

Whorlton Hall

Quality Report

Whorlton
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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 well-led?

Good



Overall summary

We rated Whorlton Hall as requires improvement because:

- The provider had not taken sufficient action to address the requirement notice we issued following our inspection in March 2016. Although resuscitation equipment was clean and in date an essential stock item for anaphylaxis which we identified at our March 2016 inspection was not available at the time of our inspection.
- There were gaps in cleaning records and domestic staff vacancies meant that some days there was not a domestic on duty.
- Some minutes from governance meetings were brief and there had been gaps in monthly internal service reports. This had the potential to affect the organisations ability to effectively monitor performance and quality.
- The provider had not completed all the requirements for a patient being cared for away from other patient who was in long term segregation as defined by the Mental Health Act code of practice.
- A patient who had been given as required high-dose antipsychotic medication regularly refused physical health monitoring. The patient's refusal was not always recorded.
- It was difficult to locate items in some paper care records.

However:

- The service had been proactive in addressing significant staffing and management issues which had occurred between June and August 2016. Senior

Summary of findings

managers in the organisation had put safeguards in place to support new managers. Active recruitment to vacant posts was continuing and a new post of deputy manager had been created.

- The provider was making good progress in addressing actions highlighted in recent audits and internal reviews. We saw improvements had taken place with regard to the environment, staff training and record keeping.
- Staff completed risk assessments of patients at admission and on an ongoing basis.
- Low morale amongst staff had been recognised and the service had worked actively with staff to respond to their concerns and make changes that would benefit them. Staff reported things had improved and they enjoyed their jobs.
- Senior manager support was continuing to maintain the improvements which had been made. An action plan was in place to ensure improvement was maintained and outstanding actions were monitored.

Summary of findings

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Requires improvement 

Whorlton Hall

Services we looked at

Wards for people with learning disabilities or autism

Summary of this inspection

Background to Whorlton Hall

Whorlton Hall is an independent hospital owned by the Danshell Group. It provides assessment and treatment for men and women aged 18 years and over living with a learning disability and complex needs. The hospital also cares for people who have additional mental or physical health needs and behaviours that other's find challenging.

The hospital is registered with the Care Quality Commission to provide the following regulated activity:

- Assessment or medical treatment for people detained under the Mental Health Act.
- Treatment of disease, disorder or injury.

The hospital's current manager had been in post less than one week and was progressing the application to become the registered manager. The accountable officer for controlled drugs was a manager from a nearby hospital.

The hospital had been registered since 2013 to accommodate 24 patients. However changes to the layout and environment meant this had been reduced to 19 beds. At the time of our visit there were eight patients at the hospital.

There had been three previous inspection carried out at Whorlton Hall. The first comprehensive inspection took place in August 2015. Not enough evidence was gathered to give an accurate assessment and hence the inspection was repeated in March 2016. At this inspection the hospital was found to be in breach of with Regulations 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We carried out a third visit in August 2016 as part of a focused inspection following concerns regarding the quality of care. We looked at the 'safe' domain as the concerns related to patient and staff safety. At the time of our November 2016 inspection this report had not been published or made available to the provider.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and one learning disability nurse specialist advisor.

Why we carried out this inspection

We undertook this inspection to find out whether Whorlton Hall had made improvements since our last comprehensive inspection on 3 and 4 March 2016 and our focused inspection on 15 August 2016.

When we undertook our comprehensive inspection in March 2016, we rated it as good overall. We rated the safe domain as requires improvement and the effective, caring, responsive and well-led domains as good.

Following the inspection in March 2016 we told the provider that it must take the following action to improve services:

- The provider must ensure the availability of equipment and medicines for use in an emergency.

We issued one requirement notice. This related to Regulation 12 Health and Social Care Act 2008 Regulations 2014 Safe care and treatment.

Since the March 2016 inspection the provider had experienced staffing issues leading to safeguarding concerns for patients. We undertook a focused visit in August 2016 in response to these concerns. We found that the provider had identified a number of areas where

Summary of this inspection

improvement were needed and had an action plan already in place. At the time of our November 2016 inspection this report had not been published or made available to the provider.

