with staff and regular activities took place. During the inspection, there was a trip to Blackpool and another visit to a local restaurant taking place.

The consultant psychiatrist visited the hospital once a week to review the patients. With on call cover provided by the mental health trust. If medical attention for physical needs was required in an emergency, the emergency services would need to be used.

Initial data provided by the hospital showed 90% attendance at training, which had increased to 93% at the time of inspection. However, basic life support was not a mandatory training course for support workers. They provided the majority of the care to patients and escorted them out into the local community and on trips. Support workers would not be able to respond to emergency first aid situations with the skills and competence required. The hospital director had identified that support workers required basic life support training and had planned a training course for September 2015.

Assessing and managing risk to patients and staff

The hospital did not use prone restraint. From March to end July 2015 there had been one incident of restraint used which was not in the prone position. Restraint methods used were lower level holds and steering a patient away from a situation. Regular physical interventions were used for one patient to assist with his personal care which had been care planned.

We reviewed all 13 care records. Not all patients had their risks assessed on admission. Five of the care records did not have a risk assessment completed at admission. However, 12 of the 13 patients did have a risk assessment in place. Seven of the risk assessments were in date and staff had reviewed them within the last three months, as stated within the policy. However, staff had not reviewed five risk assessments in over three months. The most recent admission paperwork, for a patient admitted at the end of July 2015 did not have a comprehensive risk assessment in place.

The hospital used the Galatean Risk and Safety tool behavioural risk assessment, which was very detailed and thorough.

Patients had access to bedrooms throughout the day. Visiting was allowed throughout the day and evenings. There was one blanket restriction with patients not allowed to keep lighters for safety reasons. However, staff carried lighters and patients were allowed to smoke in designated areas.

The hospital had an observation policy dated July 2013 that defined the levels of observation as recommended by National Institute for Health and Care Excellence (NICE) clinical guidance 25. However, the NICE guidance has been superseded by NG10, published May 2015 and the policy did reflect current guidance. The policy stated that staff

should not complete observations for more than two hours in duration unless in exceptional circumstances. We were informed that staff were allocated the responsibility of completing observations for one hour. However, we observed that the observations were not being carried out by the member of staff allocated to that hour. Other staff were signing the observation sheet retrospectively because the person allocated had not completed it. Staff completing the observations had a rota, check sheet and evaluation sheet to complete but this was not happening and was not discussed at the handover we observed. Staff we spoke to were not aware that there was an observation policy. We observed observations being recorded retrospectively on the observation charts hourly and not when the observations took place. Staff did not receive training in how to complete observation.

All staff had attended the safeguarding vulnerable adults training. Qualified staff understood the safeguarding process and how to make a referral, and if a support worker was concerned about a potential safeguarding, they would pass this on to the nurse on shift.

Staff attended the daily "stand up" meeting as the handover. We observed one of the "stand up" meetings, this took place at 10am when the shift started at 8am, and meant support workers were receiving their handover two hours after starting their shift. Within the meeting risks were not discussed, nor were the observation levels of patients. When this was questioned, the nurse reported sharing information with support workers on a "need to know" basis.

We reviewed thirteen medication charts. All had pictures attached and name, date of birth and allergies/sensitivities noted. Where there were particular administration plans (for example, for the use of thickened fluids) these were noted. Staff followed good practice in the form of care plans for the administration of 'as needed' medication. These were stored with medication administration records (MARS) charts and were regularly reviewed. Original prescriptions were stored in the nurse's office, despite the medicines policy outlining that these be stored with the MARS chart.

There were no arrangements for children to visit at the hospital. One relative said that it would be helpful if this were possible, to enable a patient's grandchildren to visit him.

Track record on safety

One serious incident occurred in the last twelve months, where a patient collapsed and died. Anonymous feedback to CQC reported that staff had not had basic life support training and found it difficult to perform cardiopulmonary resuscitation. Training records and support workers confirmed they had not had basic life support training and felt vulnerable when supporting patients into the community. The mental health inpatient care quality standards 2014-15 from the Resuscitation Council (UK) states " All healthcare staff must undergo resuscitation training at induction and at regular intervals thereafter to maintain knowledge and skills"

The serious untoward incidents and adverse events policy dated July 2013 identified what a serious incident was, how to report it and had examples of the forms to be completed and how to grade an incident. Following a serious incident there was a debrief form to be completed and a checklist to ensure that all actions had been followed including informing other bodies.

