Lakeside

Quality Report

Lakeside
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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

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

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

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

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 did not rate this service.

We found the following areas the provider needs to improve:

- Data given to us during inspection showed that the provider had 11 vacancies for full time registered staff having in 22 full time registered nurses in post and a vacancy rate of 35% for registered staff.
- There were vacancies for 31 healthcare assistants. The provider had recently recruited 26 healthcare assistants who were waiting to go through the induction process leaving a 15% vacancy rate for unregistered staff once induction of these staff is completed.
- We noticed that some ward areas needed redecoration and repair. Staff told us that issues such as door frames that had been ripped down on Cooper 3 had been reported to the maintenance department and were awaiting repair.

Summary of findings

- Staff told us that there was always a registered nurse present on the wards. However, we observed that there were two occasions on different wards when the registered nurse was not present on the ward for example; due to attending meetings or taking breaks.
- Patients with epilepsy did not have up to date risk assessments about bathing or restraint.
- Not all staff were trained in how to care for patients with epilepsy. At the time of inspection, 55% of staff had received training. Managers told us that further training was planned. There was a risk that patients could die if they were not cared for safely in the event of a seizure.
- The process of assessing, planning and evaluating care appeared disjointed. There was different information in different sections of the records. Three separate folders for each patient were kept.
- It was not easy for staff to find significant information quickly in care records. The patient voice was not always evident indicating whether the patient had agreed to the plan or not. Action plans and other documents did not all have dates and signatures on.
- Three out of eight care plans on Elstow 1 contained unrealistic goals, relating to time frames for settled behaviour without clear explanation.
- We found a discrepancy between one care plan and the prescription. We brought this to the manager's attention and the issue was rectified immediately.

We also found the following areas of good practice:

- The mandatory training compliance rate for permanent staff at this provider was 92% on 7 June 2018.
- The provider had been interviewing three days per week during the weeks prior to inspection and had recruited 26 unregistered staff and one registered nurse to these posts although seven staff were yet to complete induction.
- Ward managers told us they could adjust staffing levels in response to patient acuity and could increase staffing if necessary.
- We saw that care records had comprehensive assessments that were completed promptly after admission.
- Care records showed that patients received physical examination on admission and that there was ongoing monitoring of physical health problems.
- The provider had recently recruited a practice nurse who worked between the hours of nine in the morning to five in the afternoon to address the physical healthcare needs of patients. There was a local GP who attended the hospital on a weekly basis to conduct a surgery.
- The recently appointed psychology lead had introduced a range of evidenced based outcome measures to ensure psychological therapies were evidence based.
- We observed staff speaking with patients in a positive and caring manner.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for people with learning disabilities or autism		Not rated.

Summary of findings

Contents

Summary of this inspection

Background to Lakeside

Lakeside is part of the Accomplish Group Support Limited and consists of the following:

Ashwood unit provides ten beds for women. This is a locked unit for people with autism, personality disorders, and challenging behaviours. The unit is split over two floors and has an upstairs annex.

Elstow 1 unit provides five beds for women. This is a locked unit, but for more stable patients stepping down from Ashwood Unit.

Elstow 2 unit provides six beds for younger men (18-25 years). This is a locked unit.

Elstow 3 unit provides nine beds for men. This is a locked unit. (Elstow 4 closed at present)

Elstow 5 provides eight beds for men. This is a locked unit for more stable patients stepping down

Cooper 1 unit provides seven beds for men. This is a locked male intensive care and admission unit.

Cooper 2 unit provides seven beds for men. This is locked unit for men with a learning disability.

Cooper 3 unit provides four beds for men. This is a behavioural support unit, for patients who require intensive support from staff due to risk behaviours.

Lakeside is registered to carry out the following regulated services:

• Treatment of disease, disorder, or injury.

• Assessment or medical treatment for persons detained under the Mental Health Act (1983)

The registered manager is David Lewis and Controlled Drug Accountable Officer is Victoria Hulström.

The last time Lakeside was inspected was March 2018 this was a comprehensive inspection. Following that inspection, it was decided to carry out a focused inspection looking at:

Staffing

Staffing numbers for each unit. Staff training to enable staff to provide care to people with such complex needs. Mandatory training for permanent and bank staff. Staff induction, supervision and annual appraisal compliance. Specific training for this patient group.