During our inspection in November 2016 we looked at the 'safe' domain and the 'well led' domain to find out if patients and staff were being protected against risk and to see if the provider had made the necessary improvements.

How we carried out this inspection

We asked the following questions:

- is it safe?
- Is it well led?

On this inspection, we assessed whether Whorlton Hall had made improvements by inspecting the whole 'safe' and 'well led' domains.

Before the inspection visit, we reviewed information that we held about the location and reviewed a recent Mental Health Act review visit report.

During the inspection visit, the inspection team:

- spoke with the hospital's manager

- spoke with 10 other members of staff including support workers, qualified nurses activities co-ordinators, director of operations and human resource manager
- spoke with six patients
- spoke with one carer
- attended a daily 'flash meeting'
- reviewed the risk assessment records for all eight patients
- reviewed the medication charts for all eight patients
- carried out a specific check of the medication management
- reviewed policies, procedures and other information relating to the running of the service.

What people who use the service say

During our visit we talked with six patients and one carer, the feedback we received was positive. Patients told us they felt safe at the hospital and that their possessions were safe. They liked the staff and thought they were caring and treated them well. Staff knocked on their bedroom door before entering.

Most patients said there were always enough staff around and that leave or activities were not cancelled.

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:

- An essential medication stock item for anaphylaxis was not available at the time of our inspection.
- There were gaps in cleaning records and domestic staff vacancies meant that some days there was not a domestic on duty.
- The provider had not completed all the requirements for a patient being cared for away from other patient who was in long term segregation as defined by the Mental Health Act code of practice.
- A patient who had been given rapid tranquilisation refused physical health monitoring. The patient's refusal was not always recorded.
- It was difficult to locate items in some paper care records

However:

- The service had been proactive in addressing significant staffing and management issues. Senior managers in the organisation had put processes in place to support new managers.
- Active recruitment to vacant posts was continuing and a new post of deputy manager had been created.
- Staff completed risk assessments of patients at admission and on an ongoing basis.
- Equipment required for emergencies was available and fit for use.

Requires improvement



Are services well-led?

We rated safe as good because:

- Low morale amongst staff had been recognised and the service had worked actively with staff to respond to their concerns and make changes that would benefit them. Staff reported things were much better and they enjoyed their jobs.
- The provider was making good progress in addressing actions highlighted in recent audits and internal reviews. We saw improvements had taken place with regard to the environment, staff training and record keeping.
- Senior manager support was continuing to maintain the improvements which had been made.

However:

Good



Summary of this inspection

- Some minutes from governance meetings were brief and there had been gaps in completing the monthly internal service reports. This had the potential to affect the organisations ability to effectively monitor performance and quality.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for people with learning disabilities or autism	Requires improvement	N/A	N/A	N/A	Good	Requires improvement
Overall	Requires improvement	N/A	N/A	N/A	Good	Requires improvement

Wards for people with learning disabilities or autism

Safe

Requires improvement 

Well-led

Good 

Are wards for people with learning disabilities or autism safe?

Requires improvement 

Safe and clean environment

Whorlton Hall was a former country house converted for use as a hospital. This meant that there were blind spots and the layout did not allow staff to observe all parts easily. These risks and other identified risks were mitigated by the individualised admission assessment processes. A ligature risk audit was in place which identified ligature points throughout the hospital. A ligature point is a place where a patient intent on self harm might tie something to strangle themselves. At the time of our visit no patients were at risk of harm by ligatures.

Male and female sleeping and bathing areas were separate which complied with department of health mixed sex accommodation guidance. A separate lounge for male and female patients was available as well as a communal lounge.

There was a well-equipped clinic room which was clean and tidy. Medicines were stored securely with access restricted to authorised registered nursing staff. An automated external defibrillator and resuscitation equipment was stored in the hospital's main office. This meant it could be accessed quickly for use. When we visited in March 2016 we found that some equipment for use in an emergency was out of date and unclean. When we visited in November 2016 we saw that all equipment was in order and was fit for use. For medical emergencies, staff needed to call emergency services. Essential stock medication for anaphylaxis was not available at the time of our visit. This had been ordered and the provider confirmed it had arrived after our visit.

