

Forest Hospital

Quality Report

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Date of inspection visit: 31/05/2016 02/06/2016
Date of publication: 24/10/2016

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



Summary of findings

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Requires improvement 

Forest Hospital

Services we looked at

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

Summary of this inspection

Background to Forest Hospital

Forest Hospital, owned by Barchester Healthcare, is a 30-bed independent mental health hospital that provides accommodation, personalised care, and support for men and women. The hospital shares a site with a 20-bed care home, which is a separate service. There are two single-sex wards, Horsfall Suite (female) and Maltby Suite (male). The hospital opened in 2013 and is set in large grounds with gardens and ample car parking. The hospital is in a residential area served by public transport.

Regulated activities that Forest Hospital is registered with the CQC to provide are:

- treatment of disease, disorder or injury
- assessment or medical treatment for persons detained under the Mental Health Act 1983.

Patients cared for at Forest Hospital:

- have diagnoses including dementia, Parkinson's, Huntington's disease, Korsakoffs, and depression
- may be detained under the Mental Health Act (1983)

- may be detained under Deprivation of Liberty Safeguards (DoLS), which are part of the Mental Capacity Act (2005)
- have a primary diagnosis of mental illness with complex needs
- may have a history of substance, drug and alcohol misuse
- may have a history of sexual abuse or domestic violence
- may be treatment resistant.

At the time of our inspection, the hospital had recruited a temporary registered manager from another Barchester service because the previous registered manager had recently left. Senior managers were in the process of recruiting to the vacant post for a new registered manager. There have been four previous inspections at Forest Hospital; the most recent was 4 - 5 April 2016 when we rated the provider as good in all the areas we inspected.

Our inspection team

Team leader: Julie Bains, CQC Inspector (Mental Health) Central West region

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We carried out this unannounced focussed inspection after CQC received a number of concerns from whistle-blowers and patients regarding safe staffing levels, medicine management, and the physical

safeguarding of patients. CQC did not review every aspect of the safe domain as this was covered in the comprehensive inspection on the 4 and 5 April 2016, the service was rated as requires improvement.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited the two wards, looked at the quality of the ward environment, and observed how staff were caring for patients
- spoke with the temporary registered manager
- spoke with six other staff members, including clinical leads, nurses, an occupational therapy assistant and rehabilitation assistants
- spoke with one patient
- observed five patients eating lunch in the dining room
- attended and observed one multidisciplinary daily meeting

Summary of this inspection

- looked at two care and treatment records of patients
- checked the medication management on one ward; and
- looked at incident reports, safeguarding referrals, staffing rotas and handover paperwork.

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 rated safe as requires improvement because:

- Not all staff had the required specialist training required to meet the physical health needs of all their patients.
- The hospital did not carry out medicine audits in line with its policy.
- Rotas, staff returns, observations paperwork, safeguarding paperwork, and handover notes were not always completed and filed appropriately.
- Medicine chart records were not always completed to record that medication was given to patients.
- The provider did not have effective medication management systems in place resulting in over stocking or having no stocks of certain medication.
- Staff did not follow hospital procedures for the reporting of all incidents.

However:

- The hospital had single-sex accommodation, comprising one male and one female ward.
- The wards were visibly clean, airy, well maintained, and suitably furnished.
- Safe staffing levels for day and night shifts were met on both wards.
- The wards had access to weekly occupational therapy, psychology, and consultant psychiatry sessions.
- Staff we spoke with said they knew how to report incidents and make safeguarding referrals to the local authority.
- Staff said they learnt from incidents and we saw an incident discussed in the hospital daily meeting, attended by management, ward staff, maintenance, and the head chef.
- Medication was stored securely in a locked room and staff carried out the required checks for the storage and dispensation of controlled drugs, in line with the hospital policy.
- Staff we spoke with said there were enough staff to deal with the physical healthcare needs of patients.

Requires improvement



Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

Safe

Requires improvement 

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

Requires improvement 

Safe and clean environment

- The ward layout allowed staff to observe all parts of the ward. The hospital had single-sex accommodation, comprising one male and one female ward.
- All areas of the ward were visibly clean, well maintained, and suitably furnished.
- All staff we spoke with were aware of increased observation procedures for patients with specifically identified risks.
- Infection control posters, policies and procedures were in clear view in the clinic room.
- We saw staff following good infection control principles, such as handwashing.
- The clinical rooms were small with no treatment couch, making storage difficult and examinations had to take place in patient's bedrooms
- We saw cleaning staff carrying out a range of cleaning duties on both days of our visit. The dining areas were bright, visibly clean and met the needs of patients. We saw patients using specially adapted plates and sealed cups to reduce food and fluid spillage. We saw the menu catered for patients with specific dietary requirements, including culturally appropriate options
- The service did not have a seclusion room

Safe staffing

- There were 16 patients at the hospital; 10 on Maltby and six on Horsfall.
- When fully staffed, the hospital employed six registered mental health nurses and 25 rehabilitation assistants. A clinical lead nurse provided ward management for both wards and a hospital director was responsible for the delivery of the service. Occupational therapy and psychology staff attended the hospital one day a week and consultant psychiatry provide two sessions a week and out of hours cover to support the running of the

wards; managers had transferred an additional full-time temporary clinical lead from another Barchester hospital to support the full time clinical lead to address staffing and governance issues.

