Waterloo Manor Limited

Waterloo Manor Independent Hospital

Quality Report

Waterloo Manor Independent Hospital, Selby Road, Garforth, Leeds, LS25 1NA.

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This report describes our judgement of the quality of care at this hospital. 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 hospital

Inadequate 

Summary of findings

Letter from the Chief Inspector of Hospitals

We rated Waterloo Manor Independent Hospital as **Inadequate**:

Patients were cared for in unsuitable environments that compromised their health and well-being. Dirty wards with tired furnishings were not conducive to patients' recovery.

Managers had no plan to reduce the number of fixtures on the ward that could be used by patients to tie a ligature. Also no action was taken to reduce the risk to patients with suicidal thoughts and behaviours.

Staff did not maintain comprehensive risk assessments.

Staff did not manage medication safely and no action was taken on reports from external agencies with a monitoring role to oversee audit and safe practices in relation to medication.

The senior management team did not ensure that learning from serious incidents was always shared with front-line staff. This meant that these staff members did not always benefit from learning the lessons of investigations into incidents, meaning poor or unsafe practices could be repeated.

Staff did not plan, assess, or provide care to an adequate standard. For example, they did not seek the advice of professionals where patients' physical health care needs were potentially compromised, particularly in relation to nutrition, weight management, and healthy life choices.

Patients were transferred from one ward to another during their admission without proper planning or communication. This affected the continuity of care and increased the possibility of making mistakes because historical information, care planning, and relationships between key workers and patients were disrupted.

Staff did not demonstrate a good understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). When staff did assess the mental capacity of a patient to consent to care, their assessment was often not thorough enough.

The overall leadership and management of wards was poor. There were limited systems to audit the quality of care or to listen to patients' concerns and complaints, and insufficient action was taken to improve the overall quality of care.

The service had an improvement plan, developed since the previous Care Quality Commission inspection, but the senior management team did not monitor this closely enough and key actions were not carried out. Staff were not clear when or how improvements were taking place, this meant that improvements to the service were not happening quickly enough.

The senior management team had looked for reassurance on progress in the hospital since the last inspection rather than seeking assurance and taking control and responsibility for the areas of non compliance which had been identified.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

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:

The wards were not safe environments for a number of reasons. They had 'blind spots' where staff could not easily observe patients and maintain safety. They also contained fixtures and fittings that patients at risk of suicide could use to attach a ligature.

Wards were dirty and not routinely cleaned. Some wards did not have a recognisable cleaning protocol. These wards presented an increased risk of infection as cleaning was not being monitored or audited in a systematic way.

The services' risk register had identified damaged furniture as a major concern, however, the service had not taken appropriate action to rectify this.

Staff did not recognise concerns and failed to act appropriately in response to incidents or near misses. When concerns were raised or things went wrong, the response to reviewing and investigating causes was insufficient or slow. There was little evidence of learning from events with a lack of clear actions taken to improve safety.

There were frequent staff shortages of appropriately skilled staff and poor management of agency staff.

Patients were not effectively safeguarded from abuse or the possible risk of abuse occurring.

Staff did not effectively assess, monitor or manage risks to patients.

Are services effective?

Inadequate

We rated effective as inadequate because:

Patients' care and treatment did not fully incorporate current evidence-based guidance, standards or practice.

There was no use of effective evidence based tools used to assess the quality of care patients' received to ensure their outcomes were positive. For example, some patients with risks related to their physical health did not have adequate care plans to meet their needs. There was no focus or professional support in relation to nutrition and diet..

The management of the hospital did not prioritise the training and development of staff, this had an impact on their ability to provide

Summary of findings

high quality care. Staff did not receive adequate supervision and appraisal. Without the appropriate training, patients were receiving care from staff who did not have the skills or knowledge needed to deliver high quality, safe and effective care.

Staff teams provided care in isolation rather than in an integrated way. There was a lack of cohesive working between key members of the multi disciplinary team.

Staff had limited knowledge and understanding of the Mental Health Act 1983 Code of Practice because training had not been identified as a priority.

Are services caring?

Inadequate

We rated caring as inadequate because:

Patients did not feel cared for and feedback about staff interactions was negative.

Some patients said that they had experienced being bullied by staff or other patients at the hospital.

Care plans were not holistic and person centred. Care plans did not demonstrate that patients were adequately involved in developing their care and treatment. Feedback from the family and carer surveys showed that the the hospital was not involving them sufficiently or engaging them collaboratively in care planning as appropriate.

Patient's preferences were not always listened to, or acted upon.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

There were no protocols in place for moving patients between wards within the hospital. This meant that patients were at risk of receiving inappropriate treatment or care because moves were frequently made quickly and without proper planning. This resulted in patients being cared for by staff who were unfamiliar with their needs .

There were no plans in place to effectively manage the discharge of patients from the hospital. Without proper plans the service could not ensure that patients' needs would be appropriately met and so put them at risk of being detained in services for longer than clinically necessary or appropriate.

We found wards to be dirty with damaged furniture. The environment did not therefore promote or enhance patients' recovery.

Patients, families and carers did not believe their complaints were listened to or responded to appropriately.

Summary of findings

The service did ensure people had access to religious representatives and interpreters, but patients said meal choices in relation to cultural identity were limited.

Are services well-led?

Inadequate 

We rated well-led as inadequate because:

Staff were not aware of the care provider's over arching vision and values. The service was unable to present us with a credible statement of vision or guiding values.

The governance arrangements and their purpose were unclear. There was no effective process in place to review key issues, such as the strategy, values, objectives, plans or governance framework.

The staffing culture in the hospital was poor. It was recognised by senior managers as a serious concern, however, they were unable to evidence any clear strategy or action plan to address this. There appeared to be an inability on the part of the senior managers to recognise and address, or improve, the culture and ways of working within the hospital. Communication between the staff delivering the care and treatment and the senior management team of the hospital was poor.

Summary of findings

Service	Rating	Why have we given this rating?

Inadequate

Waterloo Manor Independent Hospital

Detailed findings

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Low secure mental health wards for working-age adults

Detailed findings

Contents

Background to Waterloo Manor Independent Hospital

Waterloo Manor Independent Hospital provides low secure and rehabilitation services for women with mental disorders and complex needs.

The hospital consists of:

- Three low secure wards: Cedar (12 beds), Maple (13 Beds) and Larch (8 beds).
- Three locked rehabilitation wards: Beech (6 beds), Holly (4 beds), Hazel (8 beds).
- One open rehabilitation ward: Lilac (5 beds).

The hospital has a total of 56 beds.

The service had been inspected three times since it was registered in October 2010.

At the time of the last inspection, Waterloo Manor Independent Hospital did not meet the essential standards relating to:

- care and welfare of people who use the service (Regulation 9)
- safeguarding people from abuse (Regulation 11)
- management of medicines (Regulation 13)
- staffing (Regulation 22)
- supporting workers (Regulation 23)
- assessing and monitoring quality (regulation 10)
- records (Regulation 21).

These compliance actions were inspected as part of the comprehensive review and the requirements remained unmet.

Our inspection team

The Lead Inspector was Graham Hinchcliffe

Deputy Inspector Barry Wilkinson

The team that inspected Waterloo Manor Independent Hospital consisted of eight people: one expert by experience, three inspectors, one Mental Health Act reviewer, two nurses, and one consultant psychiatrist.

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?

Detailed findings

Before the inspection visit we reviewed information that we held about these services and asked a range of other organisations such as NHS England and Clinical Commissioning Groups for information.

During the inspection visit, the inspection team:

- visited all seven wards, looked at the quality of the ward environment, and observed how staff were caring for patients.
- spoke with 24 patients who were using the service.
- spoke with the charge nurses or acting charge nurses for each of the wards.
- spoke with 22 other staff members; including doctors, nurses, and senior managers.
- interviewed the divisional directors with responsibility for this service.
- observed two hand-over meetings and one multi-disciplinary meeting.

We also:

- looked at 20 treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service.

Inadequate

Are services safe?

Our findings

Safe and clean environment

Ward environments were not adequately safe or clean. We inspected all ward areas and observed that there were areas which patients had access to that could not be safely observed. Overall, wards lacked enough parabolic mirrors to ensure all areas of the ward could be observed, including potential blind spots. We saw examples within incident reports where patients took opportunities to harm themselves in the absence of safe and effective staff observation.

There were no qualified nurses based in the communal ward areas where patients had unrestricted access. We observed qualified nursing staff spending time in the ward office and not engaging with patients on the wards or carrying out core nursing tasks. We did not observe nursing staff effectively leading staff teams to ensure wards were well organised and structured. This meant staff were not following the organisation's observation policy, dated October 2014, to ensure the safety and well-being of patients.

Incident records that showed a number of serious incidents, involving the use of ligatures, had occurred in the service during the months prior to our inspection. We asked the service to provide us with the exact number of incidents which had occurred in the service over a 12 month period involving ligatures and other self-harm activity. The service did not have this information available when it was requested, despite repeated attempts from inspectors to obtain the information.

Staff carried out assessments of ligature risks on all wards in May 2014. The ligature assessments had identified many high level risks on all wards. The service took some action to address the risks identified, such as the replacing of some shower taps. There were plans in place to conduct a larger programme of works to address many of the existing risks. However, the plans had no clear time scales stating when the actions to reduce the risks should be completed. We raised concerns directly to the senior management team regarding ligature points in high risk areas.

The permanent staff we spoke to knew where ligature cutters were located and told us that they knew how to use them. However, due to high numbers of agency staff employed within the hospital, there was an increased risk that some staff would not be able to identify and use ligature cutters in an emergency.

Communal areas were dirty. We found dirt and debris under kitchen appliances, furniture that was broken or damaged, bathrooms in patient bedrooms that had mould and stagnant water on the floors and walls. There was what appeared to be blood stains on a door frame of one ward. Ward cleaning was not consistent across the hospital. For example, some wards had domestic cleaning staff with daily cleaning schedules in place which were monitored, other wards had domestic cleaning staff who cleaned twice weekly, but there were no cleaning schedules in place to allow monitoring of cleaning. Patients cleaned communal areas of wards, however, there were no protocols in place to ensure patients cleaned effectively.

The cleanliness of the wards and standard of furniture had repeatedly been brought to the attention of the senior management of the hospital through patient meetings and governance meetings and had been placed on a risk register, however, no action had been taken to address the inadequate standards within the ward environments. Patients told us that they were unhappy with the ward cleanliness and standard of furniture provided.

We concluded that the poor environment impacted on the health, well-being and recovery of the patients at Waterloo Manor Independent Hospital.

There was no consideration of any quality of life indicators to assess the health and well-being of patients.

Emergency equipment, including oxygen, was in place. It was checked daily to ensure it was fit for purpose and could be used effectively in an emergency. Medical devices and emergency medication were also checked daily. However, training records we looked at showed 76% of staff had received training in life support. The service did not have any processes for ensuring agency staff had received training relevant to the care and treatment to be provided at Waterloo Manor hospital.

Staff had personal alarms to use in the event of an emergency, however one member of staff was working alone with patients in an isolated area of the hospital and

did not have access to a personal alarm. We raised this as an urgent concern to the management team and as a consequence the member of staff was provided with an alarm.

Safe staffing

The service carried out a review of nurse staffing levels, this was used to set staffing levels on each of the wards. We reviewed the staff information available to us prior to our inspection and saw that staffing levels were in line with the levels and skill mix determined by the service as safe.

However, we could not establish if staffing levels on individual wards were adequate, as we found staff were regularly moved around the hospital to meet the needs of wards, and it was not possible, based on the information provided, to understand how frequently staff were being moved. There were no records kept of times nursing staff were deployed to other wards. Inspectors repeatedly requested information on how staffing levels were determined on a daily basis and what tool was used. The service did not have this information available despite repeated requests by inspectors.

The hospital managers told us they had a high number of staff vacancies across the service, which included nurses and health care assistants, but could not tell us what the staffing gap was, only that it was "high". They told us that the vacancies resulted in a significant use of temporary agency staff. We looked at minutes of board meetings, these stated that the service struggled to recruit and retain nursing staff. The service covered 263 shifts with bank and agency staff for the low secure service and 351 shifts for the rehabilitation services.

Three charge nurses told us they could not obtain additional staff when the needs of patients changed unless a senior manager agreed to the request. Hospital managers stated that the company directors placed financial constraints upon them. Hospital managers also told us that they lacked autonomy to address concerns regarding staffing levels, which meant there were instances when staffing shortages occurred. We asked how frequently this happened, but hospital managers could not to provide us with any specific details.

Temporary agency staff, who had not worked on a ward at the hospital before, were given a brief induction to the ward. This included orientation to the layout of the ward. They were provided with written guidance on the local health, safety, and security procedures for the wards. They were expected to read these at the start of their shift. It did not provide sufficient detail to ensure staff were adequately informed about the nature and responsibilities of the ward. Hospital managers told us that temporary agency staff were responsible for the daily management of the ward and although the service tried only to use nursing staff who had worked in the hospital previously, this was not always guaranteed.

All of the patients in the hospital presented risks to themselves or others, and at times may have required the use of physical intervention. Since staffing rotas did not make clear which staff had training in the use of physical interventions it was impossible to say whether there were enough staff with the right skills on duty. Also it was unclear if agency staff had received the same intervention training as permanent staff and the hospital management team could not provide us with any assurances.

Patients using the service could not always take up agreed escorted leave as there were not always enough staff to escort them. We asked for information to clarify how many times leave was cancelled due to short staffing over a three month period. The information provided simply stated “many cancelled”. The service could not tell us exact numbers or how they analysed this information to review staffing levels to ensure patient leave was supported.

All nursing staff we spoke with told us the majority of patients were offered a one-to-one meeting with a member of staff every day. However, many patients told us they did not have sufficient one-to-one time with staff because staff were unavailable. The service could not provide us with any information about any quality assurance systems in place to monitor one-to-one time with patients.

Regarding arrangements for accessing emergency medical assistance, medical staff told us that in the event of an emergency the service accessed emergency services, used local GP services, or used out of hours services.

Assessing and managing risk to patients and staff

We spoke with patients on all the wards we visited. A few patients felt unsettled and unsafe after incidents on the wards. These included patient on patient assaults and bullying occurring by other patients. There were reports of staff bullying patients. Records we examined showed that the service had upheld 22 allegations of abuse by staff towards patients between January 2014 and January 2015.

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Are services safe?

Only six of these allegations were reported to the local safeguarding authority. No safeguarding alerts had been made by senior managers or nursing staff, despite some allegations being serious in nature, such as staff being verbally abusive to patients and failing to follow a patient's diabetic regime.

There were 46 other allegations of patients stating that they were being bullied by other patients since January 2014. Fifteen patients told us they did not feel supported or listened to by staff when raising concerns about their safety.

The service had identified bullying on the wards as an issue and set up patient forums. However, these were only in their infancy at the time of our inspection and it was unclear if they were proving to have a positive effect. Staff told us the forums were positive and bullying appeared to have reduced. However, we asked what tools were used to formulate the assessment, but none were in place.

While staff stated they had received training in safeguarding adults and children, records we saw showed it was not always up to date. Some staff received training in 2011 with no further updates evident since.

The service also had a confidential whistleblowing line staff could use if they felt patient safety was compromised. However, the service had only been used on two occasions at the time of our visit. Staff told us they did not feel confident their concerns would be taken seriously if they used the whistle blowing service and therefore often said nothing, or made referrals to other agencies to take action, such as the CQC.

Patients did not describe the service positively. They talked about being bullied by staff, both permanent and temporary, about being insulted and treated in a disgraceful manner. We brought the patient feedback to the attention of senior managers in the organisation. We spoke with the safeguarding lead for the organisation who told us that staff required additional training because it was not always evident staff knew how to report incidents of abuse.

Managers told us safeguarding was discussed at ward meetings and it was a standing item on the agenda. They also told us safeguarding discussions with staff also took place during supervision to ensure staff had sufficient awareness and understanding of safeguarding procedures.

However, when we requested to look at ward meetings we found they had no agenda and there was an overall lack of staff supervision and we could not evidence that safeguarding being discussed.

We were told that each patient had a risk assessment completed on admission. We looked at patient records and each contained assessments of their individual risks.

Staff told us that, where particular risks were identified, measures were put in place to ensure the risk was managed. For example, the level and frequency of observations of patients by staff were increased. Individual risk assessments that we reviewed took account of patients' previous history, as well as their current mental state. However, despite these being in place the credibility was compromised because there were three assessments in place that staff regarded as risk assessments and each assessment was contradictory of the other, which meant there was no consistent approach to managing risk.

Risk assessments were generally updated, but we saw four examples where they were not current. A generic risk assessment tool was used for assessing patients who were going on leave from the hospital. However, this did not take into account the individual risks of each patient or effectively consider the risks prior to a patient going on leave. We saw an example in one patient's record where they had failed to return from leave and placed themselves at risk of harm. The risk assessment completed prior to the person leaving was not sufficiently robust and failed to take into account the patients risk profile.

We observed a morning handover on two wards. Some staff turned up late and important information was not repeated, therefore, these staff did not receive the necessary information to meet the patients' changing needs. There was no discussion of current risks and no discussion around the patients' care and treatment. The overall handover process was inadequate.

Staff told us there was a problem with some patients taking illegal drugs when patients left the ward. This posed a possible risk of drugs being brought into the hospital by patients returning from leave. However, staff we spoke with were confident that the use of drugs on wards was low due to security measures in place that all staff were aware of.

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Are services safe?

There was a policy in place in respect of searching premises, patients and/or their property; this was up to date. The policy described the search procedure and the use of drug detection.

Staff told us there was a greater emphasis within the service on the use of de-escalation techniques, which resulted in a reduction of the number of times patients were restrained. Guidance published by the Department of Health in April 2014 called "Positive and Safe" includes new guidance on the use of face-down restraint. Senior staff told us that the guidance on restraint was being revised. Further work was needed on this to reduce the risk of physical and psychological harm to patients and staff. Records we looked at were unclear on the number of incidents that included the use of de-escalation techniques which then escalated to the use of restraint over the past year. We could not confirm if the use of restraint had reduced and the service did not have a clear audit to demonstrate the use of de-escalation or restraint.

We reviewed the medicine administration records of several patients on wards we visited. We spoke with the visiting pharmacist about medication management. The pharmacist informed us that they were not invited to attend or contribute to the medicines management meetings at the hospital. The minutes of monthly medicines management meetings from the last six months prior to our inspection visit confirmed this. We were also informed that the pharmacist completed a weekly audit of medicines management. They raised issues every week about the untidiness of clinic rooms and the temperature of the storage facility, but no action was taken to make any changes. We asked to see the pharmacy audits and action plans but these were not provided to us despite repeated requests from inspectors to hospital managers.

On Hazel ward the clinic room was used as a staff office and storage area for coats and bags. There were cups in the clinic sink that staff had used for drinks, these were alongside medication spoons and utensils. There was no apparent consideration of how inappropriate this was in relation to managing infection control and basic hygiene.

We could not always find evidence that the Responsible Clinician had discussed treatment with patients, or assessment of their capacity to consent to treatment. For example, a Responsible Clinician had prescribed up to 175% of the British National Formulary (BNF) in regards to an anti-psychotic drug and recorded that "the client agrees to ECG and bloods". There was no record stating the patient consented to the treatment provided or whether or not they had the mental capacity to do so. On one ward there was an overall absence of recorded reviews of medication when they were prescribed over BNF limits by the Responsible Clinician.

Patients on Maple ward told us that they did not receive much information about their medication and were not always consulted on the medication and treatment provided and were not therefore always aware of possible side effects that they should be aware of.

Track record on safety

Between the 7 January 2014 and 2 January 2015 there had been 56 serious untoward incidents identified by the service.

Eight Incidents related to incidents of self harm.

24 incidents of patient on patient abuse.

Four sexual related incidents.

12 incidents of abuse by staff.

Three incidents of patients being absent without leave.

Five incidents of another nature such as financial abuse and historic disclosures of abuse.

Reporting incidents and learning from when things go wrong

Staff we spoke with on all wards could describe how they reported incidents and told us about log books, which were then uploaded onto an electronic system. All nursing staff told us there was no overview of incidents reported on their wards. They described how graphs showing incidents and trends were produced by one consultant psychiatrist. However, they did not understand the information provided and failed to see how it was beneficial or useful. We took time to review the data and found the system complex and while the information demonstrated a reduction in incidents for some patients, it was unclear how the information was collected.

Nursing staff told us that the feedback they received about incidents was inconsistent because they often were not informed about incidents across the hospital. They told us there were weekly lessons learnt meetings. We attended one of the meetings and found there was no discussion regarding incidents which had occurred, or even any

Inadequate

Are services safe?

sharing of information regarding incidents. The meeting was poorly structured, there was no agenda, no focus for discussion, and no focus on patient safety. The meeting was chaired by a senior manager within the service but there was a lack of preparation prior to the meeting.

Inadequate

Are services effective?

Our findings

Assessment of needs and planning of care

The assessment of patient's needs and planning of care was inadequate.

We looked at the physical health care needs of patients and found they were not sufficiently assessed. For example 15 patients we reviewed had a Body Mass Index (BMI) between 30 and 50 and had health conditions associated with obesity, such as diabetes. A person with a BMI of 30 or over is regarded as clinically obese and, therefore, in order to remain healthy, a weight reduction programme and health promotion are essential. There was no input from a dietician in any of the care plans we reviewed.

We looked at relative/carer satisfaction survey which was undated but was a period of up to June 2014. Some of the comments highlighted were " visits and outing cancelled suddenly, physical health neglected, appointments missed or not made". Other comments were "staff are unqualified for their positions". The comments highlighted by relatives and carers from June 2014 were reflected in our inspection of the service

Eight nursing staff, including charge nurses, told us that they did not understand the risk assessment tools used and how these should inform patient's care plans. The psychologist and the occupational therapists had compiled assessment and treatment plans, but these were not incorporated by the nursing staff into effective care plans for the patients.

Care records were not always up to date. For example, the front sheet of patient information for five patients had not been updated since the patients had moved wards within the hospital. The dates of admission to the ward were not listed accurately. We also found 'AWOL information' did not contain the most up to date risk factors as listed in the care plans as these had not been updated since admission for some patient's.

Best practice in treatment and care

Wards did not have any lead nurse for physical health to ensure patients needs were met. Regular physical health checks were not actively taking place because staff did not have the suitable skills to ensure this was done effectively. They had not received training in physical healthcare and this was confirmed by senior managers . We saw one record where training had been sourced but we were told by senior managers that it was not completed. The senior manager could not explain to inspectors why the training had not been completed.

The hospital cook had not received any training on healthy eating. We looked at the food available on the four weekly menu and saw that there was only 'plated salad' as a healthy option each day. Many patients that we spoke with told us that there were not enough healthy options and that they were concerned about their weight. Minutes of the patient community meetings from Cedar, Hazel, Larch and Maple from December 2014 to February 2015 showed on multiple occasions that patients had expressed a desire for more healthy food options.

We observed during the inspection that an activity on offer was baking cakes. Patients who were at risk of further weight gain were encouraged to participate in this activity and it was deemed by staff as supporting patients with daily living skills. We questioned a senior manager about the appropriateness of the activity being offered given the health and well-being of many patients. We were told the service had a healthy eating programme. We were shown the details of the programme, but it was not an effective plan as it simply consisted of a poster detailing when a healthy eating group was due to commence . No staff had received training in obesity, healthy eating, diet or nutrition and yet were expected to give advice to patients.

We looked at the care plan of one patient who had unexplained continence problems. There was no input from a continence nurse and no care plan in place to manage incontinence. Failing to manage continence correctly can have a negative impact, such as development of pressure sores, additionally there can be issues of dignity and respect for the patient which should be carefully and sympathetically considered.

One patient required referral to a sexual health clinic. Staff told us and records showed an appointment had been made, but the appointment was not attended and staff were not able to give a suitable explanation as to why not. No further appointment had been made.

The wards did not use any recognised systems such as for example Modified Early Warning Signs (MEWS) to identify

physical health concerns. Because no such systems were in place, if a patient's physical health was deteriorating or giving cause for concern, this may not have always been identified.

Patients could access psychological and occupational therapies as part of their treatment. Psychologists and occupational therapists were part of the ward team. However two occupational therapists we spoke with told us they did not feel valued by nursing staff. They told us that intervention plans as well as advice and guidance was readily ignored.

The ward staff assessed patients using the Health of the Nation Outcome Scales (HoNOS). These covered 12 health and social domains and enabled the clinicians to build up a picture over time of their patients' responses to interventions. However staff did not understand how to use the information and had not been trained to use HoNOS. All the nursing staff we spoke with told us they thought it was another tool to carry out risk assessments; HoNoS is not a risk assessment tool.

The service had implemented 'Total Team Therapy',however, none of the staff we spoke with, other than some of the hospital management team, were able to tell us about this approach to care. Most staff showed a lack of awareness of or understanding of Total Team Therapy, therefore, it was not particularly well embedded into the service.

Skilled staff to deliver care

Staff were not appropriately skilled or supervised to ensure patients received safe high quality care.

Staff told us that clinical supervision was given on a one to one basis or at 'reflective practice' groups which were held on a weekly basis. We attended a reflective practice group on 20 February 2015 at 1pm. There was no set agenda for the group or minutes taken. There were no previous records of minutes taken. The discussion within the meeting was about problems within the hospital and was not about clinical matters.

Staff told us, and records we looked at confirmed, that there was limited management supervision in place available for staff. The information provided showed only 56% of staff had received supervision over a 12 month period.

Throughout the inspection we spoke with staff on all seven wards about appraisals. Insufficient numbers of staff had received an appraisal within the last 12 months.

We were provided with a copy of the appraisal database as at week commencing 8 February 2015.

- 21 out of 74 permanent health care staff had not had an appraisal within the last 12 months.
- Six out of 19 nursing staff had not received and appraisal within the last 12 months.
- 12 out of 44 other (management and admin staff) had not received an appraisal within the last 12 months).
- ·No bank staff had received an appraisal.

The training records we looked at saw staff from records of the 19 February 2015 showed that there were large gaps in mandatory training such as:

- · First Aid; 78% of staff had up to date training.
- · Moving and handling; only 15% of staff had up to date training
- · Management of Actual or Potential Aggression;70% of staff had up to date training
- · Health and safety; 74% of staff had up to date training
- · Mental Capacity Act; 48% of staff had an up to date training

No staff received training in physical healthcare or HoNOS.

Multi-disciplinary and inter-agency team work

Patient records included advice and input from different professionals involved in patients' care. Patients we spoke with confirmed they were supported by a number of different professionals on the wards,such as nurses, health care workers, occupational therapists, psychologists and psychiatrists. Information provided by the MDT was not formulated into any robust nursing care plan.

We observed one MDT meeting and found there was sharing of information about patients with a focus on reviewing their progress. Different professionals worked together effectively to assess and plan patients care and treatment. However, our findings were that this appeared to be an exclusive way of working for one psychiatrist who was the hospital clinical director and this way of working was not consistent across the hospital. Records we examined in relation to 15 patients under other psychiatrists did not demonstrate the same collaborative way of working.

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Are services effective?

We did not observe inter-agency work taking place such as care co-ordinators attending meetings. This did not appear to regularly occur from the records we examined or was not clearly recorded.

Adherence to the MHA and the MHA Code of Practice

Records showed that only 48% of staff received training on the Mental Health Act and the Code of Practice.

We could not find evidence of capacity assessments regarding the consent and use of medication in the patients' notes. We did not see any capacity assessment forms for this purpose. Also we could not find evidence that statutory consultees were recording in the patient's file their discussion with the visiting Second Opinion Approved Doctors. We were equally concerned that staff were not aware that this was required by the Code of Practice.

The use of anti-psychotic medication for some patients was high and at times above British National Formulary (BNF) limits. Although this was properly authorised it's usage should be reviewed and recorded at agreed regular interval. Patients should always be made aware of any use over BNF limits unless the reasons for not informing them are clearly documented in the patient's notes.

Information on the rights of people who were detained was displayed in wards and independent advocacy services were available to support patients.

We saw evidence on patient files that patients had appealed to the Mental Health Review Tribunal and had contact with solicitors for advice and support with this process.

We could not find the renewal of detention documents for one patient whose detention was due for renewal in December 2014. We were told that the documents had not yet been filed and they were not found during our visit.

Good practice in applying the MCA

Some staff told us they had received training in the use of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff were not aware of any audits taking place to monitor the use of the MCA 2005.

We looked at the records of two patients where we had identified concerns regarding the application of the MCA 2005 and found the staff knowledge to be very limited. For example one patient who required physical intervention for personal care had neither a capacity assessments or a best interest assessment, nor input from an independent mental health advocate.

Inadequate

Are services caring?

Our findings

Kindness, dignity, respect and support

Patients told us that staff did not always treat them with respect. They told us that their privacy and dignity was not always considered and often felt unable to raise concerns about the attitudes of staff towards them. Records we looked at showed that out of 106 complaints made within the 12 months prior to our inspection, 48 of them related to allegations of abuse by staff. 22 of these allegations had been upheld by the organisation, but only six had been referred to the local safeguarding authority for independent investigation. The allegations made were against temporary and permanent staff.

We observed staff interacting with patients and found there was an overall lack of engagement. We found that patients spent hours of time sat around with very little to do. Staff appeared to lack interest and did not engage in providing good quality care to patients. For example, we observed staff over an 18 hour period over three days and found staff spent considerable time sat on sofas in communal areas with up-to eight patients at a time and they were not seen to offer activities or motivate patients to participate in anything therapeutic, other than baking cakes which was detrimental to some patients health and well-being.

The involvement of people in the care they receive

Care plans were not personalised, holistic or person centred. On some wards patients had made written comments about their care plans. Patients we spoke with on different wards were generally aware of the content of their care plans, although five patients said they had not seen them and were unaware of its contents. Some care plans had been signed by patients to say they understood their care and treatment.

Staff told us patients were encouraged to involve relatives and friends in care planning if they wished however we did not see any input into care plans from patient relatives/ carers. Comments from a relative and carer survey in June 2014 had comments such as " I don't know if I am happy with her treatment, nobody tells me anything"; "I have requested updates on a regular basis, but get told nothing".

Details of local advocacy services were displayed in all the wards. Patients told us they were supported to access an advocate if they wished. We saw the advocates had raised a number of complaints on patients' behalf, such as needing new plates and cutlery. However, no action had been taken to address these patients' complaints.

We saw all wards had weekly community meetings where it was formally recorded that patients did not engage in the meetings, as they believed their views were not taken into account or acted upon. We saw examples in meeting minutes where patients complained about no action being taken to resolve issues such as healthy diet options or the standard of furniture and cleanliness on wards. Patients told us they did not feel listened to.

We did observe staff respond to one patient who was in distress in a calm and respectful manner. They de-escalated the situation by listening to and speaking quietly to the patient.

When staff spoke to us about patients, they discussed them in a respectful manner but were not always able to tell us about their care and treatment plans in sufficient detail to evidence appropriate understanding of individual's needs; an enhanced understanding is needed in order to manage individual risks appropriately.

Inadequate

Are services responsive?

Our findings

Access and discharge

The service had an admission policy. Staff we spoke with told us that they often felt patients referred to the service were not suitable either due to their complex needs or physical healthcare requirements. Staff told us this made delivering care to a high standard was often compromised. There were patients in the service who had learning disabilities and Asperger's syndrome who were at more risk of not having their needs met because staff had not received any training in these areas.

We looked at the discharge arrangements across all wards and found in all the care records we looked at that none of the patients had discharge plans in place. Furthermore, there was no information within the care plans detailing the needs of patients and the services they require in order to progress towards discharge. We found some patients had been detained at the service for a period of up to five years without any clear plans for discharge. The average length of stay was 24 months for secure services and 10 months for rehabilitation services.

Some patients experienced several moves between wards for non-clinical reasons during their stay at the hospital. Of these, some were transferred during the night and/or went to wards where they did not know, or were not known by, the multidisciplinary team. There were informal agreements rather than a clear protocol on the management of transfers between wards. This meant that transfers between wards were not managed in a planned or co-ordinated way. This type of poor management can lead to patients needs not being met.

The facilities promote recovery, comfort, dignity and confidentiality

The wards had a full range of rooms and equipment. This included space for therapeutic activities and treatment. However, during our inspection we did not observe patients accessing any rooms other than communal sitting areas where they were observed by staff.

The service had a number of rooms which could be used by patients to meet their relatives/friends/carers. There was also a family room where children could visit. This was located away from all wards.

The service had multi-faith rooms that were also used as staff handover rooms and meeting rooms. The rooms were not being used for the intended purpose and did not reflect patients' religious and cultural needs appropriately.

Each ward had access to a phone and patients had access to it.

All the wards offered access to an outside space, which included a smoking shelter. However, we found some of the areas to be in a state of disrepair. The areas were not clean and many were littered with used cigarette ends with no apparent system to ensure that these areas should be maintained appropriately.

Food was served at specific meal times. We found that, where patients may be absent from hospital, during meal times for reasons such as medical appointments and granted leave, upon their return, the choice in meals was limited. Patients told us the food was not to a good standard. They often felt it was unhealthy and that there was insufficient choices available. Records we looked at showed that food was often complained about and the meals provided were not of a healthy nutritious nature. Patients who were of particular faith or culture had limited choice in food, there was nothing specific on the menus we looked at which took into account patients' religion and culture.

Weekly activity programmes were advertised on all wards and the activities were discussed as a “day planner” for each ward. Records were kept of daily activities provided on the wards and a register of who had participated. Staff told us that planned activities were sometimes cancelled at busy times because of a lack of staff available to run them. We did not observe patients participate in any activities on the wards during the course of our inspection. Patients sat around in chairs being observed by staff who appeared to make little effort to engage them in any kind of meaningful activities.

Patients also had access to occupational therapy. An occupational therapist was assigned to each ward and conducted individual assessments of patients’ needs. Two of these therapists told us that patients were more interested in taking leave so they could purchase crisps and fizzy drinks than engage in therapy sessions such as walking groups, swimming and gym sessions. They told us nursing staff did not encourage patients to use their leave effectively. It was acknowledged by senior managers that

Inadequate

Are services responsive?

activities were often not participated in unless it was section 17 leave where patients could access the local area to purchase fizzy drinks and crisps. It was equally acknowledged that no audits of activities were carried out by the service to measure engagement and effectiveness.

Meeting the needs of all people who use the service

The service had an external organisation providing support to those who defined themselves as lesbian, gay, bisexual and transgender. However, it was unclear how the wards were representing safe wards through inclusion for all. Patients told us that bullying between patients occurred because of sexual orientation. We saw examples in incident records to support what we had been told.

Attempts were made to meet patients' individual needs including cultural, language and religious needs. Contact details for representatives from different faiths were available within the hospital. Local faith representatives visited patients where a request had been made.

Interpreters were available to staff and were used to help assess patients' needs and explain their rights, as well as their care and treatment.

Listening to and learning from concerns and complaints

As stated in other areas of this report, complaints and concerns were not listened to, responded to or investigated effectively. Patients knew how to raise concerns and make a complaint but told us that they had stopped complaining "because nothing ever happens when you do". Feedback from family and carers was similar to what patients told us. For example in a survey June 2014 people said "when I complain it seems you take no notice" and "I find specific complaints made not really addressed adequately". There were no positive comments to note.

Inadequate

Are services well-led?

Our findings

Vision and values

The organisation's vision and values for the service were not evident. They were not displayed around ward areas and staff we spoke with other than senior managers had no knowledge of what the vision and values were.

Several staff suggested that communication was mostly one way, from the board down to the wards. They were not sure whether messages travelled effectively in the opposite direction and told us they felt they were not listened to.

Senior managers acknowledged that there was a poor culture in the hospital and that they believed certain staff were intentionally attempting to sabotage the reputation and credibility of the hospital. We were told that where issues regarding individuals had been identified then disciplinary action was being taken. However, there was still no effective plan implemented to ensure that the communication between staff and management improved. There equally appeared to be a lack of recognition from senior managers of their own shortfalls and contribution to the negative culture between some staff and management. By not providing suitable training and supervision as well as not listening to concerns raised by staff through the complaints process, the senior managers had allowed the poor culture to prevail.

Good governance

The overall governance for the service was inadequate. The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the organisation but these were either not used or understood.

Three charge nurses told us that they did not have enough time or autonomy to manage the wards. They also said that, where they had concerns, they did not feel that they could raise them and that appropriate action would be taken. They gave examples of when they questioned the management about staff being moved around the wards, they were told "staff were there to meet business needs." This was recorded in a complaint we reviewed.

The organisation's risk register did highlight concerns such as ligatures and poorly maintained physical environments, however, no actions were taken by the senior management team to ensure patients' were in receipt of high quality, safe and effective care. Senior managers told us that they did not have the necessary autonomy or permissions from the organisation's board of directors to address these concerns adequately, as financial constraints were placed on them by directors, preventing them from taking sufficiently robust actions.

Leadership, morale and staff engagement

We found the wards to be poorly led. There was no evidence of clear leadership at a local level. Charge nurses were not visible on the wards during the day-to-day provision of care and treatment, they were not always accessible to staff, and they were not proactive in providing support. The culture on the wards was not open and staff did not feel encouraged to bring forward ideas for improving care.

The ward staff we spoke with were not enthusiastic and did not appear engaged with developments on the wards or in the hospital. They told us they did not always feel able to report incidents, raise concerns and make suggestions for improvements. They told us they did not feel listened to by their line manager. Some staff gave us examples of when they had raised concerns about the care of patients' and said this had been received negatively by senior managers and that no changes being made.

All nursing and healthcare staff we spoke with told us that, following significant changes in the service within the recent year, morale in the service was very low. They also felt that although they had confidence in the new hospital director, the service was not moving forward effectively because other senior managers were hindering relationships and effecting possible improvements because of what they perceived as bullying and harassment.

Sickness and absence rates were high and the ability to recruit new staff was proving a difficult issue for the service. However, when we asked the service to provide specific details regarding this they could not, despite repeated requests from inspectors.

At the time of our inspection there were grievance procedures being pursued within the wards, and there were allegations of bullying and harassment. We were unable to determine from the data provided exactly how many.

Inadequate

Are services well-led?

Staff were aware of the whistle blowing process if they needed to use it, but told us they would rather contact other agencies such as CQC because they did not feel listened to by their own organisation and they also believed that their concerns would be ignored.

Ward managers told us that they had only very limited access to leadership training and development within the hospital.

Commitment to quality improvement and innovation

At the time of this inspection we could not identify any evidence to demonstrate the service was committed to quality improvement and innovation.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

Action the provider MUST take to improve

The service MUST ensure that the environment adequately meets the needs of patients by ensuring that action is taken to minimise the risk of harm.

The service MUST ensure that people have appropriate risk assessments in place which reflect patient risks and actions to be taken to reduce the possibility of harm.

The service MUST have effective arrangements in place for the safe management of medication.

The service MUST have appropriate methods in place to analyse incidents and learn lessons when things go wrong.

The service MUST ensure that staff have the necessary skills and experience to ensure the safety of patients. The service must review the way staff are deployed around wards to ensure they are sufficiently staffed.

The service MUST ensure that patients are protected from the risk of abuse or possible harm by ensuring that there is an open and transparent culture within the hospital and the wider organisation to allow and encourage staff and patients to discuss concerns openly without fear of victimisation, bullying or harassment.

The service MUST ensure that patients' physical, social and psychological needs are appropriately assessed and that care is delivered effectively.

The service MUST ensure that patients have discharge plans and that effective inter agency working relationships with partner agencies are being managed appropriately to ensure optimum outcomes for patients.

The service MUST ensure that best practice and guidance is followed in managing and treating physical and mental health conditions.

The service MUST ensure that staff receive adequate training, appraisal and supervision to meet both management requirements and clinical development needs.

The service MUST ensure that patients receive a healthy and nutritious diet.

The service MUST ensure that the Mental Health Act and Code of Practice are complied with and that staff have the necessary training to ensure compliance.

The service MUST ensure the Mental Capacity Act is applied correctly when required and that staff have the necessary training to ensure compliance.

The service MUST ensure that patients are involved in the planning of their care and appropriate arrangements should be made to meet the needs of patients' religious, cultural and other individual needs.

The service MUST ensure that it has effective governance arrangements in place to ensure effective oversight of all risks within the service and to promote high quality, safe, effective and responsive care and to ensure that appropriate actions are taken to mitigate risks and to promote an open and transparent learning culture within the hospital.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13 (1) Practical steps had not been taken to prevent the risk of abuse to patients.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9 (1) (2) (3) (a) (b) (c) (d) (e) (f) Practicable steps were not taken to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be. Patients did not receive appropriate care and treatment that met their needs. Patients and those acting on their behalf were not adequately involved in the planning of care. Assessments did not take into account current legislation and consider relevant nationally recognised evidence based guidance. Assessments did take into account specific issues that are common in certain groups of patients and can result in poor outcomes for them if not addressed. These include diseases or conditions such as continence support needs and diabetes. Patients' preferences were not taken into account, and make provision for, A clear care and/or treatment plan, which includes agreed goals, was not developed and made available to all staff and others involved in providing the care. Where relevant, the plan should include ways in which the person can maintain their independence. Nationally recognised evidence-based guidance when designing, delivering and reviewing care.

This section is primarily information for the provider

Enforcement actions

The views of patients who use the service and those lawfully acting on their behalf was not sought effectively by demonstrating there was action taken in response to any feedback.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 (1) (2) (a) (b) (c) (d) (e) (f) (g) (h) (I) Assessments, planning and delivery of care and treatment was not based on risk assessments that balance the needs and safety of patients using the service. Practical steps had not been taken to mitigate risks that were identified which compromised patient safety and well-being. Staff were not suitably qualified, competent and skilled to carry out their roles. The environment was dirty and not free from the risk of infection and where furniture and fixtures were damaged they were not repaired or replaced. There was not proper and safe management of medication. The service did not work collaboratively with other professionals external to the hospital to ensure patients received safe and effective care.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17 (1) (2) (a) (b) (c) (d) (e) (f)

This section is primarily information for the provider

Enforcement actions

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 Regulation 18 (1) (2) (a) (b) Sufficient numbers of suitably qualified, competent, skilled and experienced persons were not deployed in order to meet the needs of patients. Staff did not 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.
	The service did not effectively assess, monitor an 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); The service did not effectively 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. The service did not effectively 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;