The hospital did not have a seclusion room and no seclusion was taking place in any other rooms.

When we visited in August 2016 in response to concerns about staffing and patient safety we found some areas of the hospital were not clean. When we visited in November 2016 all areas of the hospital were clean and tidy. Domestic staff were on duty during our visit and we talked with them. We reviewed cleaning schedules. The schedules were due to be reviewed in order to ensure all requirements were covered as current schedules did not include everything. There were domestic staff vacancies and we were told that these had been filled and new staff would be taking up post soon. We saw gaps in the cleaning records where work had not been completed due to the vacancies.

The décor and furnishings were in good order; some areas had been recently painted. Some patients and staff told us they thought the decoration could be improved.

Appropriate handwashing facilities were available as well as personal protective equipment such as aprons and gloves to protect staff and patients against health and safety risks.

Staff wore personal alarms and these were linked into the hospital alarm system. We saw staff responding to an alarm during our visit.

Business continuity and environmental audits had recently been updated.

Safe staffing

Staffing of the hospital was based on patient needs and staff worked shifts which were 7.45am to 8pm and 7.45pm to 8am. The hospital had seven qualified nurses and 40 support workers. There was a qualified nurse vacancy and eight support worker vacancies. Proactive plans to recruit to these posts were in place. We were told that one qualified nurse and three support workers had been recruited to the vacant posts and were going through the recruitment process.

We reviewed the staffing rotas for September and October 2016. They showed that actual

staffing levels matched the planned staffing levels. Bank and agency workers were used on a regular basis. Staff we

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talked to told us they tended to use the same pool of bank and agency staff which meant that agency staff were familiar with the hospital. This ensured consistency for patient care. When we visited in August 2016, some staff were undertaking multiple roles due to the staffing situation. When we visited in November this was no longer happening. All staff we spoke with told us there was now enough staff and the manager was able to adjust staffing levels when needed.

There were enough staff to ensure meaningful one to one time with patients. Only occasionally were activities or outings cancelled or rescheduled. Mainly this was due to the hospital vehicles breaking down. Four staff members highlighted that the hospital minibus was very unreliable and on occasions outings had had to be cancelled or rearranged at short notice. Hire vehicles could be used when the minibus was out of order but staff found this frustrating.

Staff turnover rate at October was 46%. Long term sickness, which lasts four weeks or over had reduced from 5% in August to 3% in October. Short term sickness of less than four weeks was 1.5% in October.

Staff told us they felt safe in the hospital and were supported by colleagues. Previously they had not felt safe earlier in the year due to new admissions and high sickness amongst staff which had led to reduced staffing numbers. Staff and patients across the hospital told us that there was now sufficient staff to meet patients' needs.

We observed staff during our visit. We saw staff dealing with patients' requests in a prompt and respectful manner. There was a friendly and warm atmosphere between staff and patients. Staff knew patients' needs well. There were multiple activities occurring during our visit including escorted leave, sports activities and computer work.

Medical cover was provided by a consultant psychiatrist. Weekend and out of hours medical psychiatric cover was provided by an on call consultant psychiatrist for the north east region who covered other Danshell hospitals.

Overall mandatory training compliance at the end of October was 72% which was below the provider's target of 80%. Medication management, Mental Capacity Act, data protection, moving and handling, fire safety and management of violence and aggression for non care staff were all under 75%.

The provider had an improvement action plan in place with dates for outstanding training to be completed by the end of November 2016.

Assessing and managing risk to patients and staff

Seclusion was not used at the hospital. There had been 32 incidents of restraint between 1 September and 31 October 2016. The majority concerned three different patients. Staff told us they would only use restraint if de-escalation had failed. None of the restraints were in the prone position which is when the patient is placed face down.

