South View Independent Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated South View Independent Hospital as requires improvement because:

- The ward had a stairwell with a waist height bannister and open spindles. This was a risk to patients and not included on the ligature audit. The environmental risk assessment was out of date.
- The provider did not have a current risk register in place.
- The provider did not follow their medicines management policy, and staff did not always adhere to infection control principles when administering medication.
- Staff had a varied understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- South View did not define itself as a long stay hospital, yet there was a lack of discharge planning evident in the patients' care records. Four patients had remained in the hospital for between two and six and a half years. Three patients identified as ready to move on had yet to do so, with no planned discharge date.

However:

- Staff delivered care that was individual to the patient's needs. They were passionate about caring for the patients and spoke to them in a kind and respectful manner.
- Patients had access to a range of rooms and equipment to support their care and treatment, including outside space. Activities were planned that were individual to patient's needs, and staff made an effort to engage with patients on a one to one basis.
- Staff felt supported by the management team, with regular access to training and supervision. Staff knew and agreed with the organisation's values, and there was a sense of support and teamwork amongst the staff.

Summary of findings

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Requires improvement

South View Independent Hospital

Services we looked at
Wards for older people with mental health problems

Summary of this inspection

Background to South View Independent Hospital

Barchester Healthcare Homes Limited cares for more than 10,000 people in over 200 care homes and independent hospitals. Barchester Healthcare is the registered provider for South View Independent Hospital.

South View Hospital provides care for adults aged 65 and over. It provides services for people with mental health problems, with additional services for people whose rights are restricted under the Mental Health Act. The service also provides care for patients who have consented to be there.

The hospital is registered to provide the following regulated activities; Assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury. There is a registered manager and an accountable officer in post.

The hospital has 15 beds, which are all contained within Hazeldene Ward.

South View Independent Hospital was last inspected in January 2014 and found to be compliant in all areas under the previous inspection framework.

Our inspection team

Team leader: Patti Boden

The team that inspected the service included two CQC inspectors and a variety of specialists:

Psychologist

Registered Mental Health Nurse

Ward Manager

Mental Health Act Reviewer

Expert by experience who has previously used mental health services

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all parts of the ward, looked at the quality of the ward environment and observed how staff were caring for patients.
- attempted to speak with all 12 patients, four of whom engaged with us
- spoke with five sets of carers whose relatives were patients at the hospital
- spoke with the registered manager.
- spoke with 12 other staff members; including the consultant psychiatrist, nurses, occupational therapist, support workers and trainers.
- observed one weekly ward round and one weekly multi-disciplinary meeting.

Summary of this inspection

- looked at 11 care and treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the hospital.

We also returned to observe the hospital on a further unannounced date, using a tool designed by the Bradford dementia group and the Care Quality Commission. This short observational framework for inspection tool allows us to capture the experiences of patients who may have cognitive or communication impairments and cannot verbally give their opinions on the services they receive.

What people who use the service say

The patients and carers told us that staff treated them well and respected their privacy. They told us they could speak to staff and raise any concerns.

Patients and staff told us they felt safe on the wards and they received enough support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- A stairwell with a waist height banister and open spindles was a risk to patient safety.
- The environmental risk assessment required updating, and no risk register was in place
- Single use pots were being washed and re-used in the clinic room, and a teaspoon was used for administering medication.
- The provider did not follow their own medicines management policy.

However:

- The ward was visibly clean and welcoming.
- Patients and their families told us they felt safe.

Are services effective?

Good

We rated effective as good because:

- Patients received a comprehensive assessment of need and risk on admission. This included continued monitoring of mental and physical health.
- Care records were well organised, comprehensive and kept up to date. They were stored securely and accessible when needed.
- Care plans were personalised and reviewed regularly, and some showed the views of patients and carers.
- A training programme supported staff learning and development.
- A range of staff from all disciplines attended the weekly ward round and a weekly ward meeting.

However:

- Staff had a varied understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), and of its application in practice.

Are services caring?

Good

We rated caring as good because:

- We observed genuine caring interactions between staff and patients. Staff spoke to patients in a kind and respectful manner and treated them with dignity and compassion.
- Staff knew patients well, and responded to their needs.

Summary of this inspection

- We spoke to the relatives of five patients who spoke highly about the care their relatives received, and the majority of patients reported they felt well cared for.
- Families received invites to attend family meetings, and all reported feeling involved in their relatives care.
- Patients had access to information on advocacy services.