Learning from other services within the Barchester Healthcare Homes Limited group were shared at the hospital and diverse services division meeting which started meeting in June 2015.

Minutes from the hospital clinical governance committee from December 2014 and June 2015 noted discussions around risk management and serious incidents.

Reporting incidents and learning from when things go wrong

Health and safety eLearning was a mandatory course of which 91% of staff had completed.

Of the seven clinical staff we interviewed regarding incident reporting process, all knew how to report an incident. Six of the seven staff interviewed reported having a debrief following incidents. One staff member reported not receiving feedback following an incident.

A review of team meeting minutes from January 2015, showed that there was no standard agenda and learning from incidents and health and safety were not discussed.

Staff recorded incidents in the patient's progress notes and there was a separate incident file to store incident forms.

Following an incident in May 2015, where a patient sustained an injury following a fall. The safeguarding team confirmed neglect by omission to act. Learning from the

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Requires improvement

incident included the need to make notes that were more detailed. Also if a patient falls or has an unwitnessed incident, emergency services should be contacted immediately. Staff we spoke to were aware of the event and lessons learnt. A further action from the review of the incident was for the hospital to review the GP visiting arrangements, as the GP only visited once a week. Records reviewed showed the patient had physical observations that were of concern after the fall and prior to the hospital admission, which did not appear to have been acted on. If a GP had visited more frequently this may have been acted upon. At the time of the inspection, the GP contract was still under review with visits to the hospital once per week.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed 13 care records. There were current care plans in 12 of the records; one patient admitted at the end of July 2015 had a care plan from their previous service. The admission of patients policy dated 1 July 2013 stated that all patients would have a formal care plan in place within 72 hours of admission.

Two patients had plans detailing covert administration of medication. However, one of the patients' plans detailed the use of injectable medication to control a physical health condition if oral medication was refused, which was not covert medication. There was no record to show that a mental capacity assessment had taken place, or a best interest's meeting held if the patient lacked capacity.

Two patients were being prescribed combined antipsychotic medication above the BNF maximum limit. The hospital did not have monitoring care plans for the patients in relation to risks associated with the prescribed medication.

One patient prescribed clozapine had regular plasma levels undertaken when the dose had changed and when smoking status changed, which was an example of good practice. However, there was no information detailed in care plans regarding side effect monitoring or issues relating to clozapine specifically other than blood monitoring. Common side effects include constipation, hypersalivation, weight gain and indicators of life threatening side effects include rapid heart rate and faecal impaction.

Care plans were in place for physical health monitoring and specific conditions, for example, diabetes.

There was no evidence in the clinical records of physical examinations, either on admission or annually. The GP or practice nurse completed the physical examinations, blood tests and ECGs but there was no record of them kept in the patient notes at the hospital. Notes on them were stored in the surgery records. The hospital occasionally requested reports or results; otherwise, the GP service provided verbal assurance regarding results.

Of the 13 records reviewed, six care plans were holistic, personalised and included the patients views. Three of the care plans were recovery focused. Other care plans were nurse-led and not patient centred.

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, DOLS applications and MHA paperwork were stored in separate files.

Best practice in treatment and care

Management of actual and potential aggression training was provided to staff as the NICE guidance "Violence and aggression: short-term management in mental health, health and community settings" (NG10) recommends with 96% attendance. Staff spoke positively about the training and felt more confident supporting patients.

NICE guidance CG178 "psychosis and schizophrenia in adults: treatment and management" states that staff should "monitor and record the following regularly and systematically throughout treatment, but especially during titration: …side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia (for example, the overlap between akathisia

and agitation or anxiety) and impact on functioning." There was no information detailed in care plans regarding side effect monitoring or issues relating to clozapine other than blood monitoring.