There had not been any recent episodes of rapid tranquilisation. However, we saw in one patient's record that they had received rapid tranquilisation on several occasions. Physical health monitoring following these instances was not always recorded. Staff explained that the patient regularly refused physical health monitoring. The patient's refusal was not always recorded.

We looked at risk assessments for all eight patients. Patients had up-to-date risk assessments which identified the risks patients posed to themselves or others. Risk management plans to manage identified risks were in place. We observed that it was sometimes difficult to locate items in the paper care record and some records appeared to be repeated which meant staff were duplicating entries.

Policies were in place for patient observations. When we visited in August 2016 we heard that some staff were observing patients for long periods of time without sufficient breaks. When we visited in November 2016 we found that this had been resolved and staff told us this was no longer an issue. Staff carrying out observations were supported by nurses who carried out a walk around hourly. Staff did not observe patients longer than two hours without a break and they could request breaks at any time.

When we visited in August 2016 a patient was being cared for in their own suite of rooms away from other patients. This was in order to maintain both the patient's safety and the safety of other patients. The provider told us they had considered if the circumstances of the patients care could be described as long term segregation as outlined in the Mental Health Act code of practice and had decided it did not. We considered that this patient's care did meet the definition of long-term segregation and that the provider was in breach of regulation 9 Health and Social Care Act (RA) Regulations 2014, person-centred care. When we visited in November 2016 the provider had not received the

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findings from the inspection and hence had not completed any necessary action. We found that the provider was in the process of arranging the additional safeguards in relation to the patients long term segregation as identified by the code of practice. This included arranging an external review in addition to the multidisciplinary monitoring and review processes they already had in place.

Ninety percent of staff had attended safeguarding training. Staff knew how to make safeguarding alerts and gave examples of when this had happened in the past.

We reviewed all eight patients' medication charts and found them completed correctly. When we visited in March 2016 we found there was an excessive stock of some medication. We also found that medicines with limited life after opening did not always have the date of opening written on the container. When we visited in November 2016, we found the provider had resolved these issues.

Children did not routinely visit the hospital. Any visits were encouraged off site.

Track record on safety

There had been five serious incident reported between 1 September and 31 October 2016. These related to allegations of abuse and a major equipment failure (power outage). We reviewed incident data and saw that appropriate action was taken.

Reporting incidents and learning from when things go wrong

The hospital used an electronic incident reporting system to record all incidents including safeguarding issues. Only qualified staff had access to the system which meant support workers passed on information that needed to be reported. Staff gave examples of the types of incidents that were reported which included the use of restraint, physical and verbal abuse, allegations of abuse and accidents. We saw reviews of incidents and lessons learnt in patient multidisciplinary team meetings.

Feedback on incidents and learning was shared with staff during handovers, 'flash meetings', team meetings and supervision. Additional de-brief meetings were arranged for serious events.

The manager was aware of the duty of candour requirements. The incident reporting system captured incidents that fell within the requirements so the process could be followed.

Are wards for people with learning disabilities or autism well-led?

Good 

Vision and values

The organisation had a quality strategy which outlined the vision, mission and implementation framework for improving quality. The vision had been developed in partnership with patients and stakeholders. The vision was "to ensure that every individual accessing our services has

a truly person centred experience that meets their needs, wants and wishes in a way that is:

Safe - person centred and rights based

Sound - high quality and appreciative

Supportive - empowering and transforming"

We saw evidence of the vision on noticeboards throughout the hospital. Staff told us the senior managers visited often and they had a good relationship with them. When there had been difficulties in the summer the chief executive and the chair had visited.

Good governance

The Danshell group had a clear structure for clinical governance in place. Unit led clinical governance meetings fed into regional clinical governance meetings. Monthly internal service reviews by the manager collated key performance and governance information including incidents, clinical issues and audits. These helped senior managers check the quality of the service provided. We heard that there had been gaps in the monthly internal service reviews over the summer months which reflected the difficulties the service had had. We reviewed minutes from the regional clinical governance and health and safety meetings. Some minutes were brief so it was difficult to see how effective the meetings were in monitoring the quality of service provision.