- There were vacancies for a hospital director, two registered mental health nurses, and four rehabilitation assistants. The acting hospital director said the hospital had recruited candidates for the nursing and rehabilitation assistant posts and managers were in the process of gaining references and disclosing and barring service criminal record checks.
- We looked at 18 recent staff rotas. These showed Maltby required six staff on the day shifts (including one qualified nurse). Horsfall required five staff on the day shifts (including one qualified nurse). This was the staffing level we observed at the time of our visit. The hospital used agency staff to cover vacant posts. Where possible the agency sent the same staff as they were familiar with the wards and patients.
- The occupational therapy assistant was full-time and worked across both wards but, due to the number of staff vacancies, was sometimes required to undertake a rehabilitation assistant role.
- As a result of nurse vacancies, the clinical leads were sometimes required to cover nursing shifts. Managers accepted this affected the clinical leads' ability to undertake their role. This included not completing routine audits in line with policy to protect patient safety.
- The hospital director had the authority to increase staffing levels to meet enhanced observation levels of patients and to cover staff leave or sickness.
- Staff reported they could be called to undertake duties between the two wards at any point during their shifts. The hospital director said from the week starting 6 June 2016 each ward would have dedicated staff to address this issue and the clinical leads would be responsible for the staffing of their own wards.
- From 1 April 2016 to 31 May 2016, the administrator reported two members of staff on long-term sickness absence and there were seven periods of short-term absence by other staff.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement 

- The hospital director told us they had recently introduced 'back to work' interviews for staff returning from sickness absence and managers monitored sickness in supervision.
- We reviewed 18 rotas and staffing returns from 1 April to 31 May 2016. Staff were unable to find some rotas because they said they had not been filed correctly. Each of the rotas we looked at showed every shift was fully staffed by permanent and, when needed, agency staff.
- Staff said vacancies and sickness absence increased the pressure on them to effectively deliver their roles and the constant use of agency staff reduced the continuity of care patients received.
- Staff and management recognised that one patient who exhibited behaviour which was challenging had a negative impact on staff morale. Staff reported feeling unsupported by management in dealing with the patient. The hospital director said a management plan for the patient was being written. However, they recognised no management plan was in place to support staff to deal with the impact of the patient's behaviour on their health and wellbeing.
- At the time of our inspection there was a lack of trained nurses to deal with one aspect of physical healthcare required for a patient. The clinical lead told us this was due to the current staff vacancies. Previously, the provider had commissioned training in this aspect of care and said they would arrange for further training once the new staff were in place. However, there were enough staff to deal with all other physical interventions required.

Assessing and managing risk to patients and staff

- Staff completed incident forms for patients on Maltby ward. Patients had electronic records that detailed the incident, and the actions staff took. One patient had no record of incidents but the hospital director said there had been a number of incidents for this patient.
- We looked at the process and procedures staff used to identify and report safeguarding concerns. We saw electronic and paper records used in the process matched up to the incident reports. Staff stored response letters from the local authority, which confirmed receipt of the referral and actions taken by the local safeguarding team. Some local authority letters were loose and not attached to the relevant safeguarding referral. While all relevant paperwork was available for inspection, the filing system was not easily accessible to staff because there was no alphabetical or date order to the system.
- The provider had not notified CQC of 13 safeguarding incidents between 21 January 2016 and 12 May 2016. The provider is required to notify CQC of safeguarding incidents. This was brought to the attention of the hospital director, who assured us this would be done retrospectively and staff would send future notifications to the CQC promptly.
- We tracked a safeguarding incident through the care records of one patient who had experienced a fall. Staff had updated the risk assessment and implemented suitable enhanced observations. We asked to see the paper records of these observations but staff were unable to find them all because there was approximately one month's worth of records waiting to be filed. Therefore, we only saw twelve observation records. The records we did see were completed effectively. Managers told us night staff were expected to carry out filing duties but, between April and May, the filing had not been done effectively. Managers assured us this would be rectified as soon as possible. Analysis of care records showed that staff identified when patients needed specialist physical health assessment and treatment. They made appropriate referrals and implemented specialist care and treatment programmes for them. This showed the staff on the wards assessed and managed the risk to the patient.
- CQC received a concern regarding the provision of a specialised physical healthcare intervention. We scrutinised the relevant care records and found staff had implemented appropriate care plans, risk assessments, and support plans. The support plans followed national guidelines set down by the national professional body. Managers told us they had commissioned specialist training for staff in this area. However, some agency staff had not received this training. Managers told us they planned to commission additional specialised training in the near future. Managers also noted that there were always staff on duty that could support with this specialist care if required. Managers told us they had a backup plan in place where they would call for support from the local GP practice. They had reason to use the