Care planning

Specialised care planning. The standard of care plans and whether they met patient need. The standard of physical healthcare.

Therapeutic activities

To review the range of activities provided and whether they were recovery focused not just leisure focused.

Our inspection team

Team leader: Margaret Henderson

The team that inspected the service comprised four CQC inspectors, two specialist advisor nurses and one specialist advisor cognitive behaviour therapist.

Why we carried out this inspection

We carried out this inspection to further investigate concerns identified.

Summary of this inspection

How we carried out this inspection

This was a focused inspection looking at specific key lines of enquiry from the safe and effective domain.

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

During the inspection visit, the inspection team:

- visited all eight wards at the hospital, and observed how staff were caring for patients
- spoke with the registered manager and managers for each of the wards
- spoke with 26 other staff members; including doctors, nurses, occupational therapy assistant, psychologist and healthcare assistants
- looked at 27 care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

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?

We did not rate this service.

However, we found the following areas the provider needs to improve:

- Data given to us during inspection showed that the provider had 11 vacancies for full time registered staff having 22 full time registered nurses in post and a vacancy rate of 35% for registered staff.
- There were vacancies for 31 healthcare assistants. The provider had recently recruited 26 healthcare assistants who were waiting to go through the induction process leaving a 15% vacancy rate for unregistered staff once induction of these staff is completed.
- On Elstow 5, we observed that the registered nurse was absent from the ward attending a meeting. Staff told us the providers policy was that unit general managers would cover breaks for registered staff to ensure that there was always a registered nurse present on the ward. This had not happened on this occasion.
- Not all staff were trained in how to care for patients with epilepsy, although managers told us that training was planned.
- Care records for patients with epilepsy did not contain robust risk assessments of shower, bathing risks and use of restraint, leaving patients vulnerable to serious harm or death in the event of a seizure.
- We noticed that some ward areas needed redecoration and repair. On Cooper 3, staff told us that issues such as door frames that had been damaged leaving sharp edges on which staff and patients may harm themselves, had been reported to the maintenance department and were awaiting repair.

We also found the following areas of good practice:

- The mandatory training compliance rate for permanent staff at this provider was 92% on7 June 2018.
- The provider had three substantive doctors covering the hospital and operated an on-call rota for medical cover at night.
- Ward managers told us they could adjust staffing levels in response to patient acuity and could increase staffing if necessary.

Summary of this inspection

- Risk assessments were comprehensive; the provider had recently trained staff in the use of the short-term assessment of risk and treatability (START) and this was being rolled out across the wards.
- The provider had been interviewing three days per week during the weeks prior to inspection and had recruited 26 unregistered staff and one registered nurse, although seven staff were yet to complete induction.

Are services effective?

We did not rate this service.

However, we found the following areas the provider needs to improve:

- The process of assessing, planning and evaluating appeared disjointed. There was different information in different sections of the records. Three separate folders for each patient were kept.
- It was not always easy for staff to find out significant information quickly in care records. The patient voice was not always evident indicating that the patient had agreed to the plan or not. Action plans and other documents did not all have dates and signatures on.
- Some care plans were contained unrealistic goals.
- We found a discrepancy between one care plan and the prescription. We brought this to the manager's attention and the issue was rectified immediately.

We found the following areas of good practice:

- We saw that care records had comprehensive assessments that were completed promptly after admission.
- Care records showed that patients received physical examination on admission and that there was ongoing monitoring of physical health problems.
- The provider had recently appointed a full-time practice nurse to carry out physical healthcare interventions. A local GP held a weekly surgery at the hospital and would see patients on their respective ward if necessary.
- The provider could offer psychological therapies recommended by National Institute of Health and Care Excellence guidance. The provider had appointed a psychology lead in December 2017 who was working to embed the use of evidence based outcome measures for psychological therapies.
- The provider had invested in specialist training for staff who worked with patients who harm themselves.

Summary of this inspection

Are services caring?

- We did not inspect this key question in detail. However, we observed that staff interactions with patients and carers during the inspection were responsive, discreet and respectful. It was clear to us that patients had good relationships with staff and that staff were passionate about the care they provided.

Are services responsive?

We did not inspect this key question.

Are services well-led?

We did not inspect this key question.

Detailed findings from this inspection

Mental Health Act responsibilities

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

- We did not inspect this part of the key question in detail however, staff we spoke with knew who the Mental Health Act administrator was and could seek support to ensure the Mental Health Act was followed correctly.
- The provider kept clear records of the leave granted to patients. The records included assessment of patient's mental state before and after hospital leave.

Mental Capacity Act and Deprivation of Liberty Safeguards

- We did not inspect this part of the key question in detail however, 92% of staff had completed training in the Mental Capacity Act (2005).
- All 47 patients were detained under the Mental Health Act (1983). There were no Deprivation of Liberty Safeguard applications.
- We saw evidence in care records that patients who lacked capacity were assessed and the outcome recorded appropriately on a decision specific basis.
- People were supported to make decisions where they lacked capacity decisions were made in their best interest.

Wards for people with learning disabilities or autism

Safe	
Effective	
Caring	

Are wards for people with learning disabilities or autism safe?

Safe and clean environment

- We did not conduct a full examination of ward environments however we noticed that some ward areas needed redecoration and repair. Staff told us that issues such as door frames that had been damaged and contained sharp edges on which staff or patients may harm themselves on Cooper 3 had been reported to the maintenance department and were awaiting repair.
- Wards complied fully with guidance on same sex accommodation.

Safe staffing

- The provider gave us data which showed that they had recently increased their shift requirement by 13 staff per day which equated to 26 additional full time equivalent staff since 6 March 2018.
- Data given to us during inspection showed that the provider had 11 vacancies for full time registered staff having 22 full time registered nurses in post and a vacancy rate of 35% for registered staff.
- There were vacancies for 31 healthcare assistants. The provider had recently recruited 26 healthcare assistants who were waiting to go through the induction process leaving a 15% vacancy rate for unregistered staff once induction of these staff is completed.
- Wards were staffed on a ratio of two patients to one staff member during the day and three patients to one staff member at night. There was one registered nurse on each shift and the remaining staff complement was made up of unregistered staff. Managers told us that they could increase staffing levels if necessary. The provider told us that the unit general manager covered for when a registered nurse had to attend meetings or training, however we observed two occasions where this had not happened.
- In the months from March to May 2018 the provider used 22% unregistered agency staff and 46% registered agency staff. Accumulative agency hours used was 33,643 hours, against employed total of 99,744 hours, giving a combined total of 133,387 staffed hours. Therefore, the provider used 25% agency staff for this period. Staff we spoke with told us that agency staff were staff who were familiar to the wards.
- On Elstow 5, we observed that the registered nurse was absent from the ward attending a meeting. Staff told us the providers policy was that unit general managers would cover breaks for registered staff to ensure that there was always a registered nurse present on the ward. This had not happened on this occasion.
- Staff told us that there were enough staff so that patients had regular 1:1 sessions with their named nurse. We saw evidence in care records that this happened.
- The provider had three substantive doctors covering the hospital and operated an on-call rota for medical cover at night.
- The mandatory training compliance rate for permanent staff at this provider was 92% on 7 June 2018. The provider also extended mandatory training to regular bank staff although compliance for these staff was lower at 69%.

Assessing and managing risk to patients and staff

- We reviewed 27 care and treatment records. Except for two records, all had up to date risk assessments.
- Risk assessments were comprehensive the provider had recently trained staff in the use of the short-term assessment of risk and treatability (START) and this was being rolled out across the wards.
- Where rapid tranquilisation had been used we saw that this had been done following the National Institute of Health and Care Excellence guidance.
- Staff were trained in safeguarding and knew what to report and how to do so.
- All staff had received conflict resolution training including bank staff.

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- We saw that care records had comprehensive assessments that staff completed promptly after admission.
- Care records showed that patients received physical examination on admission and that there was ongoing monitoring of physical health problems. Reviewed 27 care and treatment records all had hospital passports. A hospital passport is a document containing information about the patients ongoing care and is taken with the patient to different physical healthcare appointments they contained important information such as the recording of allergies and a summary of their mental health care. Nine patients also had an additional document entitled My Health Action Plan which contained detailed physical care plans for those with more complex health issues.
- Care records were regularly updated and for most of records were personalised and contained individualised information. However, five care records did not always evidence the patient's views on their care or the reason for not including the patient's views. Action plans and other documents did not all have dates and signatures on.
- On Elstow 1 the wording of three care plans contained unrealistic goals. For example, two care plans reference explicit time frames during which patients had to demonstrate settled behaviour to be able to partake in specific activities. There was no clear rationale for these time frames. A further care plan referred to the "removal of warmth" (interpersonal warmth) as a consequence for self-harming behaviour. The same plan stated that if the patient abstained for self-harm for 24 days they could have a reward of social activity such as a visit to see family. The wording of these care plans did not reflect the care given, which we observed to be caring and compassionate. However, if staff followed the care plans to the letter it may appear punitive to patients rather than caring.
- The process of assessing, planning and evaluating appeared disjointed. There was different information in different sections of the records. Three separate folders for each patient were kept. One for current information, one for physical health care and one for static current assessment information
- We found a discrepancy between one care plan and the prescription. The care plan stated to give medication if the patient had a seizure however, the medication was not prescribed on the medicine chart. The discrepancy in prescribing could mean staff would not be able to give the medication to the patient in seizure and so the patient could suffer injury or even death. We brought this to the attention of the registered manager who took immediate action to ensure this was rectified.
- Having three separate folders made it difficult to find information for example; each patient had three separate files, one for current care plans and running records, one for physical health care and one for static current assessment information such as occupational therapy assessments and more detailed formulations. When we asked staff to show us an assessment it took them a considerable amount of time to find it because it was stored in the static assessment file although still in date.

Best practice in treatment and care

- We saw that all patients had positive behavioural support plans. However, the rewards system did not evidence psychological oversight to provide the rationale for the planned interventions and to show monitoring of interventions. Neither was it clear that patients had agreed to the plan.
- The provider offered psychological therapies recommended by National Institute of Health and Care Excellence guidance. The provider had recently invested in Dialectical Behaviour Therapy training for staff. Dialectical Behaviour Therapy aims to equip patients who experience emotionally instability and self-harm with the skills to manage their emotions and relationship difficulties. The provider told us about plans to open a Dialectical Behaviour Therapy ward in mid July 2018 and assured us that all staff that had been recruited to work on this ward were trained.
- Records contained detailed formulations for all records we reviewed, and where clinically necessary patients had received sensory assessments and nutrition and

hydration charts. We reviewed 27 notes and found that 15 had sensory assessments and three patients that needed monitoring of their nutrition and hydration had food and fluid balance charts.

- Staff used recognised rating scales to assess and record severity and outcomes of treatment such as the Health of the Nation Outcome Scale, the model of creative ability, the Beck Depression Inventory, the Glasgow Anxiety and Depression Scale and the CORE Outcome Measure.
- The psychology lead told us that the provider was in the process of restructuring the role of the Star Centre manager to increase recovery focused groups and activities. At the time of inspection patients had access to weekly mindfulness and coping skills groups as well as occupational and leisure activities such as going out for a drive, cooking and shopping.
- The provider had recently recruited a practice nurse who worked between the hours of nine in the morning to five in the afternoon to address the physical healthcare needs of patients. There was a local GP who attended the hospital on a weekly basis to conduct a surgery.
- We saw evidence in care records that patient's nutrition and hydration needs were assessed and met.

Skilled staff to deliver care

- The multi-disciplinary team at Lakeside included a senior occupational therapist, occupational therapist, social worker, registered nurses, a consultant psychologist, full time locum psychologist, assistant psychologist, therapy assistants and a trainee counselling psychologist, practice nurses and healthcare assistants, two consultant psychiatrists and an associate specialist.
- Staff were experienced and qualified. Staff had a range of qualifications in addition to their registration and unregistered staff had completed or were working towards their care certificate.
- Staff said they had received a comprehensive induction including a corporate induction and training and then a two-week induction in the clinical area. The provider sent us their induction statistics for 7June 2018 which showed that 92% off all new staff had completed their care certificate of these 95% of permanent staff had completed their care certificate with written competencies. The provider told us that only 69% of bank staff had completed their care certificate with written competencies although 100% of bank staff had started this work. This was an improvement on data we were given in March 2018 when bank staff had completed only 53% of required mandatory training courses.
- Staff told us they had regular supervision with their line manager. The provider submitted data which showed that from 1 November 2017 to 31 April 2018, 88% of staff had regular monthly supervision. The provider only submitted supervision figures for bank staff for the month of March 2018 which showed that 35% of bank staff received supervision in that month.
- The percentage of non-medical staff that have had an appraisal in the period between 1 June 2017 and 1 June 2018 was 86%.
- Staff told us they received the necessary training for their role. However, staff had not received specific training in how to support patients with epilepsy. We brought this to the attention of the registered manager who told us this was planned.

Adherence to the MHA and the MHA Code of Practice

- We did not inspect this part of the key question in detail however staff we spoke with knew who the Mental Health Act administrator was and could seek support to ensure the Mental Health Act was followed correctly.
- The provider kept clear records of the leave granted to patients. The records included an assessment of patient's mental state before and after hospital leave.
- 83% of staff had completed their mandatory training in the Mental Health Act (1983)

Good practice in applying the MCA

- 92% of staff had completed training in the Mental Capacity Act (2005).
- All 47 patients were detained under the Mental Health Act (1983). There were no Deprivation of Liberty Safeguard applications.
- We saw evidence in care records that patients who lacked capacity were assessed and the outcome recorded appropriately on a decision specific basis.
- People were supported to make decisions where they lacked capacity decisions were made in their best interest.

Wards for people with learning disabilities or autism

Are wards for people with learning disabilities or autism caring?

Kindness, dignity, respect and support

- We did not inspect this key question in detail. However, we observed that staff interactions with patients and carers during the inspection were responsive, discreet and respectful. It was clear to us that patients had good relationships with staff and that staff were passionate about the care they provided.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure staff are competent to manage patients with epilepsy and that care plans detail management of a seizure.
- The provider must ensure that all care plans are person centred and recovery focused, with achievable goals and that records show the rationale for decisions taken in relation to the care and treatment. Records must always be signed and dated by staff and where possible by the patient.
- The provider must ensure that patient involvement is always recorded or the reason for not is recorded.

Action the provider SHOULD take to improve

- The provider should ensure that there is always a registered nurse on each ward.
- The provider should expedite repairs to ensure that ward areas that have been damaged do not cause harm to patients or staff.
- The provider should consider a review of the record keeping system.
- The provider should ensure that bank staff receive regular supervision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Management of epilepsy – we saw that people with epilepsy, who were stable on their medication and had not had a seizure for some time, did not have a recent risk assessment in relation to bathing/showering and restraint. The risk was that the patient could still have a seizure whilst bathing/showering and there was a risk of injury. Staff on two wards were unclear about the management of epilepsy. For example, what to do if a patient had a seizure. Not all staff had been trained in giving Midazolam. Untrained staff were carrying the drug with them whilst escorting a patient. Staff may not manage a patient in seizure correctly leading to injury or death. This was a breach of regulation 12

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 Record keeping – (Five out of 27 records reviewed) Records did not always evidence the patient's voice or reason for not including the patient's voice. Action plans and other documents did not all have dates and signatures on. On Elstow 1 the wording of three care plans contained unrealistic goals. For example, two care plans reference explicit time frames during which patients had to demonstrate settled behaviour to be able to partake in

Requirement notices

specific activities. There was no clear rationale for these time frames. A further care plan referred to the "removal of warmth" (interpersonal warmth) as a consequence for self-harming behaviour. The same plan stated that if the patient abstained for self-harm for 24 days they could have a reward of social activity such as a visit to see family. The wording of these care plans did not reflect the care given, which we observed to be caring and compassionate. However, if staff followed to the letter the care plans it may appear punitive to patients rather than caring.

The process of assessing, planning and evaluating appeared disjointed. There was different information in different sections of the records. Three separate folders for each patient were kept. It was not easy for staff to find significant information care records.

We found a discrepancy between one care plan and the prescription. The care plan stated to give Midazolam if the patient had a seizure however, Midazolam was not prescribed on medicine chart. The discrepancy in prescribing could mean staff would not be able to give Midazolam to the patient in seizure and so the patient could suffer harm.

This was a breach of regulation 17