The GP referred patients for psychological therapy to the psychology service at the local hospital, there was one patient accessing the service.

A music therapist visited the hospital one day a week offering group therapy and one to one sessions with patients. We observed a music session, which the patients thoroughly enjoyed and during which they seemed relaxed.

The provider had reviewed the service level agreement and reduced the GP visiting arrangements to the hospital from twice a week to once a week. The hospital director and safeguarding team did not feel that once a week was sufficient and would be reviewing the situation. Notes relating to the safeguarding recorded the GP service was going to be increased again in June 2015.

Staff completed a nutritional profile and malnutrition universal screening tool for all patients upon admission. We saw support workers assisting patients to have their meals and drinks, using thickeners for patients that required this. One patient who was very active was offered and encouraged to eat and drink regularly to ensure he had the nutrition intake he required for the energy he exerted.

The hospital completed health of the nation outcomes scales at admission and regularly reviewed.

Skilled staff to deliver care

An occupational therapist attended the hospital one day a week to provide group activities including art and craft. The occupational therapist was not available to interview during this inspection.

A music therapist visited the hospital one day a week offering group therapy and one to one sessions with patients. We observed a music session, which the patients thoroughly enjoyed and during which they seemed relaxed.

There was no psychology input provided by the hospital. One patient was receiving psychology input locally following referral by the GP.

The consultant psychiatrist visited the hospital one day a week to review patients.

A local chemist provided pharmacy support. The hospital director and clinical lead were qualified mental health nurses.

The dementia quality standard, NICE quality standard 1 states that staff caring for people with dementia should be appropriately trained in dementia care. Staff had not attended dementia awareness and communication skills training. A number of the patients had dementia and had very limited verbal communication. We observed a staff member finding it difficult when supporting a patient with limited verbal communication to have his breakfast.

There were five nurses including the clinical lead who were all qualified in mental health nursing and had at least seven years post qualifying experience each. Support workers were not qualified. However, they received a 12-week induction at the start of employment, including four days of office based learning including the mission and values, safeguarding, MCA, DOLS and moving and handling. Staff completed e-Learning in topics of health and safety, infection control, food safety and food allergies. In addition, staff attended training in management of violence and aggression.

Staff reported receiving managerial supervision on average every two months. However, of the 23 supervision files reviewed, eight showed that staff had not had a supervision session recorded and three had not had supervision for over four months. A supervision template was used which recorded the length of supervision, this ranged from 15 minutes to 45 minutes and staff told us this was informal within the nurses office.

Staff had not had an appraisal of their work performance. We were told that this was due to the hospital director having to provide management cover to other locations.

The support workers and qualified staff had separate team meetings. Support workers attended a team meeting in January and June 2015 and qualified nurses attended a meeting in March and May 2015. Staff never met all together to discuss issues relating to patients or organisational issues.

Multi-disciplinary and inter-agency team work

Multi-disciplinary meetings took place weekly when the psychiatrist visited to review patients.

Handovers took place at 10am for the day shift with the nurse in charge and support workers on shift. Support

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Requires improvement

workers had been working for two hours before receiving a handover. The nurse in charge would have had a handover at 8am from the nurse working on the night shift. We observed a handover that started earlier at 9am, the meeting covered the activities for the day, any diary appointments, environmental audit, guidance for supporting patients in hot weather including hydration, PRN medication, how the patient slept and any visits they had. However, observation levels, risks and mental health symptoms and management were not discussed.

There was positive links with the residential care home next door, which was managed by the same provider. Some patients had transferred from Arbour Lodge to the care home and staff shared necessary information.

Adherence to the MHA and the MHA Code of Practice

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

There were five patients detained under the MHA.

Information provided by the trust showed that seven out of 22 staff (32%) had attended training in the MHA. The hospital director advised that an informal training session had been provided to the staff team but there were no records available to verify this. Four of the ten staff interviewed could not explain the guiding principles of the Act or the Code of Practice and their role in relation to the MHA.

Copies of T2 and T3 forms, consent to treatment under the MHA were available with the medication administration recording charts.

We saw evidence within care records that the section132 rights were read to patients on a monthly basis.