However:

- Six of the eight care plans reviewed lacked evidence of the involvement of the patient or family members, and not all patients and families knew about the care plan.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- South View did not define itself as a long stay hospital, yet there was a lack of discharge planning evident in the patients' care records. Four patients had remained in the hospital for between two and six and a half years. Three patients identified as ready to move on had yet to do so, with no planned discharge date.
- We found patients' full names displayed outside some of the bedrooms, and were not assured of the need for this given it had implications on patient confidentiality and data protection.
- We found a lock on the downstairs corridor that prevented access for those patients to the rest of the ward. This had no purpose and plans were in place to rectify this.

However:

- Patients had access to a range of rooms and equipment to support their care and treatment, including outside space.
- Activities were planned that were individual to patients' needs, and staff made an effort to engage with patients on a one to one basis.

Are services well-led?

Good

We rated well-led as good because:

- Staff knew and agreed with the organisation's values.
- Staff reported feeling supported by the management team, with good lines of open communication.
- Staff accessed mandatory and additional training, and took part in clinical audits.
- Staff felt able to inform practice and service development.
- All staff had access to regular supervision and 91% had received an appraisal in the last 12 months.

However:

Summary of this inspection

- We found that staff rotas did not accurately reflect who was on shift on any given day, and the systems for recording staff attendance were not robust.

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.

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed the detention documentation for the two detained patients.

Staff received training in the Mental Health Act, and in protection of vulnerable adults incorporating the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). On 31 August 2015, 75% of staff were compliant with the MHA training.

The use of the Mental Health Act (MHA) was good with detention documentation complying with the Act and code of practice. The provider had a Mental Health Act administrator who completed audits and scrutinised documentation. Staff felt supported by this and we saw an efficient and effective range of systems to support nursing staff in meeting the responsibilities of the Act.

Completed consent to treatment forms were recorded and authorisation for treatment was located with prescription charts. Emergency treatment was given appropriately and second opinion appointed doctors (SOAD) requested. There were no discrepancies between medications administered and medications authorised by the SOAD.

Information on the rights of patients was shared verbally and in a variety of written formats. The provider had access to an independent mental health advocacy service with all patients able to access this. We were concerned that those who could not understand continued to have their rights repeated without a clear action plan to address this. Patients had not been given the correct telephone number for the tribunal service and there was no CQC poster detailing the contact number for detained patients to complain. These issues were addressed during the inspection. Informal patients were also given their rights on a monthly basis.

We found there was a standardised process in place for authorising section 17 leave. Forms were clear and struck out or ended after review. We saw evidence of risk assessment prior to section 17 leave being taken.

Mental Capacity Act and Deprivation of Liberty Safeguards

Although 85% of staff had received training in the Mental Capacity Act (MCA), we had concerns about staff's understanding of the MCA and Deprivation of Liberty Safeguards (DoLS). Staff reported that patients subject to DoLS were able to leave of their own free will, and care records indicated that staff had told patients subject to DoLS that they were informal patients. We were not assured that staff fully understood the MCA, as none of those we asked could tell us what a relevant person's representative (RPR) does. An RPR is the person allocated to be involved in decisions about care where a person is deemed to lack capacity to do so.

We saw conditions attached to DoLS standard authorisations that required care plans to be linked to the DoLS, and we could not see evidence of this in the patients care records. There was no reference within care plans to the involvement of the nominated RPR.

Systems were in place to ensure that the local authorities were alerted in good time when a DoLS authorisation was due to expire.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Notes

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

The ward had two floors with access to a lift. The ground floor had a communal lounge and dining area, with a conservatory and access to gardens. There were five bedrooms on the ground floor for male patients. The nurse's office was located near the communal area. Staff offices were along a locked corridor, and there were plans to add double doors and windows on one side of the staff corridor to integrate it with the ward. The first floor had two separate corridors, each with five bedrooms, with one corridor being for female patients and one for male patients. All bedrooms were en suite. There was a female only lounge available on the first floor, and various rooms for occupational therapy.

All ward areas were clean with good furnishings. They appeared well maintained and welcoming to meet the needs of the patients. An internal health and safety audit completed on 31 August 2015 received 100% pass mark with no actions needed.

