Astracare (UK) Limited

Connolly House

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-121813172	Connolly House	Connolly House	CO16 9JF

This report describes our judgement of the quality of care provided within this core service by Astracare (UK) Limited. 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 Astracare (UK) Limited and these are brought together to inform our overall judgement of Astracare (UK) Limited.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service

Are services safe?	
Are services caring?	
Are services well-led?	

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

- The environment contained multiple ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff could not explain what a ligature risk was and the provider's ligature risk assessment was out of date.
- Female patients did not have an identified female lounge limiting their access to female only areas. The provider had no available bathing facilities for patients within the hospital. The bath was broken and there was one shower in the male corridor for all patients to use. Female patients had to access the male corridor to use the shower room. This did not meet the Department of Health's guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice requirements. We reviewed the providers 'bath and shower book' which is a record of when patients had bathed. We found that over nineteen days patients did not receive regular baths or showers.
- The hospital décor was poor; the environment was dirty in places and poorly designed to meet the needs of the patient group. The floors were uneven causing a trip hazard. There were blind spots where staff could not easily see all parts of the ward. Despite the provider completing individual patient risk assessments, it was not clear how staff managed the risk of falls for patients, given the environment and patient group.
- The provider did not check physical health equipment regularly. We could not tell when the blood monitoring machine was last calibrated (a test to ensure readings are accurate). We found expired needles and syringes, no recording of fridge temperature on five occasions and no recording of drug disposal.
- The provider had not ensured staff had appropriate information for safe administration of covert medication to patients.
- The provider did not have an evacuation chair for immobile patients to exit the building in the event of a fire. We addressed this urgently with senior managers who replaced the chair immediately. Patients did not have personal evacuation care plans so staff knew how to support patients to exit the building.
- Staffing levels at night were not sufficient to managing patients at risk of falls. Staff told us that two staff would work at night and manage patient observations for those who woke, with a risk of falls. Staff could not predict when patients would sleep or wake throughout the night, and therefore, we were unclear how staff safely managed patients at the hospital during the night.
- Staff were observed to use unapproved manual handling techniques on two patients.
- We observed restrictive practice for one patient with manual handling needs who was lying on a bean bag. The patient was unable to move independently and required assistance from staff to do so. There was no care plan for this patient on the use of a bean bag.
- We reviewed incident form outcomes and found observation levels were not always increased for patients following falls.
- One member of staff told us the male and female toilets were too small to attend to patients' personal care needs safely. Staff occasionally attended to the personal care needs of patients in the corridor outside the toilets. This did not promote the privacy or dignity of patients.
- We reviewed eight care records and found limited involvement with family members in care planning.
- The provider did not ensure regular supervisions or staff meetings took place for staff.
- The provider was unable to provide us with a copy of their risk register.
- The provider did not demonstrate they were reviewing and learning from incidents.
- The provider had three outdated policies and 22 staff had not signed signature lists attached to 49 policies to say that they had read them.
- The hospital did not produce accurate and contemporaneous records of incidents.

However:

- Staff had received and were up to date with all mandatory training. Compliance rates were between 90% and 100%.
- Easy read signage was available for patients to be able to identify rooms and facilities.
- The provider was reviewing risk assessment documentation and implementing new assessment tools.

Summary of findings

- We reviewed multi-disciplinary records and found family involvement in some best interest decisions for patients.
- We saw advocacy information posted on notice boards in the lounge and in folders in patient bedrooms including complaints information, complaining to the care quality commission, social services and the health ombudsman.
- We saw updated patient 'my charts' completed with family involvement on patients' interests, preferences, history, likes and dislikes.
- The provider recently appointed the clinical manager who was working with the deputy director and director to improve the service.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