Independent Mental Health Advocacy services were provided by a local organisation, with information of how to access displayed on the notice board.

There was a MHA file in place to store documentation for patients relating to the MHA. We found one patient who was detained by the request of the Ministry of Justice who did not have his authorisation relating to leave in his file or his section papers. This was located from the archives when requested.

Good practice in applying the MCA

Three of the 13 patients were subject to a deprivation of liberty safeguards (DOLS). Two further patients had an urgent authorisation submitted. The full applications were still being assessed. Of the three patients who had their DOLS authorised only one had the authorisation in their care records.

Staff told us that for those patients subject to a DOLS a capacity assessment was regularly reviewed, however we could not find this within the records.

The hospital provided Mental Capacity Act (MCA) training to staff with 100% attendance.

The hospital had a mental capacity checklist in place with 10 forms completed in detail for patients. However, three of the files did not have documented capacity checklists in place.

Staff we spoke to had an understanding of the MCA and best interests.

There was a MCA policy in place dated July 13. A list at the back of the policy should be signed by staff to show they had read the policy. However, there were no completed policy checklists for us to view on the inspection. Therefore, it was difficult to know if staff had read the policy.

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

Good

Kindness, dignity, respect and support

Staff assisted patients with their meals and drinks and provided nurturing and encouraging interactions from staff to patients. All staff knew the names of patients and referred to patients in a warm, interested manner. One staff member we observed seemed to find it difficult to support a patient with high needs who had limited verbal communication. They asked another staff member what he would like to drink rather than directing the question to the patient. When another staff member supported him a little later and asked what he wanted to drink, he replied.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

However, there were occasions when staff were watching television in the communal lounge and not interacting with patients.

During an activity within the local community, we saw support workers supporting patients in a respectful and caring manner, involving patients in the conversations and enabling patients with limited mobility to participate by using wheelchairs.

Four patients spoke about their experiences of living at Arbour Lodge. Patients reported that staff were very caring and approachable. However, it was noted by a patient that they felt staff spent a lot of time supporting patients with higher needs.

Patients' relatives reported that their relatives were happy and safe at Arbour Lodge and were looked after well. They reported their family members were calmer and more settled since moving into the hospital. They felt involved in their families' care, attended reviews and the hospital always made them welcome when they visited. Staff were approachable and relatives felt able to raise concerns with them. Areas for improvement from relatives were for their loved ones to be able to go out more and for there to be more drivers to enable this to happen.

Some staff appeared confident about the needs of the patients, knowing how to assist them with their meals, drinks and moving and handling. Other staff seemed more cautious and relied on other staff to take the lead.

Within the handover meeting, support staff knew the patients well and suggested patients that they thought would benefit from the proposed activity.

The involvement of people in the care they receive

The brochure aimed at patients and potential referrers was out of date. It referred to a previous hospital director and stated there was a team of psychiatrists, doctors, occupational therapists and music therapists, implying there was several of each role when there was one of each disciplines. The brochure also referred to activity coordinators who were no longer part of the team. Structured one to one psychology sessions led by the consultant psychiatrist were part of the daily activities, which were not happening. The brochure had small font and was not accessible for patients with visual difficulties. There was no information given to patients to orientate them to the hospital upon admission.

A carers and relatives group had been suggested and relatives we spoke to referred to this and said they would like to attend.

One relative spoke about their experience of transition, where their loved one had moved from Arbour Lodge to the adjoining residential home. They were encouraged to go to visit the residential home and spend time there before he moved across. Staff shared information about his needs and how best to support him with the residential home to ensure continuity of care.

We reviewed the patient survey, nine patients had responded. Three patients reported never being offered a copy of their care plan. Two patients reported sometimes being involved in their care plan. One patient reported not being involved in his care plan. Five patients reported always being involved in their care plan. Six patients reported staff offered them a copy of their care plan.

Of the patients spoken to at inspection, three reported they were involved in their care decisions however had not been given a copy of their care plan.

Advocacy was available to patients and contact information was displayed on the notice board. Three patients reported they knew how to access the advocacy service.

