Abbey Court Independent Hospital

Quality Report

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Date of inspection visit: 08 August 2016
Date of publication: 13/10/2016

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	Good
Are services safe?	Good
Are services effective?	Requires improvement

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 Abbey Court Independent Hospital as **requires improvement** because:

• Staff did not record patients' baseline physical health observations accurately on modified early warning scores charts. We raised this concern during our last inspection of the service in January 2016, but this had not been adequately addressed. In addition, we found that staff were not monitoring and recording patients' baseline physical health observations at least once a month, as per provider policy. The service were not completing regular audits or checks to identify whether staff had monitored and recorded patients' baseline physical health observations.

• The service had no permanent registered manager in post since February 2016. Two senior nurse practitioners had also left the service in the last six months. This effected clinical leadership and support for staff, including access to regular supervision.

• The service had a high staff turnover rate at 16.9%. This could affect continuity of care and familiarity for patients where agency staff were booked to cover staffing shortfalls.

• Staff did not monitor the clinic room temperature. This could affect the shelf-life of some of the medicines stored there.

• There was no protocol in place to guide staff on the correct use of posture support chairs. Patient risk assessments and care plans did not identify how staff would use posture support chairs to support patients appropriately and safely.

However:

• The service had established an effective working relationship with a local GP practice. A GP from the practice ran a weekly ward at the hospital to address patients' physical health needs.

• The provider delivered a comprehensive mandatory training programme that all eligible staff had completed. Training provided by the five nursing agencies used by Abbey Court was compatible with training provided by Alternative Futures Group.

• The service had employed a full-time occupational therapist in June 2016. They completed specialist functional assessments for patients living with dementia to identify the level of support they required in activities of daily living, such as washing, dressing and eating.

• With the exception of the appropriate use of posture support chairs, staff completed comprehensive risk assessments for all patients. This included identifying triggers that may cause a patient to become agitated or distressed.

• The service met national standards for mix-sexed accommodation; since our last inspection in January 2016, the service had established a female-only lounge area.

• The service did not use rapid tranquilisation or prone restraint. Staff were skilled in the use of de-escalation techniques to support patients who were distressed or agitated.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Good 	This report describes our judgement of the quality of care provided within this core service by Alternative Futures Group. Where relevant we provide detail of each location or area of service visited. Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations. Where applicable, we have reported on each core service provided by Alternative Futures Group and these are brought together to inform our overall judgement of Alternative Futures Group.

Summary of findings

Contents

Good

Wilderspool Ward

Services we looked at

Wards for older people with mental health problems

Summary of this inspection

Our inspection team

Team Leader: Lisa Bryant, Inspector, Care QualityCommission.

The team that inspected Abbey Court Independent Hospital comprised two inspectors from the Care Quality Commission.

Why we carried out this inspection

We undertook this inspection to find out whether Alternative Futures Group had made improvements to Abbey Court Independent Hospital since our last comprehensive inspection of the service between 11 and13 January 2016.

When we last inspected the service in January 2016, we rated Abbey Court Independent Hospital as requires improvement overall. We rated the service as requires improvement for Safe, requires improvement for Effective, good for Caring, good for Responsive and good for Well-led.

Following this inspection we told the provider that they must take the following actions to improve Abbey Court Independent hospital:

• The provider must ensure that patients' physical health assessments are accurately recorded to enable staff to make appropriate and timely interventions.

• The provider must ensure that they are meeting the Department of Health guidance on same-sex accommodation.

We also told the provider that they should take the following actions to improve:

• The hospital should ensure that there are enough adequately trained nursing staff to meet the holistic care needs of all the patients using the service.

• The hospital should ensure that all patients' care plans and assessments are fully completed and routinely reviewed.

• The hospital should ensure that all patients detained under the Mental Health Act have their legal rights read on admission and routinely thereafter. This must be recorded in patients' care records. The hospital should ensure that, where appropriate, patients' relatives are informed of this.

• The hospital should ensure that there are a range of professionals in the multi-disciplinary team so that patients' holistic care needs are assessed and managed effectively.

• The hospital should ensure that all staff have the opportunity to provide feedback into how the service is delivered.

We issued the provider with two requirement notices that affected Abbey Court Independent Hospital. These related to:

• Regulation 10(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Dignity and respect.

• Regulation 12(1)(2)(a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

How we carried out this inspection

We asked the following questions of the service:

• Is it safe

• Is it effective?

On this inspection, we assessed whether the provider had made improvements to the specific concerns we identified during our last inspection.

• spoke with the interim manager

• spoke with the clinical lead nurse

Summary of this inspection

• spoke with five other staff members, including nurses, nursing assistants and an agency nursing assistant

• looked at five patients' care and treatment records

• looked at ten patients' medication charts

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

During the inspection visit, the inspection team:

• visited one of the wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients.

• looked at the physical health monitoring records for ten patients

• carried out a specific check of the medication management on both wards

• looked at a range of policies, procedures and other documents relating to the running of the service

What people who use the service say

Due to the severity of their illness, patients on Wilderspool ward were not able to communicate what they thought about the service. However, we observed how staff were caring for patients and found that they treated patients with dignity and respect. Staff displayed a good understanding of individual patients' needs and effectively used de-escalation techniques, such as verbal reassurance and diversion techniques, to support patients if they became agitated or distressed. Staff were mindful to promote least restrictive practice and only used restraint techniques when all other attempts to deescalate a patient who was agitated or distressed had failed.

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?

Good

Are services safe?

We rated safe as **good** because:

• The service had identified a female only lounge to comply with Department of Health and Mental Health Act code of practice guidance on same-sex accommodation.

• With the exception of the appropriate use of posture support chairs, staff produced robust risk assessments for all patients and updated them regularly.

• Staff did not use restraint in the face down position or rapid tranquilisation. Staff were skilled in the use of de-escalation techniques to support patients that were distressed or agitated.

• The service had good systems and processes in place to support good medicines management practices.

• The service had a comprehensive mandatory training programme that all eligible staff had completed.

However;

• The service had not had a registered manager in post since February 2016. Two senior nurse practitioners had also left the service in last six months. This affected the quality of clinical leadership within the service. However, we addressed this with the provider during our inspection and they immediately made an application to fill the registered manager post.

• Staff were not monitoring the clinic room temperature. Whilst some medicines will be unaffected at temperatures above 25 degrees, this is not the case for all.

• There was no protocol in place to guide staff on the correct use of posture support chairs for patients.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

Summary of this inspection

• Staff were not fully recording patients' baseline physical health observations on modified early warning scores charts. This meant that staff did not have the information available to identify when a patients' physical health may be deteriorating.

• Staff were not monitoring and recording baseline physical health observations for all patients at least once a month as per provider policy.

• There was no system currently in place to monitor the recording of patients' baseline physical health observations.

• Staff supervision rates were low since our last inspection of the service in January 2016.

However:

• With the exception of modified early warning scores charts, staff completed a variety of patient health assessments that addressed their holistic care needs. Where patients lacked capacity, staff completed some of the assessments by seeking input from their family to ensure the patient's views and preferences were captured.

• The service had introduced on-site GP clinic that ran one morning a week. A visiting GP ran the clinic and maintained a good oversight of patients' physical health needs.

• The service had employed a full-time occupational therapist who completed comprehensive functional assessments for patients living with dementia

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.

There were 12 patients detained under the Mental Health Act at Abbey Court Independent Hospital at the time of our inspection. All patients who lacked capacity to consent to treatment had the appropriate certificates authorising the administration of medication.

The service received training and on going support in the correct use of the Mental Health Act and the Code of Practice from a local NHS trust. The trust had an audit schedule in place to monitor and address the service's compliance in the correct use of the Mental Health Act and its guiding principles.

For patients detained under the Mental Health Act, staff made prompt referrals to independent mental health advocacy services. An advocate attended the service regularly to provide detained patients with independent support. This included attending multi-disciplinary and care programme approach reviews.

Mental Capacity Act and Deprivation of Liberty Safeguards

The provider delivered training to all permanent staff in the Mental Capacity Act on induction to the service and a refresher every two years thereafter. At the time of our inspection, 87% of staff were up to date.

The service had submitted one Deprivation of Liberty Safeguards application between 1 March and 1 August 2016. The local authority had approved the application and a standard authorisation was in place.

Staff demonstrated a good understanding of the Mental Capacity Act, including the assumption that people have the capacity to make decisions and that consideration of capacity is specific to the decision being made.

Overview of ratings

Our ratings for this location are:

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

Good

Wards for older people with mental health problems

Safe	Good
Effective	Requires improvement

Are wards for older people with mental health problems safe?

Good

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory

abuse

Our findings

Safe and clean environment

The ward layout on Wilderspool ward did not allow staff to observe all parts of the ward. However, the risk was adequately mitigated by regular staff presence across the ward and increased patient observations where necessary.

The ward's nursing office was located between two adjoining bedroom corridors. This meant that staff were located near to patient bedrooms during the night which allowed them to monitor and support patients more easily.

The environment reflected best practice in dementia care with consistent flooring throughout the communal areas and contrasting handrails along all corridors. Bedroom corridors were painted in bright, contrasting colours to help orientate patients to their bedroom. All patients had a memory box in place outside their bedroom. A memory box is an evidence based resource that contains items of sentimental and memorable value to the person with dementia. In placing a personalised box outside of their bedroom, a patient with dementia can identify the items as significant to them which helps orientate them to their bedroom.

A kitchen led onto the main dining area. Patients could use this during the day and night under staff supervision. There was a large communal bathroom with a specialist bath installed (a bath with a seat that can lower to assist patients with limited mobility).

Larger bedrooms were available for patients who required mobility equipment to move safely, such as a hoist.

Staff had completed a ligature risk assessment (to identify items that patients intent on self-harm could use to strangle themselves). Alternative Futures Group's health and safety lead completed a monthly environmental ligature risk check. This was to identify ligature risk points and to identify actions to reduce patient risks. The ligature risk assessment identified several ligature risk points, such as window handles in patient bedrooms and grab rails in en-suite and communal toilets. However, due to the patient group accommodated on the ward, the risk of ligaturing was identified as low. Patient risk assessments identified that they were not at risk of deliberate self-harm. The ward had two anti-ligature bedrooms in the event that a patient at risk of ligaturing required accommodation on the ward.

These en-suite bedrooms contained no ligature points. All patients had individual bedrooms with en-suite facilities. These were located across three bedroom corridors. At the time of our inspection we found that there were separate corridors for male and female patients.

However, when allocating patient bedrooms staff also took into account other factors such how patients slept during the night, falls risk and if they required a bigger bedroom for mobility equipment.

The service had identified a female only lounge area that was clearly signposted. This met the conditions of the requirement notice issued following our inspection of the service in January 2016. The requirement notice identified that the service must provide a female only lounge area to comply with Department of Health guidelines (2015) on mixed sex-accommodation. Department of Health guidance states that women only lounges are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse.

Wilderspool ward had a good size clinic room. An electronic baseline physical observation recording machine was stored in the clinic in addition to an oxygen cylinder.

Good

Wards for older people with mental health problems

Emergency equipment, including a defibrillation machine, was stored within the ward's nurses' office. Emergency equipment was in date and was reviewed daily by nursing staff to ensure that it was ordered promptly when required. The service had a contract with an independent cleaning

company who cleaned all areas of the ward daily. Cleaning rotas reflected that this was being done as per contract.

The ward area was clean and tidy. Nursing staff were responsible for cleaning any bodily fluids as this was not the responsibility of the independent cleaning company.

Spillage kits were available and flow charts to guide staff in the correct cleaning processes were displayed. The service had procedural guidance to support the management of the prevention and control of infection. This guidance was covered by appropriately qualified trainers in the infection control module that formed part of the staff induction to the service. Staff then had refresher training in infection control annually thereafter. At the time of our inspection, 87% of staff had completed this course.

Furnishings about the ward were in good repair. The building was modern, well-furnished and well maintained.

The Alternative Futures Group maintenance team, from the estates department, regularly attended the hospital to do routine maintenance work and safety checks. Staff recorded any repairs in an environmental risk assessment folder that was kept in the senior management team's office. The service's health and safety lead completed monthly environmental checks, including testing the nurse call alarm system.

Safe staffing

The service provided the following figures of their staffing establishment at the time of our inspection:

Establishment levels: qualified nurses (whole time equivalent): 6

Establishment levels: nursing assistants (whole time equivalent): 30

Number of vacancies: qualified nurses (whole time equivalent): 3

Number of vacancies: nursing assistants (whole time equivalent): 0

Staffing sickness rate in 12 month period (July 2015 – July 2016): 8.9%

Staff turnover rate in 12 month period (July 2015 – July 2016): 16.9%

Between 8 May 2016 and 8 August 2016, 30% of shifts were covered by agency nursing assistants. The number of shifts covered by agency nurses was higher, averaging 36%. Although the service had no vacancies for nursing assistants, they used agency workers to support patients that required continuous supervision by a member of care staff. At the time of our inspection, three patients required one to one nursing support from staff due to their level of need (for example, high levels of agitation and distress). Staffing rotas confirmed that most agency workers worked regularly at the service and therefore had the opportunity to develop a good rapport and familiarity with patients. We observed positive interactions between patients and agency workers during our inspection and found them to be knowledgeable of individual patient's needs.

The service had had no registered manager in post since February 2016. An interim manager had been in post since June 2016 and had worked for Alternative Futures Group's regional operational management team for eight years. In July 2016, the senior management team told us that they were due to interview candidates for the registered manager's post. However, this did not happen. At the time of our inspection we advised the provider that they needed to appoint a registered manager to ensure adequate leadership within the service. As such, the provider submitted an application to appoint the interim manager as the registered manager shortly after our inspection.

Two of the service's senior nurse practitioners left the service in the last six months. This meant that there was only one senior nurse to provide clinical expertise and support to staff. As such, nursing staff were not receiving regular clinical supervision which was affecting staff morale.

The service based their current vacancy rate on providing care for the 13 patients that were accommodated on the ward. This was sufficient because senior management team had decided not to admit any more patients to the ward. This was because the service was due to close in approximately six months.

Senior management had estimated safe staffing levels for the ward. They established that they needed two qualified

nurses on shift in the day and one qualified nurse at night. We reviewed the staffing rotas for the six weeks before our inspection and found that the hospital were meeting this requirement.

There was a sufficient number of qualified nursing staff to ensure that patients had regular one to one contact with their named nurse. Patients were being reviewed by their named nurse weekly and this was reflected in their review of care plans and assessments. The senior management team had assigned all patients a named nurse and at least two nursing assistants. They were responsible for completing named nursing duties, such as meeting with the patient on a one to one basis and ensuring all their care records were up to date.

Due to their high level of need, many patients were not able to access authorised leave in the community for their own safety. Staff told us and records confirmed that patients' families and friends visited the ward where leave was not permitted.

There was medical cover day and night with arrangements for medical staff to attend the hospital quickly in an emergency. Alternative Futures Group employed two consultant psychiatrists and they attended the service once a week to review their specific patients. Enhanced GP services were in place from a local practice. There was a rota to cover medical emergencies out of hours. This was covered in the first instance by the service's two consultant psychiatrists with support from a local NHS Trust.

Rotas confirmed that staff were able to attend mandatory training as planned within working hours. The service had a comprehensive mandatory training package. This included a support essentials programme that comprised seven courses; health and safety, food hygiene, manual handling, fire awareness, infection control, safeguarding and basic first aid. Eighty-seven per cent of staff had completed this at the time of our inspection. Staff that had not completed the training were on long-term absence from the service.

All new starters completed basic life support training on induction to the service. Staff completed a refresher course annually thereafter and all staff were compliant with this.

An approved independent training company also delivered staff training in low level physical interventions for challenging behaviour. All permanent staff were compliant with this.

We reviewed mandatory training programmes provided by the three agencies that most commonly supplied staff to Abbey Court Independent Hospital. We found that all three mandatory training programmes were compatible with that of the hospital and staff were up to date with this.

Assessing and managing risk to patients and staff

The hospital submitted data showing that two incidents of restraint (holding and/or stabilising) involving two patients had taken place between 4 January 2016 and 22 July 2016.

The hospital did not use restraint in the face down position or rapid tranquilisation. However, they occasionally used holding and/or stabilising techniques (lower level forms of restraint) when de-escalation techniques failed. We checked and found that staff had received appropriate training to undertake this type of restraint, that is, holding and stabilising techniques phases one, two, three and four.

This included agency staff that received a compatible form of restraint training from their agency provider. Between February 2016 and July 2016 the service reported two incidents that alleged that agency staff had used physical interventions inappropriately on a patient. Although records identified the patient's sustained no physical injuries as a consequence, this still caused distress to the patients involved. The service immediately suspended the relevant staff from working at the hospital and the agency provider completed a full investigation into the incident.

We found that staff recorded restraints as incidents as required. An independent accredited trainer provided a training package called the proactive approach to conflict.

The training focused on using de-escalation techniques in the first instance to support patients who displayed signs of becoming distressed or agitated. This included staff diverting patients to a quieter area of the ward, distracting patients in an activity and verbal reassurance. During our inspection we found that staff were skilled in the use of de-escalation when presented with challenging behaviour. This was reflected in the low use of restraint on the ward.

The service had recently acquired posture support chairs for patients that required posture support. This could make it easier for patients to eat and drink comfortably and safely, and also prevented patients falling when using regular chairs. During our inspection, we observed that three patients were using these. We were confident that

staff were using these chairs in the patient's best interests and were not purposefully using the posture support chairs as a form of restraint. However, we did have concerns that posture chairs could potentially be used as a form of restraint. This was because when the chair is reclined, patients are not able to stand up and walk of their own free will. Furthermore, patient care plans and risk assessments did not capture how staff would assess whether a patient required the use of a posture support chair and how they would be safely supported to use it and in what circumstances. There was also no protocol or procedure in place to guide staff on how to use posture chairs appropriately and safely.

The hospital did not use seclusion and segregation practices.

We reviewed care records for five patients. With the exception of an assessment of risk for the appropriate use of posture support chairs, these all contained comprehensive risk assessments that were up to date. Staff completed an initial risk assessment on patient admission.

A senior nurse practitioner attended the initial assessments for all new patients and ensured full historical information was available. Staff used an assessment tool specific to patients diagnosed with dementia; the dementia comprehensive risk/benefit assessment. Risk assessments identified triggers that could cause the patient to become distressed and ways this could be prevented or the effects minimised. Risk assessments informed patients' care plans and staff we spoke with displayed a thorough understanding of individual patients' risks.

The provider had policies and procedures in place for the use of observation to minimise risk to patients. Staff reviewed patients' observation levels monthly or sooner if an incident occurred that changed their level of risk. Staff completed an observation rota at the beginning of every shift to ensure that patients had the required number of staff to support them at all times. We saw that staff recorded where the patient was and how they had presented immediately following observation.

Staff received training on safeguarding and were knowledgeable about what may constitute abuse. At the time of our inspection, 87% of staff were up to date with this training. We found that staff raised safeguarding concerns where appropriate and nursing staff submitted these to the provider's safeguarding lead via their electronic incident reporting system. Only nursing staff were able to complete electronic incident reports. Agency nursing staff completed paper copies that were submitted electronically by the service's senior management team.

Significant safeguarding concerns were referred to the local authority and clinical commissioning group. This ensured that all relevant stakeholders maintained an accurate oversight of the service's risk profile.

The service had a contract in place for the supply of medicines with a pharmacy company. Staff ordered medicines promptly and stock was sufficient to ensure a continuous supply. The clinic room had a fridge to store medicines that required it and staff checked an adequate temperature was being maintained on a daily basis.

However, staff were not monitoring the clinic room temperature. While some medicines will be unaffected at temperatures above 23 degrees, this is not the case for all.

This meant staff could not identify if the clinic room temperature was affecting the medicines stored there.

Between 4 January 2016 and 22 July 2016 staff reported 12 incidents that related to a drug or medication error. Five of these were reported in February 2016 and related to missing signatures or required information on patient medication administration charts. An audit completed by the service's pharmacist also identified this concern and took action to improve staff compliance. Consequently, no further incidents relating to missing staff signatures were recorded following February 2016. We also reviewed 10 patient medication administration charts and found that there were no gaps where staff had not signed to indicate the outcome.

Track record on safety

The service reported one serious incident between 31 August 2015 and 1 July 2016. This related to a patient who sustained a serious physical injury following a suspected fall. The local safeguarding authority, together with Abbey Court Independent Hospital, conducted a full investigation.

Findings from the investigation identified that staff had not reported the fall in line with Alternative Futures Groups falls policy. In response to this, the service delivered a falls policy awareness session to nursing staff. A folder was created for agency staff that included the policy and a

Good

Wards for older people with mental health problems

procedural flow chart for actions to take in the event of a fall. Agency staff we spoke with during our inspection demonstrated a good knowledge of the provider's falls management procedure.

The service reported three separate incidents to CQC between January 2016 and August 2016 that concerned agency staff and an allegation of abuse towards patients.

We checked and found that the service immediately stopped using the agency staff implicated when concerns were raised and reported their concerns to the relevant agency. We also found that the staff concerned were not all employed by the same agency. This meant the problem wasn't present within one nursing agency. The service continued to hold regular engagement meetings with the agencies involved to ensure staff provided were suitably trained, qualified and of the right character to perform their role. The service also continued to involve the local safeguarding authority of incidents that affected the wellbeing of their service users and conducted investigations where appropriate to prevent such incidents occurring again

Reporting incidents and learning from when things go wrong

Nursing staff and members of the senior management team were responsible for recording incidents on the service's electronic incident reporting system. Nursing assistants and other staff members escalated their concerns to the nurse in charge who would then record as appropriate.

We reviewed a report that detailed all incidents that had been reported on the service's electronic incident reporting system between 4 January 2016 and 22 July 2016. Staff reported 72 incidents in total. Of the incidents reported, 24 related to a patient who had become agitated or distressed and had been aggressive towards another service user or member of staff. This was the highest incident type reported. Thirteen related to patient falls, either witnessed or unwitnessed where a patient had sustained a minor physical injury. Twelve incidents related to a drug or medication error.

Staff were aware of and acting in accordance with their responsibilities under the duty of candour. The duty of candour identifies that providers of healthcare services must be open and honest with service users and other relevant persons (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Incident reports identified the staff had promptly contacted patients' next of kin where an incident had occurred. The local clinical commissioning group also held quarterly meetings with the service where the service's compliance with duty of candour requirements was reviewed. We reviewed minutes of the meetings and found that senior had provided the clinical commissioning group with evidence to support they were complying with their responsibilities under the duty of candour.

Alternative Futures Group's senior management team issued patient safety alerts that were displayed within staff areas at Abbey Court Independent Hospital. These detailed issues that had presented throughout the organisation that could affect patient safety. Incidents were discussed in nursing handovers between shifts. Senior management also shared information and learning from serious incident reviews via email. The interim manager had introduced a monthly nursing assistants' team meeting in April 2016. A team meeting for qualified nurses had been well embedded since the opening of the service in 2013.

Discussions around reflecting and learning from incidents that had occurred both internal and external to service could be reviewed within these meetings.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

We reviewed care records for ten patients. These contained a variety of assessments and care plans that related to patients' individual needs. Patients' care records could include care plans for mobility, continence, nutrition, tissue viability, communication, challenging behaviour and activities.

The service used a comprehensive physical health assessment tool that was specific to the older person with dementia. This assessment included rating the impact and severity of symptoms in advancing dementia; the

supportive and palliative care indicators tool. This is an evidenced based clinical tool that has been developed collaboratively by The University of Edinburgh and NHS Lothian.

On our last inspection we raised concerns that staff were not fully recording patients' baseline physical health observations on the modified early warning scores assessment chart. Baseline physical health observations include blood pressure, temperature, pulse, oxygen saturation levels and respiration rate. This put patients at risk because inconsistent recording of physical health observations could result in staff failing to recognise when a patient's physical health had deteriorated. As such, we issued the provider with a requirement notice for being in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Specifically, the requirement notice related to Regulation 12: Safe care and treatment, and advised the provider to take action to improve their compliance in this area. In May 2016, the service provided CQC with an action plan detailing how they would address this. The action plan stated that appropriate staffing levels would be put in place to ensure physical health checks were completed as required. It also stated that senior nursing staff would monitor staff completion of physical health checks and management would conduct a monthly sampling of documentation to ensure all records were completed.

However, during this inspection we found that the conditions of the requirement notice had not been met. We reviewed monitoring early warning scores charts for ten patients. In nine of these, we found continuous gaps where staff had not recorded baseline physical health observations. We also found that staff were not scoring the charts. A higher score indicates a higher deterioration in the patient and should be used to guide staff on what further interventions are required to keep the patient safe. This made it more difficult for staff to accurately identify how severe the patients' physical state was and to take prompt intervention.

The provider did not deliver staff training in how to monitor and record patients' baseline physical observations using the modified early warning scores tool. This meant that staff did not know how to use the tool appropriately to record patients' observations and take the necessary interventions required.

We also found that for five patients, staff were not monitoring and recording patients' physical baseline observations at a minimum of once a month. For one patient, we found that staff had not recorded any baseline physical observations for seven consecutive months. A second patient had no observations recorded for four consecutive months. This did not comply with Alternative Futures Group's physical health policy and procedural guidance that states 'weight, temperature, pulse, respiration, oxygen saturations and blood pressure of service users should be assessed and recorded at least monthly'. Despite staff not completing and recording patients' baseline physical health observations satisfactorily, we did not find any examples where a patient's physical health had been significantly compromised as a result.

We found no evidence to support that audits had taken place to monitor staff compliance in completing modified early warning scores charts. Senior management provided us with an audit schedule that was due to be completed by one of the provider's clinical pathway leads. The audit schedule included monitoring the completion of modified early warning scores charts. However, this had yet to be completed at the time of our inspection.

With the exception of modified early warning scores charts, nursing staff regularly reviewed and updated patients' care records. Senior management had also identified a different key worker group for each patient. This comprised one nurse and at least two nursing assistants that were responsible for collaboratively reviewing their respective patients' care records on a fortnightly basis; this included reviewing their care plans and risk assessments.

The service had established a good working relationship with a local GP practice and reinstated a GP ward round once a week. This took place at the hospital which meant that the service was accessible to patients that may have difficulty attending the practice site due to their physical or mental health needs.

Care records contained up to date health assessments of patients' skin integrity, weight, nutritional status and falls risk.

Care plans were personalised to the individual patient. Care plans addressed a variety of patient needs including mental health, physical health, lifestyle, relationships and leave of absence. Staff completed person centred planning

tools such as the recovery star, my personal plan and all about me. These tools were effective in communicating information relating to a patient's life history, hobbies and food preferences. Staff asked relatives and friends to assist in their completion where some patients were not able due to the severity of their cognitive impairment.

Care plans and daily records were stored in the nurses' office based on the ward. The nurses' office was locked at all times. All staff, including agency, had access using their electronic identification badge. Agency staff did not have access to the services' electronic system, however all care records were available in paper copy. This meant that all staff had access to the information they needed to be able to deliver effective care.

Best practice in treatment and care

We reviewed medication administration charts for ten patients. These demonstrated that medication was prescribed in line with best practice guidance, including National Institute for Care and Excellence guidance:

Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease (2011) and Low dose anti-psychotics in people with dementia (2015). Pharmacy completed regular audits of patients' anti-psychotic medications to ensure they were prescribed in line with best practice guidance.

Staff made referrals to specialist services as required for patients' physical health needs. This was done via a local single point of access team and included referrals to dietician services, tissue viability, physiotherapy and speech and language therapy. Staff used diet and fluid balance charts to monitor patients that were assessed as being at risk of malnutrition. Dietary supplements were available for patients where required. The service had secured a new contract with a facilities management company. In addition to providing main meals for patients who ate a regular diet, the company also catered for patients who required a modified diet. This included pureed meals for patients with swallowing difficulties.

Pureed meals were presented to look like regular meals. This had the positive effect of making meals look more appetising to patients.

The service used a range of evidenced based interventions and initiatives for patients with dementia. This included the delivery of the 'footsteps' training programme to all clinical staff working at the hospital. The footsteps program was designed to support staff to deliver creative, person centred dementia care that values a patient's individuality and to see beyond their diagnosis. The service was also part of the evidence based 'dementia care matters' initiative. The initiative involved training staff to connect with patients on an emotional level and to develop an empathetic understanding of what it is like to live with dementia.

The service had a scheduled timetable of clinical audits. Audits are a tool used to monitor and assess the quality of care provided to patients. The service provided us with an audit tool designed to monitor and assess the quality of physical health assessment and management. This included auditing service performance in relation to timely completion of patients' baseline physical health observations and recording these on the modified early warning scores chart. However, we found that this was yet to be completed by the provider's clinical pathway lead at the time of our inspection. The service had a comprehensive audit schedule for medication management on the ward. This was completed by senior nursing staff and a pharmacist on a regular basis.

Skilled staff to deliver care

During our last inspection, we raised concerns that the service did not provide adequate occupational therapy input for patients. During this inspection, we found that this need had been adequately addressed; the service had employed a full-time occupational therapist. This meant that specialist occupational therapy assessments, such as the 'functional behavioural profile' was being regularly completed. This is an important assessment because it assesses how a person with impaired cognitive function performs their daily activities and is used to form part of a patient's care plan.

Alternative Futures Group had a service level agreement in place with a pharmacist that visited the service every two weeks to support staff with medication management practices. Social workers from the relevant local authority were regularly invited to patient meetings to provide input into their care delivery.

All staff received a timely and appropriate induction to the service. Senior management assigned nursing assistants a member of qualified nursing staff to provide support and

guidance to complete the Care Certificate standards. The Care Certificate identifies minimum standards that must be covered as part of induction training for all new care workers.

Senior management provided us with staff supervision records. Records showed that senior nursing staff received supervision from their line manager every four to six weeks.

However, the frequency was lower for staff nurses who were receiving supervision every three months. Nursing assistants were also receiving supervision from a member of qualified nursing staff every three months. This was lower than our last inspection where we found all clinical staff received supervision every six to eight weeks. In part, supervision rates were lower due to the departure of two senior nurse practitioners in the last six months. This meant that there was less senior staff available to complete supervision with nurses and nursing assistants.

All clinical staff had received an appraisal of their work performance within the last six months.

Multi-disciplinary and inter-agency team work

Staff facilitated regular multidisciplinary team meetings to review patient care. Alternative Futures Group employed two consultant psychiatrists. They attended the service a minimum of once a week to review patients with the wider multidisciplinary team. A senior nurse practitioner or qualified nurse always attended the meeting. However, nursing assistants told us they would value the opportunity to provide more input into these meetings. This was because they spent a lot of direct contact time with patients so they could provide a thorough account of how the patient presented. Nursing assistants also told us that they received no verbal feedback regarding any actions or changes that had been made to patient care following multidisciplinary reviews. We did find that the documentation of multidisciplinary reviews were thorough and that nursing assistants had the opportunity to access these.

Verbal handovers of care took place between each shift. Nursing staff discussed individual patients, including any changes to their current level of risk. This was documented in a handover book so that important details were captured and communicated to the next staff on shift.

The service had established effective working relationships with other teams and organisations that were involved in the care of the patients. This included community mental health teams and independent mental health advocacy services. They were regularly invited to attend Care Plan

Approach reviews, discharge meetings and multidisciplinary reviews. The service also worked closely with their local authority and local clinical commissioning group. Senior management provided us with minutes of meetings that detailed how the services were working together to improve patient care at Abbey Court Independent Hospital.

The service had re-instated a GP ward round in partnership with a local GP practice. This was effective because patients who may find it difficult to attend the GP practice in person could be assessed and treated for many physical health ailments on the ward. Consultant psychiatrists and the respective GP worked collaboratively to meet the holistic care needs of patients using the service.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

A Mental Health Act team from a neighbouring NHS Trust provided staff training in the Mental Health Act and the Code of Practice. This was provided on induction to the service and annually thereafter. At the time of the inspection, 87% of staff were up to date with this training.

Nursing staff demonstrated a good understanding of the Mental Health Act and the guiding principles. Nursing assistants demonstrated a basic understanding and referred to qualified staff where they required additional knowledge and guidance to support their clinical practice.

At the time of our inspection, 12 patients were detained under the Mental Health Act. We reviewed medication administration charts for 10 patients. All patients who required them had a certificate authorising administration of medications by a second opinion doctor (T3) attached to their medication chart.

During our last inspection, we found that staff were not routinely explaining to patients their legal rights while detained under the Mental Health Act. This included not having a discussion with a patient's nearest relative where patients had been assessed as not having the capacity to understand their rights. During this inspection, we found that staff were documenting when they had explained

patients their rights. This included documentation explaining that a patient did not have the capacity to understand their rights. In these circumstances, staff would consult the patient's nearest relative and document this discussion in their care records.

A local NHS trust provided administrative support and legal advice on implementation of the Mental Health Act. They held all the original documents of patients' detention paperwork and copies were filed in patients' individual care records.

Patients had access to an independent mental health advocate. Staff were regularly referring patients to the advocacy service and they visited the ward frequently to provide detained patients with independent support regarding their rights. Staff regularly invited advocates to attend Care Plan Approach reviews, discharge planning meetings and patient multidisciplinary reviews.

Good practice in applying the Mental Capacity Act

The provider delivered training to all permanent staff in the Mental Capacity Act on induction to the service and a refresher course every two years thereafter. At the time of our inspection, 87% of staff were up to date.

The service had submitted one Deprivation of Liberty Safeguards application between 1 March and 1 August 2016. The local authority had approved the application and a standard authorisation was in place.

Staff demonstrated a good understanding of the Mental Capacity Act, including the assumption that people have the capacity to make decisions and that consideration of capacity is specific to the decision being made. We found good examples of thorough capacity assessments in relation to patients' covert medication plans (where medicines are disguised and given to a patient in food and drink because they would otherwise refuse to take them) and 'do not attempt resuscitation' requests. Where appropriate, patients' nearest relatives had been consulted in the decision making process. The service ran best interests meetings to discuss important decisions regarding a patient's care where that individual had been assessed as not having the capacity to make those decisions. This included decisions involving future accommodation provision.

The service had access to an independent mental capacity advocate that visited the service regularly to support patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

• The provider must ensure that patients' physical health assessments are accurately recorded to enable staff to make appropriate and timely interventions.

• The provider must ensure that there is a system in place to ensure staff are adequately monitoring and recording patients' baseline physical health observations.

• The provider must ensure that staff have the necessary training to complete assessments tools used by the service to monitor and assess patients' health needs.

Action the provider SHOULD take to improve

• The provider should ensure the use of posture support chairs are recognised as a potential mechanical restraint and a protocol is in place to guide staff on their correct use. These considerations should be captured in patients' care plans and risk assessments.

• The provider should ensure staff are monitoring the clinic room temperature to ensure all medicines are appropriately stored.

• The provider should ensure all staff receive adequate supervision.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **How this regulation was not being met** We reviewed modified early warning scores charts for ten patients. In nine of these, there were continuous gaps where staff had not recorded the relevant information. In five cases, we also found that staff were not monitoring and recording patients' baseline physical health observations at least once a month. This did not comply with the provider's policy which states these should be monitored and recorded at a minimum of once a month. This put patients at risk, as staff did not have all the information available to determine when a patient's physical health may be deteriorating, and therefore to take prompt action where required. The provider promoted the use of a specific tool, the modified early warning scores chart, but did not train staff in how to use it. We saw that staff were not calculating scores to identify the severity of deterioration in patients' physical health. This was a breach of regulation 12 (1)(2)(a)(b)

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 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA (RA) Regulations 2014 Good Governance

How this regulation was not being met

The service had not implemented an effective system to ensure that the recording of baseline physical health observations improved following the previous inspection.

This was a breach of regulation 17(2)(a)