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Although key performance indicators were used to gauge performance of the service, significant staffing issues had occurred in the summer months leading to safeguarding concerns. The provider had undertaken a review to understand how these events had happened and to prevent them happening again. Changes made following this review included the medical director to review all complex patients being considered for admission following review by the multidisciplinary team. A more robust induction for hospital managers both at location and corporate level was also implemented.

We saw evidence of an internal quality inspection in July 2016. The provider's inspection found a number of areas required improvement. Clear actions were identified and the provider conducted a re-inspection in October 2016. There was evidence of improvement and further actions highlighted to ensure all standards were fully met.

Processes were in place to ensure employment checks took place for newly recruited staff. Staff we talked to told us they received supervision and annual appraisals. At the time of our visit records confirmed that compliance with supervision was 66%. Seventy one percent of staff had an up to date appraisal. Future dates for supervision and appraisals were booked for staff and the hospital planned to have 100% compliance by the end of December 2016. Mandatory training was below the provider's target of 80% and we saw action for this to reach the target by the end of November 2016.

Shifts were being covered by sufficient numbers of staff with the use of regular agency staff.

The provider had a programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. A range of audits had taken place over the previous six months and included:

- Epilepsy Management
- Observation Policy
- Clinical record keeping
- Records management
- Health and safety
- Safer Restrictive practices
- Infection control
- Closed circuit television.

An external pharmacy audit had been completed in September 2016. Areas for improvement had been

identified in all audits. The provider had collated audit actions within an overall improvement action plan. We saw updates against these actions which demonstrated the provider was making progress.

Incidents and safeguarding reporting was taking place. Sharing and learning from incidents and complaints was taking place and some staff gave us examples of changes which had taken place in response to incidents.

Leadership, morale and staff engagement

Since our comprehensive inspection in March 2016, the hospital's registered manager had moved to a different post. Three new and interim managers had been in post since April 2016. At the time of our visit a new manager had taken up post and had been in position for four days. The new manager was from a hospital within the Danshell group and had existing knowledge of the service. This meant that they were able to quickly start addressing areas for improvement.

The Danshell group had supported the hospital with senior management visits and support. These included clinical support from the nurse consultant, governance support from the internal quality team, human resource support and weekly visits and monitoring from the director of operations. Staff were positive about this support. Weekly human resource clinics had been running since July where staff could talk about their experiences and highlight any concerns or problems they were having.

The new manager confirmed that this increased support was continuing and was well received. This was enabling them to maintain improvements and progress ongoing areas for development.

All staff felt able to raise issues or concerns. Sickness absence and vacancy rates had declined. When we visited morale was high and staff showed enthusiasm for the care of the patients. Most staff told us they were able to give feedback on services and were asked for ideas on service development and improvement.

The new manager valued the staff team and recognised that good practice was taking place. In their short time in post they had spent time observing and talking to staff and patients. The manager was knowledgeable about quality issues and priorities and was taking action to address them.

Commitment to quality improvement and innovation

Wards for people with learning disabilities or autism

It was evident that the provider was using information from interval reviews and audits to improve care. Service user questionnaires were completed and improvements to the environment were taking place.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider **MUST** take to improve

- The provider must ensure that essential stock items for anaphylaxis are always available for use.

Action the provider **SHOULD** take to improve

- The provider should ensure that actions from all audits and internal reviews are completed in order to make improvements to the service.
- The provider should ensure that clinical governance and assurance arrangements are effective in monitoring service performance and quality. This should include comprehensive recording of meetings, regular reporting of key performance indicators and review of actions to improve performance.

- The provider should ensure the appointment of domestic staff takes place in order to ensure the hospital is kept clean and tidy.
- The provider should ensure that it actions the previous regulatory breach in relation to long term segregation and ensures any episodes of long term segregation complies with the requirements in the Mental Health Act code of practice.
- The provider should ensure that if a patient refuses physical health monitoring following rapid tranquilisation that this is fully recorded.
- The provider should ensure that care records are filed logically to enable ease of use.

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 Appropriate medicines required in an emergency were not available. This was a breach of regulation 12 (1) (2f)