Support workers facilitated the community meetings monthly for patients. Topics discussed included activities. Patients expressed a desire to cook, go for walks and play Scrabble. They also wanted days out further afield to destinations including Blackpool. Patients reported enjoying the music sessions and baking. Areas for improvement included healthier food choices, having more visits to see their family, the staff photo board to be updated and the temperature in the bedrooms to be increased, as it had been cold. The minutes did not follow from the previous months and actions were not captured. However, at the time of inspection a group of patients went to Blackpool for the day, which followed a request from the patients' meeting. Support workers facilitating the meetings passed issues raised to nursing staff and managers.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

(for example, to feedback?)

Requires improvement

Access and discharge

Bed occupancy from 1 January 2015 to 3 July 2015 was 92%. There were nine active referrals to the service.

Patients at the hospital were not from the local area of Stockport. Four patients were from East Lancashire, two were from East Cheshire and there was one patient each from Blackpool, Tameside, Manchester, Cumbria, Bury, Preston and North Lancashire. Historically, Stockport had not placed patients at Arbour Lodge as they used an NHS inpatient service.

Length of stay averaged at 541 days for patients. The hospital director said the aim was to reduce this.

The facilities promote recovery, comfort, dignity and confidentiality

Facilities at Arbour Lodge included a clinic room that was very small. Only one person could fit in the room. The nurse dispended the medication and took it to the patient due the limitations of the room. The GP conducted physical health checks in patients' bedrooms due to lack of space in the clinic.

Activities took place in the main communal lounge. Patients could cook in a kitchen off the lounge.

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.

The quiet lounge accommodated four people and was used for visitors. However families with children were not able to use the room and there was no longer a visiting room available off the ward.

Patients requiring quiet time would often spend time in their rooms.

Food was of a high quality with choices available. The hospital shared feedback from the patient community meetings regarding the food with the chef and improvements were noted. Support workers served food in the welcoming dining area, which had tablecloths and condiments.

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

Staff made drinks for patients. Patients were not encouraged or enabled to make their own drinks.

Bedrooms were personalised with patients' belongings. Patients could have keys to their rooms.

Lockers were available for patients to lock their belongings in however staff had to access them for patients.

Bathrooms had symbols on the doors to assist with orientation of patients who may be confused or disorientated.

Information displayed on the notice boards included appropriate advertising of the independent mental health advocacy service, whistleblowing, CQC, activities planner for the week, occupational therapy and music therapy dates for sessions.

Resources in the communal lounge for patients to occupy themselves included DVDs, CDs, books and board games. A weekly activity board was displayed in the communal lounge. Magazine reading was on the planner on one of the mornings during the inspection. However, this activity was not facilitated. The afternoon session was a quiz. Staff had written a large word search on to a flipchart but patients did not want to participate. Music sessions occurred once a week for a full day. We observed patients enjoying the sessions. The music therapist engaged them and they seemed relaxed. Patients told us that some of the activities were not appropriate to them, for example, colouring in and biscuit decorating. Activities taking place outside the hospital included a day trip to Blackpool that had been requested by patients at the community meetings. There was also a visit to a local Italian restaurant that took place after patients had eaten lunch at the hospital; one patient had lunch at the hospital then ate again at the restaurant. There were limited activities available at weekends.

Staff identified which patients would participate in which activities during the handover meeting. Most patients who went on trips outside the hospital were physically active and capable of saying that they wanted to participate. A relative reported that their family member living with dementia would benefit from the opportunity of spending time out of the hospital.

The hospital completed individual weekly activity reports for each patient. Activities recorded included meals, radio,

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

talking to others, personal care, cigarettes, bath and watching television. Records reviewed showed six of the patients spent significant amounts of time either in bed or pursuing personal activity in their room.

Meeting the needs of all people who use the service

There was a file in the communal lounge with accessible and easy read information regarding medication patients to access.

Information provided to patients was in English, which was appropriate to the client group at the time of inspection. The hospital could access a translation service if needed.

The notice board at the entrance to the hospital had photographs of all staff with the name and role. Patients used this board and felt it was helpful. However, patients noted at the community meeting that the board should be up to date with new staff.