Blind spots occurred throughout the building. The environmental risk assessment completed on 21 May 2014 did not identify the blind spots as risks. Steps taken by the provider to mitigate the risk of ligature included angled en suite doors and sensory activated water outlets, although ligature points remained in both un-supervised and communal areas. The most recent ligature audit completed on 14 October 2014, and did not identify all ligature points.

A set of stairs had a banister at waist height with open spindles. This gave particular concern during the inspection. They posed a risk to patient safety in that they provided a ligature point in an un-supervised area, and that a patient may topple over the banister and down the stairwell. They did not feature on either the ligature audit or the environmental risk assessment. We discussed this with the manager, and following the inspection action has been taken to place perspex around the banisters from floor to ceiling.

Risks were identified and listed in various sources; however, there was no central risk register held to identify areas of risk and lessons learned. The manager stated there had been a risk register, but it was not fit for purpose. A study had been undertaken and a new way of recording risk and actions taken was now in place. This was not yet in use at the time of inspection.

The ward complied with guidance on same-sex accommodation, in that there were separate bedrooms for male and female patients, female patients did not have to walk past male bedrooms to access a bathroom, and female patients had access to a female only lounge.

Infection control principles were not followed in all areas. In both clinic rooms it was noted that single use pots were being washed and re-used, that a metal teaspoon was being used to administer medications and again being washed and re-used, and that a pestle and mortar was being used to crush medications and again being washed and re-used. At the end of the first day of inspection, this was fed back to the registered manager. Action was taken in that both single use and re-usable pots were ordered, along with single use plastic spoons and pill-crushers, and a notice was placed in the clinic room. It was also noted that the fridges in the kitchen area were unclean, with

some spillage of contents. This was again fed back and re-checked the following day, and the fridge had been cleaned. We viewed the monthly cleaning schedule and the fridge core temperature monitoring form, which were both up to date. They demonstrated the ward was regularly cleaned.

The clinic room situated on the first floor was clean, although untidy. Drugs were stored and checked correctly. Equipment was well maintained and clean. There was an oxygen notice on the clinic door; however, the oxygen was located in the nurses' office on the ground floor. There were no spare defibrillator pads for the resuscitation equipment, and records indicated that previously the old pads were out of date for two months before being replaced**.**

There were no seclusion facilities on site, and they did not prescribe rapid tranquilisation.

Safe staffing

Establishment Levels

Qualified Nurses (WTE): 7

Nursing Assistants (WTE): 18

Number of vacancies qualified nurses: 2 (1 full time and 1 part time)

Number of vacancies nursing assistants: 0

Number of shifts filled by bank staff in a 6 month period: 44

Number of shifts that have NOT been filled by bank staff where there is sickness, absence or vacancies in a 6 month period: 38

At the time of inspection, there were two staff members on long-term absence and two on maternity leave. This gave an overall percentage of staff sickness as 24%. Staff did report that numbers were sometimes low due to sickness, annual leave and maternity leave, but they felt there was adequate staff on duty to meet the patient's needs. In the previous six months five staff had left the service.

The hospital had estimated the number and grade of nurses in line with accreditation for inpatient mental health services guidance used by another Barchester Hospital in the area, and had a daily staffing establishment of two qualified nurses and five support workers during the day and one qualified nurse and three support workers during the night. The number of shifts between 1 March 2015 – 31 August 2015 that fell below this was 38.5. The registered manager stated they did not use agency staff, and that bank staff were familiar with the hospital. There were 44 shifts covered by five bank staff in the six months prior to inspection. The registered manager was clear that she had authority to increase staffing levels if required.

Communal areas had sufficient staff available to meet patients' needs, and deliver a timetable of activities that were appropriate to the patient group. Such activities included jigsaws, music from different genres and a walking group. We observed patients having one-to-one sessions with staff at various times during our visit. There were no reports of escorted leave or activities being cancelled due to staffing levels.

The ward had a multi-disciplinary team consisting of a consultant psychiatrist, occupational therapist, registered nurses (including a nurse prescriber and a clinical lead nurse) and support workers. Each patient had an identified key worker, and it was evident that staff knew the patients very well. Patients and their carers told us they felt safe here.

The consultant psychiatrist covered both Barchester hospitals in the area. He provided on-call cover, and any additional cover was provided two colleagues. Staff and patients had adequate access to a doctor, and the manager reported good relationships with two of the general practitioners in the area who had a specialist interest in this patient group. We found evidence in care records that patient's physical health care needs were assessed on admission and they were receiving ongoing physical care.

All staff were trained in the management of violence and aggression, and there were enough staff on duty to carry out interventions safely. Staff attended mandatory and legislative training that included Mental Health Act, safeguarding – Mental Capacity Act and Deprivation of Liberty Safeguards, fire training, food safety, infection control, cardio pulmonary resuscitation and clinical risk management. Overall compliance rates with this training as of 31 August 2015 were 92%, which was above the Barchester requirement of 85%.

Assessing and managing risk to patients and staff

There were no incidents of restraint in the last six months. Staff did report patients could become aggressive at times, but staff were skilled in identifying the individual patient's triggers and intervening at an early stage to prevent an incident developing.

Requires improvement

Wards for older people with mental health problems

We reviewed 11 care records for the hospital. All had up to date risk assessments in place. All patients were assessed prior to admission, and the hospital did not take unplanned or emergency admissions. They used a recognised risk tool, the Sainsbury risk assessment tool, which was reviewed monthly or earlier if required. Each identified risk had a scored risk assessment and a risk management plan that ran alongside the care plan.

The weekly ward round and multi-disciplinary team (MDT) meetings were used to update staff on patient's needs and to re-assess risk. A daily handover took place, and a daily 'ten at ten' meeting, where the leads of each department had ten minutes to discuss the day ahead and share information. On the day we arrived, a safeguarding alert had been sent in relation to an incident between two patients, and this was discussed the following day in the ward round.

We found no evidence of blanket restrictions in place, although one patient did report a restriction on the hours they could smoke but staff indicated this was not the case.

The staff stated that informal patients could leave at will, and there were notices to this effect on the exit doors. There was confusion amongst staff as to whether patients subject to a DoLS could leave at their own will, and the provider should look at the level of understanding amongst the staff of applying the Mental Capacity Act in practice.

The staff knew and understood the hospital's policy on observation and we saw this being put into practice. The level of observation required was usually decided at MDTmeetings. However, nurses were able to increase observation levels immediately dependent on need. This would then be reviewed at MDT, and only the registered clinician could reduce the observation levels.

We found that nurses were routinely writing and transcribing prescription sheets and not all of these medications had been countersigned by either a doctor or a nurse prescriber.They were not using medication administration records (MAR). Barchester policy does allow prescribing straight onto a pre-printed MAR sheet (page 6 Barchester Medicines Management policy).Their policy also suggested that each MAR chart item and any new prescription on a pharmacy generated MAR must be validated by the full signature of the prescriber, this we found was not happening.

If the MAR becomes ambiguous or unclear at any time, the practitioner responsible for the administration of the medicine must be requested either the prescriber to rewrite it or the pharmacy to print out a new chart. This too we found was not happening.

Barchester had four national strategies in place; pressure sore prevention, nutrition and hydration, falls and incontinence. Patients were assessed against all four strategies. There were no patients with pressures ulcers at the time of inspection, and ten incidents of falls in the last six months.

All wards had child visiting procedures in place and these visits took place off the ward. Other visits were able to take place on the ward provided there were no incidents occurring at the time.

Track record on safety

There had been no serious incidents requiring investigation reported in the six months prior to inspection.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and the process to follow. A manual paper based system was used for the recording of incidents, which was then inputted onto the clinical governance site. The form asked for information about the incident/accident, details about the affected person, details about the treatment given, details of the witness, a body map, and a section to document who has been informed which includes a safeguarding referral and a reminder to staff of the duty of candour. The director of care and quality would then review the information. On all of the documents viewed, the section for manager's investigation was not completed. This was also identified on the recent internal 'quality first' visit on 9 July 2015. The registered manager stated that learning from incidents was shared in handover, morning meetings and staff meetings. A new way of recording incidents and lessons learned was also being rolled out. We could not see documentation to support this, although we did observe a safeguarding referral being discussed in the ward round the following day.

We found that staff were aware of incidents and lessons learned within this hospital and across other Barchester hospitals. Staff knew what was required of them with regards to duty of candour, and patients and carers

Requires improvement

Wards for older people with mental health problems

reported they found staff to be very open. Staff received feedback following incidents and were offered the opportunity to de-brief. The consultant psychiatrist would offer staff one to one counselling, and consider referring staff to Barchester support services if required.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

The last inspection identified gaps in the assessment documentation, and reported that care plans did not always relate to the patients risk and needs. We found improvement in both of these areas. Of the 11 patient care records reviewed, all were organised well, up to date, and contained risk assessments. Care plans were reviewed monthly, however the reviews at times were brief and not reflective of the individual patient. The provider should ensure that care plans are reviewed in an appropriate and effective way.

A comprehensive assessment of need and risk had taken place on admission, which incorporated a full physical health examination. Patients physical health needs were continually reviewed using malnutrition universal screening tool documentation, choking assessments and falls assessments. Staff supported patients to eat and drink, encouraging patients to do this themselves where appropriate. Each patient file contained a 'partnership' section, showing that patients had good access to physical healthcare, as GP's would document in the care record when they had visited a patient.

All care records contained individualised care plans, however six of the eight reviewed did not contain enough evidence of patient and/or carer involvement. Two patients stated they had not seen their care plans, and two families said they were not involved in their relatives care planning. All eight care plans we reviewed lacked a focus on recovery and there was little evidence of discharge planning.

We questioned the accuracy of several of the care plan review dates in patients care records. Reviews had taken place on the same day each month for four of the patients by one staff member, and from the duty rota's we viewed it was not clear whether the staff member undertaking the review was actually on shift on that day. These reviews did not contain enough detail, and were individual to the patient.

The hospital operated a paper based and electronic system (Caresys). All documentation was stored securely and accessible when required.

Best practice in treatment and care

The provider employed an occupational therapist (OT) three days per week. Each patient had a baseline assessment using an approved tool developed by Barchester. The occupational therapistreviewed each patient monthly, and conducted audits to ensure each patient received at least the minimum hours of occupational therapy per week as per national institute for health and care clinical excellence guidelines PH16 (October 2008). The patient and their family received a report every six months outlining their progress.

Clinical staff took an active part in clinical audits, and information gained from these was shared with the rest of the staff team. The nurse prescriber completed a monthly medication audit, and the registered clinician had recently conducted audits on legal status, risk, treatment and observation levels and on medication errors.

Skilled staff to deliver care

The hospital had input from a consultant psychiatrist, OT, nursing staff and support staff. A job description had been written and approved for a specialist Doctor post. The registered manager stated that an assessment was made of each patient's individual need, and should access to other disciplines be required it would be sourced as required.

The consultant psychiatrist also provided additional training with the most recent being a day seminar on psychological therapies. The hospital was moving from the general services model of managing violence and aggression to the management of actual or potential aggression model (MAPA).The MAPA trainer expected the roll out to be completed by October 2015, and seven of the staff on Hazeldene ward had been trained in the MAPA model.

The previous inspection identified that copies of staff member's qualifications were not in their files, and this had

been corrected. Staff files contained evidence of an appropriate recruitment process and staff induction, with copies of references, disclosure and barring service checks and qualifications present.

The management team had a system in place to deliver both clinical and managerial supervision, and staff felt supported through regular supervision and meetings. In the 12 months prior to inspection, 91% of staff had received an appraisal.

Team meetings took place on a quarterly basis and minutes were available for staff to read.

Multi-disciplinary and inter-agency team work

We observed the weekly ward round on site for patients on Hazeldene ward. There were no relatives or carers present but staff did say they have an open invitation to attend the meeting, and that relatives often attend booked care programme approach (CPA) meetings. It was clear that staff knew patients very well, and felt supported to be open and honest when discussing patients care and treatment needs. Having spoken with a carer the previous day, it was felt their views were accurately discussed in the meeting. One patient was visited in a communal area during the ward round, and their care and treatment was discussed while other patients were present.

There was evidence in the patient care records of partnership working, such as a chiropodist visiting patients. Social care staff were invited to CPA reviews and liaised with when required. The OT worked with the community falls team and an optician provided regular checks on the patient's sight. The registered manager reported good links with the local safeguarding team, and in particular with two general practitioners in the area who visited the hospital to carry out an annual physical health check on their patients.

Handover's took place daily and staff felt they were kept fully informed of a patient's needs.

Adherence to the MHA and the MHA Code of Practice

A Mental Health Act (MHA) reviewer visited the hospital as part of this inspection. They reviewed the detention documentation for the two detained patients.

Staff received training in the Mental Health Act, and in protection of vulnerable adults incorporating the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). On 31 August 2015, 75% of staff were compliant with the MHA training.

The use of the MHA was good with detention documentation complying with the Act and code of practice. The provider had a MHA administrator who completed audits and scrutinised documentation. Staff felt supported by this and an efficient and effective range of systems was in place to support nursing staff in meeting the responsibilities of the Act.

A number of patients were discharged from the MHA and the MCA was used as an alternative. There were nine patients subject to DoLS. Completed consent to treatment forms were recorded, and authorisation for treatment was located with prescription charts. Emergency treatment was given appropriately and second opinion appointed doctors (SOAD) requested. There were no discrepancies between medications being administered and medications authorised by the SOAD.

Information on the rights of patients were shared verbally and in a variety of written formats. The provider had access to an independent mental health advocacy service with all patients able to access this. Patients who could not understand continued to have their rights repeated without a clear action plan to address this. Patients had not been given the correct telephone number for the tribunal service and there was no CQC poster detailing the contact number for detained patients to complain. These issues were addressed during the inspection. Informal patients were also given their rights on a monthly basis

A standardised process was in place for authorising section 17 leave. Forms were clear and struck out or ended after review. Risk assessments took place prior to section 17 leave being taken.

Good practice in applying the MCA

Eighty five percent of staff had received training in the MCA, however it was apparent that staff had a varied understanding of the MCA and DoLS. Staff reported that patients subject to DoLS were able to leave of their own free will, and care records indicated that staff were telling patients subject to DoLS that they were informal patients. We were not assured that staff fully understood the MCA, as none of those we asked could tell us what a relevant

Requires improvement

Wards for older people with mental health problems

person's representative (RPR) is. An RPR is the person allocated to be involved in decisions about care where a person is deemed to lack capacity to do so. A support worker identified that their knowledge of the MHA was 'sketchy', and viewed the application of the MCA as a nurse's role, not their role.

We saw conditions attached to DoLS standard authorisations that required care plans to be linked to the DoLS, and we could not see evidence of this in the patients care records. There was no reference within care plans to the involvement of the nominated RPR.

Systems were in place to ensure that the local authorities were alerted in good time when a DoLS authorisation was due to expire.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

We observed genuine caring interactions between staff and patients on many occasions during the inspection. Staff spoke to patients in a kind and respectful manner, and treated them with dignity and compassion. Staff had a clear understanding of patient's needs, by initially assisting them with their food and then encouraging the patient to do so themselves. We saw patients receiving dedicated one to one time with staff, either engaging in activities or simply talking with staff.

Carers and families of five patients, could not speak highly enough about the staff and the care their relatives received. Feedback showed that they felt their relatives were being well looked after, and that staff knew the patients well. One particular comment summed up the general feeling "care and compassion is a top priority from all the staff". One patient was currently receiving treatment in the local acute hospital, and despite being up all night with their relative, the carer made a special trip to speak with inspectors about Hazeldene ward. We witnessed staff engaging with the carer on their arrival, showing a clear understanding of their needs and situation, greeting them warmly and with empathy, and providing reassurance about the plans in place for the care of their relative. During interview the carer commented "they care for me too".

Carers reported that their relatives were always clean and tidy, and made reference to clothes being changed daily and to hair and nails being clean and cared for. They referred to staff as motivated and dedicated, and made reference to the homely feel of the environment and the camaraderie amongst staff.

We spoke to four patients, and three of these felt there were enough staff available to meet their needs, and that staff were caring, respectful and polite.

The involvement of people in the care they receive

On admission patients were oriented with the ward. A welcome pack was available that contained information on the hospital's code of conduct, patient's rights, the philosophy of care, and information for visitors and carers amongst other things.

Family meetings were taking place on a regular basis. All of the carers reported feeling involved in their relatives care, with one commenting "I've been involved at every stage and staff have been very open". Not all carers had seen their relatives care plan. Carers received updates from staff on a daily basis if required and staff volunteered this information, they did not have to be asked for it.

We saw evidence in the patient care records of advocacy information being given to patients.

We reviewed minutes of patient meetings which had variable attendance. There did not appear to be a standing agenda, and the main items discussed were food and activities. There was no evidence of action being taken from one meeting to the next. Patients reported they either did not have a care plan or had never seen it, and although care plans were personalised they did not always reflect patient's and carers views where possible.

There were plans to involve patients in the recruitment of staff in the future.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

Requires improvement

Wards for older people with mental health problems

Hazeldene ward had 15 beds, and over the six months prior to inspection bed occupancy was between 86-93%. The patient population at the time of inspection was nine male and three female patients, all over the age of 65. One patient was not from the surrounding area.

There were no identified discharge dates, and therefore no delayed discharges. However, three patients were identified as being able to move on to residential nursing care. Staff reported difficulty in accessing suitable placements, and there was reluctance from patient's families for them to move on. One patient had been in the hospital for six and a half years, with a further five patients having been there for between two and three years. South View does not define itself as a long stay hospital, yet there was a lack of discharge planning evident in the patients' care records. The consultant psychiatrist attributed this to patients being "treatment resistant", and spoke of previous failed placements for some patients. The consultant and the manager identified the lack of step-down services as a reason for people not being able to move on in a timely way.

The facilities promote recovery, comfort, dignity and confidentiality

The ward had a full range of rooms and equipment to support treatment and care. There was a fully equipped clinic room, a sensory room, two lounges, a dining area, and a large outdoor space with smoking shelter. Visits could take place in the visitor's room off the ward, or if they preferred in the main ward area.

Patients were able to access their own bedrooms. The only restriction was a lock on the ground floor corridor leading from the male bedrooms, which did not allow patients to leave their corridor without assistance from staff. This had been identified as an action on an internal 'quality first' visit and was due to be rectified.

Three of the four patients we were able to speak with felt the food was variable. Carers had no concerns about the food or the environment. Patients were able to access drinks through the day, and one carer reported that "hydration is a top priority".

At the time of inspection the ward had static phones available for patients to use in staff offices and mobile telephones were permitted, however no patient had a mobile phone. There were not facilities to make a phone call in private. This has been addressed and patients now have access to cordless handsets.

All bedrooms we viewed were able to be personalised, and most contained personal pictures and ornaments. There were lockable cupboards in each bedroom but they did not seem to be in use by the patients due to the risks associated with losing the keys. Some of the bedrooms did have signs on the door with the patient's full name. The provider should consider the benefit of this, and whether it impacts on patient confidentiality and data protection.

We saw evidence throughout the ward of therapy and activities being tailored to individual patients. We spoke with the activities coordinator, who knew the patients and their interests very well. An activities timetable was displayed, and during inspection, patients were involved in cake decorating, and reading books of particular interest to them, such as travel. There were no reports of activities being cancelled due to staffing levels. Patients were taken out on bus trips, and the 'you said – we did' board highlighted places to visit based on patient feedback. There were files available in the communal area containing pictures of the activities that patients had been involved in, such as trips to the local seaside and a visit from a dancing group. There were many historic pictures of the area displayed around the corridors, and newspaper cuttings from poignant times in history. The sensory room contained a karaoke machine, as one patient had a preference for karaoke, and was equipped with a light up rug, a bubble tube and fibre optic cables. Each patient also had their own memory box, and there was an old record player and old cassette tapes.

Meeting the needs of all people who use the service

The ward had disabled access, and the rooms could accommodate a wheelchair and hoist if required. The ward had disabled toilet and bathroom facilities. We saw one patient in a specialised lounge chair, with a waist harness in place. There was no care plan in the patient care record to reflect the use of the waist harness, and this was rectified whilst we were on site.

The registered manager identified that should leaflets be required in different languages or an interpreter required, then this would be actioned.

Requires improvement

Wards for older people with mental health problems

Notices around the ward informed patients of local services, and of their rights and how to complain. The CQC poster advising detained patients of how to complain was not present, and this was rectified during our visit.

The registered manager stated there were no patients who currently requested access to spiritual support, but that this would be facilitated if required.

Listening to and learning from concerns and complaints

There had been no complaints in the six months prior to inspection.

Patients and their carers felt they would be comfortable to speak to the staff if they had a complaint, and in particular the family meetings were felt to be an open environment where people were heard.

Staff knew how to make a complaint, and there were posters on the walls in relation to whistleblowing and duty of candour.

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

Good

Vision and values

Staff knew and agreed with the organisation's values. They felt supported by the management team. We saw minutes of meetings and audits conducted that showed senior managers had visited the ward and spoken with staff, and the registered manager reported good relationships with the organisations directors.

Good governance

We felt the hospital was well led based on the following:

- Mandatory training levels were at 92% which is above the Barchester requirement of 85%.
- Ninety percent of staff had received an appraisal in the last 12 months, and 87% received regular managerial supervision.
- Clinical staff actively participate in clinical audits.
- There was a system for reporting incidents, and a new process in place for identifying risk and lessons learned.
- The registered manager had sufficient authority to increase staffing if required.

A 'quality first' visit had taken place on 5 July 2015 by the regional director, and the regulations manager had visited on 29 August 2015 to conduct a pre-CQC inspection visit. Feedback was given using CQC's regulatory framework under the five key questions. The quality first audit did identify actions to be taken that were still outstanding. We reviewed the same two patient's care records that had been reviewed during the audit, and found that while some amendments had been made, others had not. The provider should ensure that the issues identified in this audit are actioned.

During inspection we needed to ascertain whether a staff member was on shift on particular days, and in order to do this the rota, daily sheet, caresys system and HR records had to be used. This does cause concern about the robustness of the staffing data, and the provider should look at how to ensure accuracy and clarity in documenting staff attendance.

The registered manager had to submit weekly information to the divisional director to inform Barchester's key performance indicators, which focussed primarily on staffing and bed availability There was a clear reporting structure in place, and the manager had to provide an explanation of any areas where the hospital was not meeting its targets. The divisional director would then report this to the board each week.

Leadership, morale and staff engagement

There were no reports of bullying or harassment. The registered manager had provided a training session for staff on whistleblowing and there were posters on the ward informing staff of their right to do so. There were three incidents of whistleblowing, with the most recent on 21 February 2015. Staff reported historical difficulties with the management of the ward; however, this had greatly improved over the last six months. The previous manager had moved on following a period of absence, a temporary manager was put in post from another Barchester hospital and a new clinical lead was appointed. Staff felt this had made a huge different to morale, and that they worked as a team and were very supportive of each other. A new registered manager has been recruited and is due to commence employment on 7 September 2015.

Requires improvement

Wards for older people with mental health problems

There was an identified accountable officer, although some clinical staff were confused as to who this was. The provider should ensure that all staff understand the role of the accountable officer and the function of the Local Intelligence Network.

One staff member identified they were keen to engage in more learning and development, and having discussed this with their manager this was being supported. The Mental Health Act administrator was currently undertaking a mental health law in practice certificate at Northumbria University that was fully funded by Barchester.

Support workers felt more involved in patient care, and since the recruitment of the clinical lead they were now involved in the weekly ward round. One of the nursing staff stated “I can trust the support workers 100%”, and all staff reported the managers having an open door policy.

Regular staff meetings were taking place with evidence in the minutes of staff being able to inform practice and service development.

Commitment to quality improvement and innovation

Staff engaged in clinical audits, and learning was shared with the team.

The ward did not currently take part in any accreditation process; however, they were considering this for the future.

The consultant psychiatrist had a keen interest in research and was the chair of an innovative group developing new ideas.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that the stairwell is made safe for patients to use, and that ligature points are mitigated.
- The provider must ensure that their own policies and procedures are adhered to when managing medicines.
- The provider must ensure that discharge planning is in place to enable patients to move when it is appropriate to do so.
- The provider must ensure a risk register is in place.

Action the provider SHOULD take to improve

- The provider should ensure that staff have a clear understanding of Mental Capacity Act and Deprivation of Liberty Safeguards and the implications for their practice.
- The environmental risk assessment should be updated, and all blind spots and ligature points should be mitigated for.
- The provider should ensure there is signage to indicate where the oxygen is stored.
- The provider should ensure infection control principles are adhered to when administering medication.
- The provider should ensure that care plans are reviewed in an appropriate and effective way.
- The provider should ensure patients care plans reflect the views of the patient/carer, and have a recovery focus with discharge planning in place.
- The provider should consider the implications for data protection of displaying patient's full names outside their bedrooms, and discussing care in communal areas with other patients present.
- The provider should address the lock on the downstairs corridor that prevents patients from leaving their corridor.
- The provider should ensure that any issues identified in internal audits are acted upon.
- The provider should ensure that there is a robust and clear system in place for recording staff attendance.
- The provider should ensure that all staff understand the role of the accountable officer and the function of the Local Intelligence Network.

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 We found a stairwell with a waist height banister and open spindles which was a risk to patient safety and also a ligature point that was not identified on the risk assessment. This was a breach of Regulation 12(2)(d)

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 The provider did not have a current risk register. This was a breach of Regulation 17(2)(b)

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 Staff did not follow the providers own policies and procedures in relation to the management of medicines. Staff did not adhere to infection control principles in the administration of medicines. This was a breach of Regulation 12(2)(g)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

There was no evidence of discharge planning for patients

This was a breach of Regulation 9 (3) (a)