- The environment contained multiple ligature points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff could not explain what a ligature risk was and the provider's ligature risk assessment was out of date.
- Female patients did not have access to a female only lounge. Out of three lounges, no lounge was identified as being specifically for females limiting their access to female only areas. This does not meet the Department of Health's guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice requirements.
- The hospital décor was poor, the environment was dirty in places and poorly designed to meet the needs of the patient group. The floors were uneven causing a trip hazard. There were blind spots where staff could not easily see all parts of the ward. Although the provider completed individual patient falls risk assessments, it was not clear how the risk of falls were mitigated due to the poor environment and the patient group.
- The provider had no bathing facilities for patients in the hospital. The bath was broken and there was one shower in the male corridor for all patients to use. Female patients had to access the male corridor to use the shower room. This did not meet the Department of Health's guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice
- The physical health equipment had not been checked since February 2016 to ensure they were in working order and we were unable to tell when the blood monitoring machine had last been calibrated (a check to ensure readings are accurate). We found expired needles and syringes, no recording of fridge temperature on five occasions and no recording of drug disposal.
- The provider had not ensured staff had appropriate information when administering covert medication to patients.
- The provider did not have an evacuation chair in case of a fire for immobile patients to exit the building. We raised this with the provider who said it had been removed due to redecoration. Staff replaced the chair while we were on site. We did not find personal evacuation care plans for patients to guide staff as to how they should support patients to exit the building.

Summary of findings

- Staffing levels at night were not sufficient to managing patients at risk of falls. Staff told us that staffing levels at night were one qualified nurse and one health care support worker. Staff could not predict that all patients at risk of falls, requiring closer observations when awake, would be asleep throughout the night. Therefore, we were unclear how staff could ensure the safety of all patients at the hospital overnight.
- The CQC received notification of concern related to the use of unapproved manual handling on patients at the service. We visited on the 19 October 2016 and observed two staff handling two different patients using unapproved manual handling practices. We raised this urgently with the provider.
- The provider identified an action plan to address unapproved manual handling practice, which included displaying manual handling signage on safe practice. However, this did not refer to manual handling needs for patients but rather to handling loads. We raised this with the provider and on our second visit, signs referring to safe manual handling of patients were seen.
- We observed restrictive practice for one patient with manual handling needs who was sitting on a beanbag. The patient was unable to move from the beanbag independently and required assistance from staff to do so. Staff had not recorded this intervention in the patient's care plan.
- We reviewed incident forms and found two incidents of falls where a doctor had not reviewed a patient following a fall.
- We reviewed incident forms and patient records and found examples of records that were not contemporaneous. Staff had updated one patient's manual handling care plan following an incident but this was not found in the patient record. The risk assessment had been re-rated at a lower severity than previously, despite the patient having re-occurring falls. Another record was poorly organised and contradictory making it unclear for staff on how to manage the patient's manual handling needs.
- We reviewed incident form outcomes and found observation levels were not always increased for patients following falls.

However:

- The clinic room was equipped and emergency drugs were stored appropriately and checked regularly.
- Staff followed infection control principles including handwashing.
- Staff had received and were up to date with all mandatory training. Compliance rates were between 90% and 100%.
- The provider had ensured easy read signage was available for patients to identify rooms and facilities.

Summary of findings

- The provider was reviewing risk assessment documentation and devising and implementing new assessments including a patient handling assessment, manual handling assessment, a client focus assessment and care plan assessment.

Are services caring?

- One member of staff told us that patient's personal care was attended to in the corridor outside the male and female toilets, as there was a lack of space in the toilets to attend to personal care needs of patients safely.
- We reviewed the providers 'bath and shower book' which is a record of when patients had bathed. We found that over nineteen days patients rarely had baths or showers.
- We observed two interactions where staff were not very attentive to patients and were conducting other tasks whilst feeding patients.
- We reviewed eight care records and found limited involvement with family members in care planning. We saw two signatures on care plans from family members.

However:

- We reviewed multi-disciplinary records and found family involvement in some best interest decisions for patients.
- We saw advocacy information posted on notice boards in the lounge and in folders in patient bedrooms including complaints information, complaining to the care quality commission, social services and the health ombudsman.
- We saw updated patient 'my charts' on our second visit completed with family involvement on patients' interests, preferences, history, likes and dislikes.

Are services well-led?

- The provider did not ensure regular clinical or managerial supervision took place for staff.
- The provider had not ensured regular staff meetings occurred.
- The provider did not have a risk register.
- The provider did not demonstrate they were reviewing and learning from incidents.
- The provider had some outdated policies and many staff had not signed signature lists attached to policies to say that they had read them.

Summary of findings

- Staff did not produce accurate and contemporaneous records of incidents. We found examples of incidents not being recorded in patient records. We found two examples of incidents, of patient on patient abuse not reported to safeguarding or to the Care Quality Commission (CQC).

However:

- The provider recently appointed the clinical manager who was working with the deputy director and director to improve the service.

Summary of findings

Information about the service

Connolly House is an independent mental health hospital run by Astracare (UK) Limited. Connolly House has a manager who is currently applying to be the registered manager, a nominated individual and a controlled drugs accountable officer. Connolly House provides the following regulated activities:

- assessment or medical treatment for people detained

under the Mental Health Act 1983

- diagnostic and screening procedures
- treatment of disease, disorder or injury.

Connolly House is a 14-bedded facility for older people with a range of mental health conditions including dementia, severe depression, and schizophrenia. Patients may be detained under the Mental Health Act. The bedrooms are provided across two floors, with three bedrooms on the ground floor and eleven bedrooms on the first floor. The first floor is divided into two corridors, one for male patients, and one for female patients. At the time of our inspection, the unit had twelve patients who were all safeguarded under a deprivation of liberty (DoLS) authorisation.

Connolly House registered with the CQC in 14 October 2010, and has received four inspections. We carried out the most recent inspections on the 19 October 2016 and 26 October 2016. These were unannounced inspections, which took place due to concerns raised to us about staff use of unapproved manual handling practices at the hospital. The last inspection took place on the 29 January 2016 where the overall rating was good except for safe which was rated as requires improvement. Breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were identified for regulations 17 good governance, regulation 12 safe care and treatment and regulation 18 staffing.

Our inspection team

The team that inspected the service comprised three CQC inspectors and two inspection managers. The lead inspector was Nese Marshall.

Why we carried out this inspection

We carried out a focused inspection of this location in response to concerns raised to the Care Quality Commission relating to unapproved manual handling practices at the hospital. The inspection focused on three domains, safe, caring and well led.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about these services and other organisations for information.

During the inspection visit, the inspection team:

- Looked at the quality of the ward environment and observed how staff were caring for patients.
- Observed staff and patient interactions.
- Spoke with the manager and deputy director and director for the service.
- Spoke with nine staff members; including nurses and support workers.
- Received feedback about the service from the local safeguarding team and one commissioner.

Summary of findings

- Reviewed nine care and treatment records of patients.
- Carried out a specific check of the medication management.
- Looked at a range of policies, procedures, and other documents relating to the running of the service.

Looked at records relating to the Mental Capacity Act (2005), and Deprivation of Liberty safeguards.

What people who use the provider's services say

At the time of our inspection, we were unable to speak with all the patients because of the communication difficulties they experienced. However, we observed staff and patient interactions for several periods of time. We observed two interactions where staff were not very attentive to patients and were conducting other tasks whilst feeding patients.

However, we observed interactions between staff and patients that were mostly responsive and supportive. Staff offered patients reassurance and discussed the caring tasks they were about to perform with the patients. We observed staff sitting with patients at meal times supporting them with their meals.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure bathing facilities are repaired and people using the service have adequate access to bathing facilities.
- The provider must ensure female patients have access to female only bathing facilities and lounges.
- The provider must ensure it maintains the privacy and dignity of patients.
- The provider must review its environment to ensure it is clean and safe for people using services particularly those at risk of falls.
- The provider must review its staffing levels to ensure adequate staff are available to assist with kitchen duties and at night when patients may require additional observations.
- The provider must ensure safe manual handling practices are used for people using services.
- The provider must ensure it does not use restrictive practices when caring for patients and all caring interventions are care planned.
- The provider must ensure people who use services are seen by a doctor following a fall and have manual handing assessments by a professional with the relevant skills and knowledge.
- The provider must ensure all physical health equipment is checked and recorded, drug disposal is recorded and expired equipment is replaced.
- The provider must ensure staff receive regular supervision.
- The provider must demonstrate they are assessing, reviewing and managing the risks to the health, safety and welfare of people using services.
- The provider must demonstrate they are reviewing and learning from incidents and concerns.
- The provider must ensure all policies are up to date and staff fully understand policy and practice guidelines at the hospital.
- The provider must ensure records and incident forms are contemporaneous, consistent and easy to follow.
- The provider must ensure staff are aware of ligature points and the ligature assessment is up to date.
- The provider must ensure all patients with mobility needs have an evacuation care plan so staff are aware of how to support them to exit the building in case of a fire.
- The provider must state which patients are on covert medication on medication charts and ensure pharmacy provide advice to staff on how to administer covert medication.

Action the provider SHOULD take to improve

- The provider should ensure patient and families are involved in care planning.
- The provider should ensure all staff have access to staff meetings to review incidents and lessons learned.

Astracare (UK) Limited

Connolly House

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Connolly House	Connolly House

Mental Capacity Act and Deprivation of Liberty Safeguards

- Ninety seven percent of staff received Mental Capacity Act (2005) training.
- All twelve patients were safeguarded under a deprivation of liberty (DoLS) authorisation. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. When they lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment only when this is in their best interests and legally authorised under the MCA.
- We reviewed four patient records and found all had capacity to consent to treatment assessments in place. For those that did not have capacity, a care plan was in place for covert medication. However, there was nothing attached to medication charts to show staff which patients required covert medication or directions, with input from a pharmacist on how to administer medication covertly for these patients.
- Out of the four patient records we reviewed, we found various decision specific mental capacity assessments in place with input from family members on best interest decisions.

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

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

Our findings

Safe and clean environment

- The environment contained multiple ligature points including taps, door handles and door closures. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Staff could not explain what a ligature risk was and the nurse in charge had not seen a ligature risk assessment. Patients did not have individual risk assessments to identify ligature risks. We reviewed the ligature risk assessment and found it was out of date.
- The hospital consisted of an old two-storey house with an attached modern, single-storey extension, and a separate administrative building. The building housed two separate units, the hospital, Connolly House, and a nursing home (The Harvey Centre), both provided by Astracare (UK) Limited. Connolly House's bedrooms, lounge and dining room were situated in the old house, which was not fit for modern mental health services. For example, despite seeing completed cleaning schedules, we observed poor décor throughout the hospital. There was peeling paint in female toilets, broken windows, cobwebs on windows, stained furniture, dirt on the floors of toilets and dirty window seals in the dining room. The floors were uneven causing a trip hazard and corridors, particularly upstairs, were narrow and difficult to navigate especially if a patient required assistance with walking. There were blind spots where staff could not easily observe patients.
- The hospital had an outside garden for patient use. We looked at the outside areas and found broken furniture, white goods, a stained beanbag and a large tub of congealed fat. Patients had to pass by these items to access the garden area. This was a risk to patients and did not promote a clean and clutter free environment.
- The provider's falls policy states that "the ward environment must be clutter free and free from obstacles. Floors should be even, clean and non-slip". This did not meet the National Institute of Health and Care Excellence (NICE) guidance on falls in older people, which states that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed. Although, the provider completed individual patient falls assessments, it was not clear how staff managed patients at risk of falls, due to the poor environment and the patient group.
- The hospital did not provide a separate lounge for females. During our two visits, we observed male and female patients using all three lounges. This does not meet the Department of Health's guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice requirements.
- The provider had no bathing facilities for patients in the hospital. The bath had been broken since September 2016 and there was one shower in the male corridor for all patients to use. Female patients had to access the male corridor to use the shower room. This did not meet the Department of Health's guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice
- The clinic room was appropriately equipped. The staff kept the defibrillator in the nursing office so that it could be accessed easily and emergency drugs were checked regularly. However, staff had not completed checks of the physical health equipment since February 2016 to ensure they were in working order. We could not tell when the blood monitoring machine had last been calibrated (a check to ensure readings are accurate). Some syringes and needles were out of date expiring in July 2016 and April 2009. No drug disposal records were available and the fridge temperature had not been recorded for five days. The provider failed to identify out-of-date medical supplies at the last inspection.
- Staff followed Infection control principles including handwashing. Personal protective equipment, such as aprons and gloves were available for staff use.
- The provider had a nurse call system for staff and patients to press if help was required. Staff also used fall motion sensors in bedrooms at night for patients at risk of falls.
- The provider did not have an evacuation chair for patients who were immobile. The Regulatory Reform (Fire Safety) Order 2005 gives a 'responsible person' a duty in law to provide a means of evacuation for people who are less mobile. We raised this with the provider urgently and were told this had been removed during

redecoration and not replaced. Staff replaced this while we were on site. According to the order, every individual who might have special needs when evacuating a building requires a Personal Emergency Evacuation Plan. We did not observe any plans for patients. The provider could not be sure staff had the information or equipment to evacuate patients safely, in the event of a fire.

- The provider had a lift, which patients used freely. Staff told us patients at risk of falls were supervised to use the lift. There were no hand rails available for patients to use if they became unsteady.
- The provider used CCTV at the facility but there were no signage to let people know this was in place. We also observed the CCTV monitor screen from the window outside the nursing office in the car park area. This is a breach of patient confidentiality, privacy and dignity.

Safe staffing

- The provider completed the dependency and staffing level assessment tool to determine basic staffing levels monthly. The deputy director explained that patient occupancy and observation levels were considered as part of the assessment. Staffing levels were one nurse and five support workers during the day and one nurse and one health care assistant at night.
- The provider had 4.55 qualified nurses in post with one vacancy and ten nursing assistant in post with two vacancies.
- The provider used agency staff to cover sickness, vacancies and absences. For July 2016, 25 staff were used to fill shifts, in August 2016, 22 shifts were filled and in September 2016, 34 shifts were filled using agency staff. Where possible, regular agency staff were booked to provide continuity of care for patients.
- The provider had not filled 23 shifts with bank or agency staff to cover sickness, absence or vacancies in the last three months prior to the day of our inspection on the 26/10/16.
- Staffing levels at night were not sufficient to managing patients at risk of falls. There were 12 patients at the hospital accommodated over two floors. Staff told us that staffing levels at night were one qualified nurse and one health care support worker. We reviewed incident forms and found that one patient had three incidents of falls at night. The action from one of the investigations was to place the patient on level 4 observations at night, when awake. According to the provider's policy on safe and supportive observations, level 4 observation requires staff to observe one patient within arm's length for "clients at the highest levels of risk or harming themselves or others. They may need to be nursed in close proximity". Additional patients at the hospital were also at risk of falls and therefore required increased observation levels if they awoke at night. These included level 2 observations where a patients whereabouts must be checked at a minimum of every 30 minutes or level 3 observations where a patient must be observed within eyesight at all times. During our visit on the 26 October 2016, two patients required continuous observations at night if they woke up. Given the level of risk of patients falling and that it was not possible to predict that all relevant patients would sleep throughout the night, we were unclear how staff safely managed patients during the night. The provider told us staff could request help from the service next door at the Harvey Centre. The director, his deputy director or manager could be called to come in if additional staffing were required. They advised that other staff would be willing to attend, at short notice, if needed. However, the provider was unable to show evidence of staff agreement to this. The provider was unable to demonstrate that additional staff had been deployed to the hospital at night
- During our second visit on the 26 October 2016, we were told that day time staffing levels consisted of one qualified nurse and five support workers. One member of staff told us they did not think there was enough staff to care for patients as one health care support worker was required to assist with duties in the kitchen three times a day. This included from 3.00pm to 3.30pm, 16.45pm to 18.00pm and 19.00pm to 19.30pm. This meant there was actually only four staff working with patients during these times.
- The provider had a consultant psychiatrist who attended the hospital twice a week to review patients and a general practitioner attended the hospital three times a week.
- Staff have received, and were up to date with appropriate mandatory training. All training compliance was between 90% and 100%. The provider had a training lead who used a monitoring database to alert when staff were due to complete training and arranged training for staff.
- Staff completed handover notes between shifts. However, we found these records contained minimal or

no information about patients. We reviewed handover information and did not find details of patients' mental state, mood or behaviours throughout the day. Many entries used one or two words to describe a patient's day. This did not provide staff with sufficient information to know how patients were presenting.

Assessing and managing risk to patients and staff

- The provider had two episodes of low- level restraint in the six months prior to the inspection. There were no prone restraints.
- Risk Assessments, apart from falls risk assessments were up to date.
- The Care Quality Commission (CQC) received information of concern in August 2016, related to staff use of unapproved manual handling techniques on patients at the service. This led to the CQC raising a safeguarding alert to the local authority. Following this, the local authority safeguarding team visited the hospital and observed staff using unapproved manual handling techniques. The CQC inspected on the 19 October 2016 and observed two staff handling two different patients using unapproved manual handling techniques. These consisted of staff placing their arms under one patient's armpit to pull them up from their wheelchair. On another occasion, two staff placed one arm under the patient's shoulder and another under the patient's thigh to move the patient back in the chair. These moves were considered unsafe, according to the Manual Handling Operations Regulations 1992 revised 1998 and updated in 2004 (MHOR) and the Health and Safety at Work Act 1974. The Nursing Midwifery Council, 2002, states: "Poor application of manual handling techniques i.e. drag lift, axilla, auxiliary, underarm, shoulder, through arm lift" are considered physical abuse. The Royal College of Nursing states, "No-one should routinely manually lift patients. Hoists, sliding aids, electric profiling beds and other specialised equipment are substitutes for manual lifting. Patient manual handling should only continue in cases, which do not involve lifting most or all of a patient's weight". The provider had not ensured that correct manual handling techniques were deployed by their staff. This was a risk to patients.
- The provider had identified an action to display signage on safe manual handling practice. However, the signs displayed during our visit did not address patient manual handling needs and referred to handling loads rather than patients. On our second visit, however, the provider had displayed adequate visual signage of unsafe techniques so that staff were reminded of safe manual handling practice.
- CQC inspectors observed restrictive practice for one patient, with manual handling needs sitting on a beanbag on the floor. The beanbag was soiled and covered with an incontinence sheet. The patient was unable to independently get up from the bean bag and was restricted from moving, as assistance was required from staff. Staff had not documented the use of a beanbag in the patient's care plan. The patient was at high risk of falls and required assistance and supervision to mobilise.
- We reviewed incident forms from 23 July 2016 until 23 October 2016 and found there were fourteen incidents of falls to patients. Staff did not consistently follow processes when managing falls of patients. The provider's falls policy, specified that patients must be reviewed by a doctor following a fall. According to guidance from the National Institute of Health and Care Excellence (NICE), 2015, on falls in older people, "When an older person falls, it is important that they have a prompt medical examination to see if they are injured. This is critical to their chances of making a full recovery". This was not consistently completed for all patients. One patient did not have a review from a doctor following a fall for five days. One patient had a fall which was not recorded in the notes and the patient did not receive a review by a doctor. The provider rated the incident at a high risk but there was no medical review of the patient.
- NICE guidelines, 1.1.2, states all patients with a risk of falling should have a multifactorial falls risk assessment with input from a healthcare professional with appropriate skills and experience. Following a recommendation from the local authority safeguarding team, the provider had referred all patients to a local community organisation for manual handing assessments. The provider had made regular contact with this organisation but continued to wait for these assessments to be completed.
- The provider was not consistently recording the management of falls for all patients. For example, one patient had a fall on the 31 October 2016. The provider's investigation outcome stated that staff should update the care plan and risk assessment to provide guidance to staff when assisting the patient to mobilise. An

updated care plan was attached to the incident form dated 01 September 2016 which gave detailed guidance on managing the patient's risk of falls. However, this care plan was not found in the patient's clinical notes or available on the ward. Staff could not refer to an accurate care plan to ensure they knew how to manage this patient's risk of falls. The only care plan found in the clinical notes for this patient's mobility needs was dated 27 July 2016. This patient had three subsequent falls dated 10 September 2016, 13 September 2016 and 01 October 2016. This care plan did not adequately address the patient's needs. We found that the patient's risk assessment was updated following the fall of the 31 August 2016, however, this downgraded the risk level to moderate when this had previously been rated as high on the previous clinical risk assessment record dated 31 July 2016.

- Staff had completed one care plan for a patient, which was poorly organised and did not clearly detail how staff should manage this patient's moving and handling needs. It also referred to the patient by the wrong gender. The care plan was also contradictory. In the goal/outcomes section it stated "to transfer safely, enable patient to gain his balance" however in the intervention section it stated "all transfers to be done by full body sling and hoist". Staff did not have accurate information for safe care and treatment.
- Staff did not always increase patients' levels of observation following falls. The provider's observation policy states that several patients at risk of falls can be observed by one member of staff under 'level three observation'. It states that 'should the period of level 3 observations where one or more clients require more attention and exceed one hour, then level 4 should be considered by the NIC (nurse in charge) rather than struggling on level 3'. The provider did not make it clear what is meant by 'more attention' and it was not clear when patient's level of observation would be increased.
- We found a used tube of ibuprofen gel left in a patient's bedroom. When we checked this patient's prescription chart, it was prescribed but had not been signed as being administered by staff.
- Staff administered covert medication to some patients. However, whilst we found appropriate care plans in place, there was nothing attached to medication charts to show staff which patients required covert medication or directions, with input from a pharmacist on how to administer medication covertly for these patients.
- Staff management of medication, was generally good.
- Two members of staff confirmed, that health care support workers were not given time to read patient care plans so that they understood the specific needs of the patients. This was an action identified by the provider on their action plan.
- The provider had identified an action for all staff to read the updated manual handling policy. However, when we visited the hospital on the 19 October 2016 and the 26 October 2016 only two staff had signed the policy to say they had read it.
- Risk assessment documentation were being reviewed and the provider was in the process of devising and implementing new assessments including a patient handling assessment, manual handling assessment and a client focus assessment and care plan assessment.
- The provider had installed easy read signage for patients to be able to identify rooms and facilities.
- Staff were trained in safeguarding. Compliance rates were safeguarding children at 93% and safeguarding adults at 97%.

Track record on safety

- The provider has had two serious incidents in the last twelve months.
- The provider has an action plan in place with a target date of 30 November 2016 to address concerns and observations by the local authority safeguarding team and CQC of unapproved manual handling practice.

Reporting incidents and learning from when things go wrong

- All staff knew how to report incidents, however, these were not reported contemporaneously on patient records. Incidents documented on incident forms were not consistently recorded in patients' records. The incident reporting system was a paper recording system.

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

- The provider had no available bathing facilities for patients within the hospital. The bath was broken and there was one shower in the male corridor for all patients to use. Female patients had to access the male corridor to use the shower room. This did not meet the Department of Health's guidance on eliminating mixed sex accommodation or the Mental Health Act Code of Practice requirements. Patients needing a bath had to go to the Harvey centre (next door) passing through the dining room. One staff member told us staff attended to patient's personal care needs whilst they sat on the toilet in their bedrooms affecting patients' dignity.
- One member of staff told us that staff occasionally attended to patients' personal care needs in the corridor outside the male and female toilets, as there was a lack of space in the toilets to attend to personal care needs of patients safely. Another staff member told us that staff had hit their heads on the sink due to limited available space whilst they conducted personal care for patients in the toilets. The door leading to the corridor was not locked. Staff and patients could access the area while staff were attending to personal care of patients. During our second visit, on 26 October 2016, a lock had been placed on the corridor door. We were told by the manager that this was a mistake and should have been fixed to the male toilet door. Therefore, the provider had addressed the issue however this had not been a planned action.
- We reviewed the providers 'bath and shower book', which showed a record of when patients had bathed. We were unclear of the provider's purpose for monitoring patient bathing as personal care needs should be attended to when required. We found that patients rarely had baths or showers. Between the 01 and 19 September 2016, out of 12 patients, one patient had three showers, four patients had just two showers or baths and six patients had just one bath or shower. There was no record of any bathing for one patient.
- Overall, we observed positive interactions between staff and patients showing compassion and respect. However, one staff member was observed interacting minimally with a patient whilst they were feeding them at lunchtime. They were feeding them inappropriately with a large spoon. This could have presented as a choking hazard, was undignified and did not give the patient time to eat their food. Another staff member was feeding a patient intermittently, leaving the patient to complete other jobs and was standing over the patient at one point whilst feeding them. We observed other interactions to be positive during lunch time with staff at most tables and we saw two positive interactions of staff feeding patients.

The involvement of people in the care that they receive

- We reviewed eight care records and found limited involvement with family members in care planning. We saw two signatures on care plans from family members. The majority of patients did not have capacity to be involved in care plans and required best interest decisions to be made for them with family input. We reviewed multi-disciplinary records and found family involvement in best interest decisions for patients.
- We saw advocacy information posted on notice boards in the lounge and folders in patient bedrooms including complaints information, complaining to the care quality commission, social services and the health ombudsman.
- 'My Charts' were seen in patients' bedrooms which were developed with patient families and documented patients' history, interests and preferences. Some of these were smudged as they were written on a white board with non-permanent pens. However, at our second visit we observed up to date My Charts that were not smudged.
- Staff placed details of activities available for patients on the notice board in the lounge. The provider offered activities including reminiscence, quiz, board games, bingo, ten pin bowling, to ride the village train, wine tasting, pottery and reading.

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Good governance

- The provider had failed to use governance systems to identify and address safety issues within the hospital.
- The provider did not ensure regular clinical or managerial supervision took place for staff in accordance with their policy. The provider's policy stated that supervision should take place every eight to twelve weeks per supervisee. The clinical supervision policy referred to management supervision but did not make any detailed reference to it. It was not clear what constituted managerial supervision. We reviewed four staff files and did not find any records of supervision. We reviewed a supervision database, which did not demonstrate that staff were receiving supervision regularly. Senior staff confirmed that supervision had not been taking place consistently. The provider could not be sure that performance issues, training requirements or developmental opportunities were identified or discussed with staff.
- The provider had not undertaken regular staff meetings. We reviewed staff meeting minutes and found minutes for meetings on five occasions since October 2015. We were unable to locate lessons learnt from staff meetings.
- The provider was unable to provide us with a copy of their risk register. Staff were unclear what the risk register included and we were originally given a risk assessment database of patient risks. The provider later emailed us a copy of their business risk assessment document. This was also the wrong document indicating they did not understand what the risk register was.
- The provider did not demonstrate they were reviewing and learning from incidents. We reviewed incident forms during our inspection and found the trend of 14 falls having occurred in the last three months with three patients having reoccurring falls. We also observed unapproved manual handling moves being used by staff despite this being observed and raised as a concern previously by the safeguarding team.
- We looked at six human resources (HR) policies and found that three of these; professional and clinical supervision, management of professional registrations and staff appraisal and development were overdue for review. Staff were required to sign to say they had read policies. We reviewed the staff signature lists for each policy and found that many staff had not signed the signature lists attached to the policies. We reviewed 49 policies. We found 22 policies that had been signed by a maximum of six staff as having been read. The majority of staff signature lists indicated that the policies had been read by just two or three staff. The provider could not be sure that staff fully understood policies and practice guidelines at the hospital.
- The provider did not produce accurate contemporaneous records of incidents. We reviewed incident forms from 30 May 2016 until the 31 August 2016 and found that staff had not recorded five incidents in patient records. The provider had not reported two incidents, involving four patients, to the local safeguarding authority or to the CQC.

Leadership, morale and staff engagement

- The provider had recently appointed a new manager who was in the process of applying for the role of registered manager. The hospital had been without a manager in post for several months. The new manager told us they were working with the director and deputy director to put systems in place to improve the service.

Commitment to quality improvement and innovation

- The provider did not participate in any quality improvement programmes or research projects.

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 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not have an up to date ligature risk assessment and staff were not aware of the location of ligature risks in the clinical environment. The provider had not ensured the evacuation chair was available to staff for use in the event of a fire. Patients with mobility difficulties did not have an appropriate evacuation care plan for staff reference. The provider had not ensured that staff had adequate instruction or advice on the administration of covert medication to patients. This was a breach of Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure sufficient staffing to assist with kitchen duties and to manage patients at risk of falls at night. This was a breach of regulation 18 (1)

This section is primarily information for the provider

Enforcement actions

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 Diagnostic and screening procedures	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect The provider had not ensured there were appropriate bathing facilities for the management of personal care needs for patients. The provider had not complied with the Mental Health Act code of practice requirements for the provision of a female only lounge for patients. The provider had not ensured there were female only bathing facilities for patients. The provider had not ensured the privacy and dignity of patients were maintained. This is a breach of Regulation 10(1)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not ensured all areas of the hospital were maintained or kept clean. Some areas of the hospital posed a risk to patients at risk of falls. Staff were not always using approved manual handling techniques. The provider must ensure safe manual

This section is primarily information for the provider

Enforcement actions

handling practices are used for people using services. The provider had not ensured all patients had a full and comprehensive manual handling assessment by a professional with the relevant skills and knowledge.

The provider had not ensured it does not use restrictive practices when caring for patients and all caring interventions are care planned.

Patients were not routinely reviewed by medical staff following a fall.

The provider did not have a clear and effective observation possibly to ensure the safe staffing and management of patients at risk of falls.

The provider had not ensured all physical health equipment was checked and recorded, or that drug disposal was recorded and expired equipment is replaced.

This is a breach of Regulation 12, (1) (2) (a) (b) (c) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured they were assessing, reviewing and managing the risks to people using services health, safety and welfare. The provider had not ensured they reviewed and learned from incidents and concerns. The provider had not ensured all policies were up to date and staff fully understood policy and practice guidelines at the hospital.

This section is primarily information for the provider

Enforcement actions

The provider had not ensured records and incident forms were contemporaneous, consistent and easy to follow.

This is a breach of Regulation 17(1)(2)(a)(b) (c)(e)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured all staff received regular supervision or access to staff meetings to allow them to review their practice. This was a breach of Regulation 18(1) (2)(a)