Some of the information displayed on notice boards had quite small font and may be difficult for some people to read.

There were symbols on the bathroom doors and the flooring was plain which is helpful for people living with dementia. However, there were no other features of a dementia-friendly environment.

The brochure given to potential patients had small print and was not accessible to people with a visual impairment or a cognitive impairment. The hospital did not provide patients with any written information at the time of admission to assist with orientation to the hospital.

Food could be prepared to meet the needs of people with dietary requirements. Staff used a thickener for a patient's drinks whose health needs required this.

Historically the hospital had supported patients to go to church. They could access spiritual support for patients if required.

Listening to and learning from concerns and complaints

The hospital had not displayed information for patients on how to complain at the start of the inspection however by the end of the inspection this was displayed on the notice board.

The complaints policy dated 1 July 2013 stated, "Oral complaints must be logged in the clinical file and the unit complaints register with notes of action taken and/or of the disinclination of the patient/carer to proceed with a more formal complaint." There was no complaints register in use at Arbour Lodge. There was a centralised electronic complaints system. However, only the hospital director could access this and the clinical lead had been providing day-to-day management whilst the hospital director was supporting other hospitals. This was highlighted during inspection and access was enabled for the clinical lead.

The data provided by the hospital advised they had had no complaints since November 2013. However, concerns were noted in patient community meetings about the standard of the food. Within supervision records, we noted a patient had complained about a member of staff and their communication but they were not recorded as complaints. At the end of the inspection, the hospital had introduced a hard backed book to record complaints and compliments.

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

Requires improvement

Vision and values

The hospital displayed the vision and values of the organisation in a collage on the wall at the entrance to the hospital. Staff were aware of them and referred to them.

The actions in the quality account for 2015-16 for Barchester independent hospital services were "to improve review of data and quality account planning for the hospital quality and clinical governance committee, to establish a reporting framework on relevant data that involves commissioners and drives forward recovery, to improve review of data on physical restraint and increase the number of staff trained to manage and reduce physical restraint, to improve screening for physical health, review and improve well-being, and to broaden the experience and training of Mental Health Act administrators." The hospital had no individual objectives apart from a proposed expansion to offer more beds and improve the facilities. The hospital expansion plans were at approval stage and would make use of some of the facilities of the residential care home adjacent to the hospital.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Staff were aware of the divisional director who had visited the hospital. The internal health, safety and wellbeing manager visited the hospital to complete health and safety monitoring visits and created an action plan. The most recent action plan highlighted health and safety training attendance which needed to improve. The regulation manager completed regulation team audits in relation to the CQC five key questions with actions of transferring information to their centralised electronic system as areas for improvement.

Good governance

The hospital director had been in post since March 2014 but he had spent several months offering management support to other hospitals and care homes, resulting in development of Arbour Lodge not progressing as he would have liked.

The provider had a number of other services, many of these were residential care homes and the training and corporate policies focused on the needs of those services. The introduction of the hospitals division had enabled the sharing of information relevant to the core service, with meetings of the hospital clinical governance team started in 2014.

The hospital collated data on tissue viability records, PRN administrations, accidents, restraints, staff and residents infected, safeguarding referrals, regulatory notifications submitted, patients on level 3 or 4 observations and audits undertaken. The infection control audit dated 7 July 2015 had five actions to be completed within the month. Follow up audit on 3 August 2015 had the same actions that had not been completed and additional actions had been added.

Key performance indicators included incidents, accidents and bed occupancy.

Staff were not able to add items to the organisational risk register.

The hospital had not submitted data to the Mental Health Minimum Data Set. The Mental Health Minimum Data Set (MHMDS) was renamed Mental Health and Learning Disabilities Data Set (MHLDDS) following an expansion in scope (from September 2014) Submission of MHLDDS data is mandatory for NHS funded care, including independent sector providers.

All of the policies provided or reviewed at inspection had the review date of 1 August 2015, which had passed. In the admissions policy, the MHA code of practice 2008 was referred to and also the CQC essential standards. Both of these have been superseded by new versions. The statement of purpose provided referred to the Resuscitation Council Guidelines (2005) but the most up to date guidelines were issued in 2010. The statement of purpose had not been updated. It referred to a family room for visitors but this had been made into an office so a room for children to visit was not available.