Long stay/rehabilitation mental health wards for working age adults

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backup plan recently, which was not successful and the managers told us they planned to strengthen this arrangement with the provision of additional specialist training for their own staff.

- Staff stored drugs effectively and safely in dedicated rooms. They kept controlled drugs in a locked cupboard.
- Staff checked the controlled drugs daily and signed the documentation, in line with hospital policy.
- We reviewed 10 medicines administration record charts. The charts were incomplete for May 2016 with signatures missing on 46 occasions from the ten records reviewed. The clinical lead confirmed staff had not completed the weekly audit since March 2016.
- Patients were all registered with a local GP practice, which the provider contacted when repeat prescriptions were required. The temporary clinical lead said the current ordering of prescriptions was ineffective, leading to overstocking of medication or medication running out. On the day of our inspection they had collected the over-prescribed stock on Horsfall ward and were arranging for the pharmacy to collect it for destruction. This had been done when we returned on 2 June 2016.
- Staff told us one patient had run out of medication and they had to wait several days over a weekend before this was resolved. The medication was prescribed when required and was not requested by the patient during this period. The hospital director said they had identified it as an issue and planned to introduce a system currently operating in the parent organisation that would prevent the problem from happening again.
- We reviewed the handover records for both wards. On Horsfall ward, the week starting 30 May 2016 did not contain any handover notes. The most recent notes

available were for the week starting 16 May 2016. On Maltby ward, there were handover notes for the weeks beginning 2 and 16 May 2016. However, these were not completed consistently at the end and start of shifts. Of the records we sampled there were no handover notes completed for the end and start of shifts for the weekends.

Track record on safety

- There was one serious incident reported in the 12 months before this inspection. This incident involved staff conduct towards a patient. We looked at records, which showed a timely investigation.

Reporting incidents and learning from when things go wrong

- The staff we spoke with said they knew how to report incidents to the clinical lead who added the information to the computer system within 72 hours. However, staff described incidents of aggression and intimidation on them by a patient that had not been reported so the provider's analysis informing governance reporting did not accurately reflect trends or patterns of incidents.
- Staff said they learnt from incidents and we observed incidents being discussed in the hospital's daily meeting, especially those concerning patients' challenging behaviour. However, incident forms had not been completed by staff, which resulted in no actions being put in place to reduce the effect on staff health and wellbeing. The hospital director recognised the need to implement a management plan to support staff in managing challenging patient behaviour.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must report serious incidents to the CQC as required by the registration regulations.
- The provider must ensure effective medication management systems are in place.
- The provider must ensure that medication audits are carried out in line with its policy. The provider must ensure all rotas, staffing returns, observations paperwork, medicine chart records, safeguarding paperwork and handover notes are completed and filed appropriately.
- The provider must ensure staff follow hospital procedures for the reporting of all incidents

Action the provider **SHOULD** take to improve

- The provider should ensure there are enough staff on the wards, allowing clinical leads to undertake their core roles.
- The provider should ensure staff receive any specialist training required to meet the needs of all their patients.
- The provider should ensure staff are supported to deal with patients who present behaviours that challenge.
- The findings of the medication audits should be discussed in team meetings to enable staff to learn from them and make improvements to the service.

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

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

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We found that the system in place for ordering and dispensing medication was not effective, as medicine stocks had run out and the medicine administration charts were incomplete.

This was a breach under regulation 12 (2)(g)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider had not undertaken medication audits in line with their policy.

Paperwork was not fully completed and it was not filed appropriately.

Staff were not reporting incidents in line with hospital procedures and policy.

This was a breach under regulation 17 (2) (a) (b) (c)

Regulated activity

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

Treatment of disease, disorder or injury

Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The registered person must notify the Commission without delay of the incidents which occur whilst services are being provided in the carrying out of a regulated activity, or as a consequence of the carrying on of a regulated a regulated activity.

This section is primarily information for the provider

Requirement notices

We found that the provider had failed to notify CQC regarding a serious incident involving a patient.