Leadership, morale and staff engagement

There was a high turnover of staff of 25% in the last year. Vacancies were two qualified nurses and nine support workers positions. Sickness rates were 4 % in the last year.

Staff reported knowing how to use the whistleblowing process and felt able to raise concerns with their supervisors and managers. They felt the hospital director and clinical lead were approachable and we observed staff seeking advice from them.

There seemed to be a divide of roles with nurses and support workers having separate team meetings. Nurses did not communicate risks to support workers at handovers.

Staff were not aware of or following policies. There was no system in place to monitor whether staff had read policies and understood them. Policies were all due for review on 1 August 2015 which had not been completed.

Team meeting minutes noted low staff morale amongst support workers, linked to rates of pay, supervision, appraisal and training needs of mental health awareness. Morale was also affected by the different approaches of the nursing staff in how to support patients. Minutes did not have actions or review of the actions at subsequent meetings.

All staff reported enjoying their role and the care provided for patients.

Qualified nurses had areas of responsibility to lead on, develop their skills and monitor progress in. Topics were care files, medication, health and safety and infection control, rotas and medical equipment.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Commitment to quality improvement and innovation

The hospital was not participating in any quality improvement projects.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all staff are trained in the Mental Health Act.
- The provider must ensure that basic life support and emergency first aid training including how to respond to choking is offered for all staff including support workers.
- The provider must ensure that staff are offered training in dementia.
- The provider must ensure that all staff have an appraisal.
- The provider must ensure that all staff receive regular documented supervision.
- The provider must ensure that there is evidence of a physical health examination completed on admission in the care records.
- The provider must ensure they have care plans in place for patients prescribed medication above BNF limits.
- The provider must ensure that staff follow the environmental ligature risk audit report and a ligature risk action plan to reduce risks to patients.
- The provider must ensure that actions from the infection control audits are completed within the timescales set.
- The provider must ensure that staff are following the observation policy and have the necessary skills and knowledge to initiate this responsibility.
- The provider must ensure that complaints are recorded and investigated. Follow their complaints policy and use a unit complaints register as stated in the policy.
- The provider must review all policies and procedures that were out of date and refer to current guidance and best practice.
- The provider must submit data to the Mental Health and Learning Disabilities Data Set.

Action the provider SHOULD take to improve

- The provider should ensure that the authorised deprivation of liberty safeguards is stored in the care record for the patient and the review of a patient's capacity is recorded in the care records.
- The provider should review the visiting arrangement for children to visit the hospital.
- The provider should review the arrangements for team meetings to ensure qualified and unqualified staff meet together.
- The provider should review the documentation that is given to patients prior to and at admission and ensure it is accessible and meaningful to patients.
- The provider should review the activities that are offered to patients, to ensure they are meaningful and appropriate to the patients.

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 18 HSCA (RA) Regulations 2014 Staffing Support workers did not receive training appropriate to their role including basic life support, the Mental Health Act, dementia awareness and carrying out observations. Staff had not had an appraisal. Staff were not receiving regular documented supervision. This was a breach of regulation 18(2) Persons employed by the service provider in the provision of a regulated activity must— (a)receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints There was no log of complaints within the hospital. Staff were not recording concerns received or following their complaints policy. This was a breach of regulation 16(1) Any complaint received must be investigated and necessary and proportionate action must be taken in response to any failure identified by the complaint or investigation.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

The monitoring systems in place were not identifying when staff were not following policies.

Staff were not aware of or following the observation policy.

Policies were out of date.

Staff were not following the actions of the ligature audit. Actions from infection control audits were not monitored and completed to identified time lines.

Risks were not discussed at handover meetings.

Care plans were not in place for patients with medication prescribed above the BNF limit or anti-psychotic medication that requires additional monitoring.

This was a breach of regulation 17(2)

(a)assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services);

(b)assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity;

(c)maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided;