Butterworth Centre

Quality Report

36 Circus Road
London
NW8 9SE
Tel: 02070551666
Website: https://www.sanctuary-care.co.uk/care-homes-london/butterworth-centre-westminster

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated wards for older people with mental health problems at Butterworth Centre as good because;

- Staff kept patients safe from avoidable harm. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed holistic, recovery-oriented care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice. Staff engaged in clinical audit to evaluate the quality of care they provided.
- The ward teams included or had access to specialists required to meet the needs of patients on the wards. Managers ensured that these staff received supervision and appraisal. The ward staff worked well together as a multidisciplinary team and with those outside the ward who would have a role in providing care.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients and families and carers in care decisions.
- The service managed beds well as part of the local continuing care pathway.
- The service was well led by an interim management team, and governance processes ensured that most ward procedures ran smoothly. A new registered manager was due to start after our inspection.

However;

- Some staff who were delivering care and treatment had not completed or kept up-to-date with their basic training.
- Some areas of the hospital environment had not been well maintained and kept in good working order.

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 	We rated this service as good overall as people received effective treatment, delivered in a caring way that met their needs. The service was well-led overall despite some issues we found relating to the safety of the service.

Summary of findings

Contents

Good

Butterworth Centre

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

Summary of this inspection

Background to Butterworth Centre

Butterworth Centre is an independent mental health hospital that offers inpatient care and treatment to older people. The service is operated by Sanctuary Care. Patients receive support for their mental and physical health needs. This includes end of life care needs and support for organic mental health conditions such as advanced dementia.

The hospital has four floors, with the first three used as wards and the fourth as office space. Both men and women use the service and each ward provides single sex accommodation for up to 14 patients. Sanctuary Care rent the building from an NHS provider who also supply additional facilities such as catering, domestic services and estate maintenance.

Patients staying at the hospital are funded by the NHS through continuing care. On the day of our inspection all patients were either detained under the Mental Health Act 1983 or staying there under Deprivation of Liberty Safeguards.

In August 2019 the registered manager and deputy manager left the service. At the time of this inspection a new postholder had been recruited but had not yet started. Interim cover had been provided by a clinical development manager and a senior nurse. Sanctuary Care's Director of Nursing, Quality and Care provided senior management oversight and input to the service.

We last inspected this service in June 2017. At that time the service received an overall rating of requires improvement due to concerns around safety and effectiveness. We issued four requirement notices and told the provider it must make improvements to the dignity and respect of patients, staffing, safeguarding and provision of overall safe care and treatment.

Our inspection team

The team that inspected the service comprised of two CQC inspectors and a specialist advisor who had extensive knowledge and experience of this service type.

Why we carried out this inspection

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

How we carried out this inspection

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

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

On the day of our inspection there were 40 patients staying at the hospital. During the inspection visit, the inspection team:

- toured all areas of the wards including clinic rooms
- spoke with three patients, one of whom was accompanied by their carer

Summary of this inspection

- spoke with seven family members and relatives
- interviewed ten members of registered and un-registered nursing staff, three of whom were agency or bank staff
- interviewed the clinical development manager and other members of the leadership team
- spoke with members of the multidisciplinary team including the consultant psychiatrist, activity therapist and pharmacist
- spoke with the GP who visited the service
- reviewed 11 patients' care and treatment records and the medication charts of 15 patients
- observed activities on the ward, two staff handovers and one ward round
- contacted other stakeholders for feedback on the service
- reviewed policies and other documents relating to the running of the service.

What people who use the service say

We spoke with three patients and seven relatives and carers during our inspection. One of the carers represented their relative's views as well as their own due to the patient's communication needs. Patients said staff were respectful, provided them with help and emotional support when they needed it and treated them kindly.

Due to the nature of their illness some patients were not able to provide verbal feedback on their care. Observations we made during our inspection showed positive interactions between patients and staff, with staff communicating and supporting patients in a calm and caring way.

Most of the feedback we received from relatives and carers was positive. Carers said that they felt staff did their best for patients and that their relatives were cared for well. Some said they had noticed positive changes to the service in the last six months. A few raised concerns that some nursing staff were sometimes task orientated, rather than patient-focused, and could occasionally be abrupt in their manner.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

Our rating of this stayed the same. We rated it as requires improvement because:

- Some staff who were delivering care and treatment had not completed, or kept up-to-date with, their basic training to keep patients safe from avoidable harm. For example, some staff had not been trained in restraint, but it was used within the service.
- Some aspects of safety had been overlooked. For example, two pieces of medical equipment had not been tested since 2016, there was an area of damaged flooring and one medicines storage cupboard was unlocked.
- In some bedrooms, the layout of furniture meant that patients could not easily reach nurse call alarms when in bed as they were fixed to the wall and out of reach.

However:

- All wards were generally clean and well furnished.
- The service had enough nursing and medical staff, who knew the patients well.
- Staff assessed and managed risks to patients and themselves well. Risk assessments had been updated to reflect current risks and there were clear plans in place to manage them. The provider had plans to increase the uptake of mandatory training.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to address any concerns. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer and record medicines. Staff regularly reviewed the effects of medication on each patient's physical health.
- The service had a good track record on safety. The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. The clinical development manager investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Summary of this inspection

Are services effective?

Good

Our rating of this improved. We rated it as good because:

- Staff assessed the physical and mental health of all patients on admission. They developed individual care plans, which they reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected the assessed needs, were personalised, holistic and recovery-oriented.
- Staff provided a range of care and treatment interventions suitable for the patient group and consistent with national guidance on best practice. They ensured that patients had good access to physical healthcare and supported patients to live healthier lives.
- Staff assessed and recorded outcomes of the care and treatment delivered to each patient. They also participated in clinical audit and quality improvement initiatives.
- The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with a range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.
- Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.
- Staff supported patients to make decisions on their care for themselves. They understood the provider's policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

However;

- There were still some delays in accessing additional services such as occupational therapy, which may have benefited patients.

Are services caring?

Good

Our rating of this stayed the same. We rated it as good because:

Summary of this inspection

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.
- Staff informed and involved families and carers appropriately.

Are services responsive?

Good

Our rating of this stayed the same. We rated it as good because:

- The service managed access to and discharge from the service well as part of the local continuing care pathway. The service had a clear admission and exclusion criteria and screened all new referrals to avoid inappropriate admissions to the service.
- The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an ensuite bathroom and could keep their personal belongings safe. There were quiet areas for privacy.
- The food was of a good quality and patients could request hot drinks and snacks at any time. Staff routinely provided drinks to those who could not request them.
- The service met the needs of all patients who used the service – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

However,

- Although the interim management team had made some improvements, further work was needed to make the hospital environment more dementia-friendly and minimise disorientation of patients.
- The service treated concerns and complaints seriously, but some family members and carers did not know how to complain.

Are services well-led?

Good

Our rating of this stayed the same. We rated it as good because:

- The interim leadership team had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. They had also appointed a new registered manager who was due to start after our inspection.

Summary of this inspection

- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were generally managed well.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.
- The interim management team had a shared focus on continuous learning for staff and had completed quality improvement activities. They had plans to embed further changes with time.

However;

- One audit process had not ensured all clinic room equipment had been tested for compliance with working standards within the required time frame.
- Some work was needed to ensure information used by managers was kept up-to-date so they had access to full and accurate information they needed.
- Further work was needed to improve how the service engaged with carers and relatives of patients.

Detailed findings from this inspection

Mental Health Act responsibilities

At the time of our inspection there were ten patients detained under the Mental Health Act 1983. Staff ensured the rights of those detained under the Act were maintained in line with the associated Code of Practice and followed the guiding principles. Information was displayed to tell any informal patients of their rights.

An independent mental health advocate regularly visited the ward and patients' care and treatment records showed frequent input from them. Staff discussed the Mental Health Act status of individual patients during ward rounds and explained their rights to them. Copies of patients' detention papers and associated records were stored correctly, and staff could access them when needed.

Most staff understood their responsibilities under the Act. Senior staff had facilitated group discussions to refresh the nursing team's knowledge and explore topics related to the Act. However, some new health care assistants had not yet completed mandatory training relating to the Act and did not know how it impacted on patients' rights or the way they supported them.

Staff could ask for support and advice on applying the Act from a Mental Health Act administrator based on site. The administrator monitored Mental Health Act compliance and liaised with staff to ensure all correct documentation was in place, ensuring patients were lawfully detained. They also coordinated hearings and tribunals for those detained under the Act.

Mental Capacity Act and Deprivation of Liberty Safeguards

The service acted in line with the guiding principles of the Mental Capacity Act 2005. Staff supported patients to make decisions and always assumed they had capacity in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.

The capacity of individual patients was assessed at weekly ward round meetings and discussed on a decision-specific basis. Capacity assessments relating to consent to treatment were completed in detail and reviewed.

Staff had a good understanding of the Mental Capacity Act (MCA) and had completed training regarding the Act. They gave examples of how they had supported patients to make specific decisions and were aware of the provider's policy on the MCA and deprivation of liberty safeguards and knew how to access it. The Mental Health Act administrator was also on hand to provide advice to staff about the MCA when requested.

Independent mental capacity advocacy was available to patients. Although the advocate did not visit the hospital regularly, we found evidence that staff had supported patients to access the service when needed and posters were displayed on wards advertising the service.

Overview of ratings

Our ratings for this location are:

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

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

Safety of the ward layout

Wards were generally clean, well equipped and well-furnished. Domestic staff employed by the building owner cleaned the wards daily. There was also a housekeeping team employed by Sanctuary Care that performed light cleaning duties. We found some stains on curtains and chairs in patient bedrooms. As the cleaning records were held by the external domestic team, staff could not easily check when these had last been cleaned and how long these stains had been there.

Aspects of the hospital had not been well maintained and kept in good working order. Areas of the flooring had become worn down over time and a light in one patient's bathroom worked intermittently. When we raised this with staff on the ward, they said there often delays in completing repairs once they had been requested from the building owner. There was clear evidence they had made attempts to follow these issues up and a rolling programme of maintenance was being completed to address some problem areas. The Health and Safety team from Sanctuary Care had met with the landlord to put an action plan in place with agreed timescales.

Staff managed environmental risk on each ward well and assessed them regularly, including potential ligature anchor points. Staff completed regular observations on all patients to mitigate this and provided one to one support for patients when needed. Since the last inspection the provider had created single sex floors. The first floor provided accommodation for males only, the other two floors provided separate accommodation for females. However, some staff stored personal belongings unattended on the ward, which posed a security risk to both staff and patients. There was not enough locker space so that staff could store their personal items securely.

Staff and patients could access alarms to call for assistance. For patients who were at high risk of falls, pressure sensors and bed rails were used to keep them safe and these were risk assessed. Patients all had nurse call alarms in their bedroom, however, they were sometimes located at the end of their beds and were not within easy reach.

Staff followed infection control procedures, including hand washing. They used personal protective equipment, including aprons, gloves and masks when needed. However, some staff had not yet completed training in infection control which could have led to potential gaps in their knowledge. Although we found no impact of this, staff should have completed training to ensure they were following the provider's internal policies.

Clinic room and equipment

Each ward had its own clinic room where medicines and equipment were kept. All were fully equipped and well organised. Staff checked medicines to make sure they were in date and monitored fridge and room temperatures to ensure they were stored in the correct conditions. A pharmacist visited the ward on a weekly basis and completed regular checks on the medicine stock.

Staff had access to the appropriate equipment they needed and kept it clean. Equipment to deal with medical

emergencies, including ligature cutters, were within easy reach of staff on each ward. However, in one clinic room we found a nebuliser and suction device that had not been serviced since 2016. When we raised this, staff removed the equipment immediately.

Safe staffing

There were always enough nursing and support staff on the wards. Patients and carers said staff were available when they needed help. The clinical development manager adjusted staffing levels daily to take account of patients' needs and brought in additional bank and agency staff when needed. Staff said they had regular breaks and that the workload was manageable. This was an improvement since our last inspection.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. An induction checklist was used to ensure non-permanent staff knew ligature risks, the ward environment, guidelines and expectations. Agency and bank staff, we spoke with understood the service and patients well.

A large proportion of nursing staff had left in October 2019 following changes to their terms and conditions of employment as a result of protection under Transfer of Undertakings (Protection of Employment) (TUPE) expiring. During this period the use of agency and bank staff had peaked to cover unfilled shifts. Since then the provider had implemented an ongoing recruitment campaign to build up permanent staff numbers and agency staff usage had decreased steadily. At the time of our inspection the service was over-recruited and had additional staffing capacity.

The only remaining vacancies were for three registered nurse posts that had been recruited to and were due to start shortly after our visit.

Medical staff

Patients could access care and treatment from medical staff on a regular basis. The provider had a service level agreement in place with a local GP who visited the service twice a week. Two separate consultant psychiatrists visited the hospital at least once a week. The service had not used any locum medical staff in the last 12 months. Medical staff worked together to ensure there was enough medical cover and a doctor was available to go to the ward quickly in an emergency. There was also an emergency department located near to the site if needed.

Mandatory training

Some staff who were delivering care and treatment had not completed or kept up-to-date with their mandatory training. This had been an issue at our last inspection. Of the training courses listed as mandatory, eight had been completed by less than 75% of staff eligible, including Management of Actual or Potential Aggression (58%), Equality and Diversity (65%), Supporting Someone Living with Dementia (68%) and Infection Control (71%). This meant some staff delivered certain aspects of care and treatment without having received training in how to do so safely.

When we raised this with senior managers, they explained there had been some delays in arranging training for the high volume of new starters recruited in the last six months. Future training had been organised for all staff and the service had started to use 'train the trainer' programmes to build in-house teaching capacity. As an incentive, staff members also received payment for any time spent completing mandatory e-learning at home. Sanctuary Care's learning and development team had also visited the hospital to deliver additional face-to-face training. The quality of the induction process for new staff had also improved. All new staff were allocated a mentor and time to shadow other staff during the first weeks of starting work.

Assessing and managing risk to patients and staff

We reviewed the care and treatment records of 11 patients across all three wards.

Staff completed risk assessments for each patient on admission and reviewed them regularly, including after any incident. A falls assessment and malnutrition universal screening tool (MUST) was completed for every patient. This had improved since our last inspection.

Staff we spoke with were knowledgeable about individual patient risks and the plans in place to mitigate them. For example, there were specific plans that guided staff on how to approach and support patients who were at risk of being

aggressive towards others. The plans highlighted signs and triggers to help staff anticipate increasing risks and intervene safely. These plans were reviewed in weekly ward rounds and daily handovers.

The service minimised the use of restrictive interventions and balanced this proportionally with patient safety. External doors were kept locked and a security code was required to access each ward. Deprivation of Liberty Safeguards were in place for, or had been applied for, patients who were unable to leave the building due to their individual risks.

Staff made every attempt to avoid using restraint by using de-escalation techniques and only restrained patients using low-level holds to keep the patient or others safe. The service did not use face-down restraint, rapid tranquilisation, seclusion or segregation. If restraint was used to support patients on a more routine basis, for example during personal care, this was carefully planned. Each incident of restraint was recorded, logged and reviewed by senior staff. However, some staff were delivering restraint without having received the proper training. This meant the provider could not be assured they were doing it safely.

Safeguarding

Safeguarding procedures had improved since our last inspection. All staff had received training in safeguarding. Staff we spoke to knew how to recognise and report abuse and said they felt confident in reporting concerns. Staff had discussed safeguarding concerns within the multidisciplinary team and put safeguarding plans in place to keep people safe from harm. They could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Safeguarding concerns, and actions taken in response, were monitored using an electronic incident reporting system. Staff worked collaboratively with other local agencies to achieve positive outcomes. The clinical development manager and senior nurses tracked safeguarding concerns to identify any key themes and trends.

Staff access to essential information

The service used paper care records to store information about patients. All patients' care and treatment records were securely stored in a lockable cupboard in the nursing office of each ward. Staff could access and update the clinical information they needed. We reviewed the care records for 11 patients and found all had been kept up-to-date. The provider was waiting to move to an electronic record system that was in the final stages of development at the time of our inspection.

Medicines management

The service used systems and processes to safely prescribe, administer and record medicines. We reviewed the medication charts of 15 patients across the hospital and found all were completed correctly. All nurses had recently completed medication competencies and understood medication management protocols.

Controlled drugs were securely stored. The temperature of the clinic rooms and fridges were monitored daily and records showed they were within normal range. We found one cupboard used to store stock medicine that had been left unlocked. When we raised this with staff, they rectified the issue immediately.

The service had a contract with a local pharmacy who visited the hospital on a weekly basis to complete checks and audit drug charts. As part of this, the service had also taken part in a pilot scheme for electronic prescribing. Since the introduction of this system there had been a reduction in the number of medicine errors across all wards. Staff said the introduction of the new system had made medicines management more effective and easier to monitor.

Track record on safety

The service had a good track record on safety and there had been no serious incidents in the last 12 months. Senior staff monitored the number of incidents and analysed data to identify trends or themes and acted to reduce the likelihood of them repeating. The service notified external organisations about any incidents when needed. For example, unwitnessed falls were closely scrutinised and investigated by staff, as a precautionary measure they were also reported to the local authority's safeguarding team.

Reporting incidents and learning from when things go wrong

Staff knew what incidents to report and how to report them. The introduction of a new electronic reporting system had improved oversight of incidents. Senior staff

reviewed all incidents reported with the multidisciplinary team daily. For example, the system had been used to track the number of falls for each patient and staff had used this to review individual risk management plans and consider if a different intervention was needed to keep the patient safe.

Staff understood the duty of candour. The service followed policies and procedures relating to duty of candour and acted in accordance with it. Patients and staff were debriefed and supported after incidents. Staff used reflective practice and handovers to identify and share lessons learnt. Learning from incidents was also shared at monthly team meetings and reviewed at the quarterly clinical governance meeting.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Staff assessed the holistic needs of each patient and developed a comprehensive care plan that met their needs. Care plans were personalised, reflected the views of patients where possible and were reviewed regularly. All patients had their physical health assessed on admission and were registered with the ward's GP. Physical health assessments were reviewed by the multidisciplinary team to ensure they were kept up-to-date and patients' physical health was monitored during their time on the ward. This included regular blood and urine tests, heart rate, pulse, temperature and weight monitoring and electrocardiogram when needed.

Staff used additional assessment tools that focused on risks associated with older patients. For example, staff completed Waterlow scores to assess and effectively manage the risk of a patient developing pressure ulcers. At the time of our inspection there were no patients with pressure ulcers. If patients were unable to move from their bed, staff made sure they regularly turned them and used specialist mattresses to prevent development of pressure ulcers.

Best practice in treatment and care

Staff assessed and supported patients with their physical and mental health needs, they worked collaboratively with specialists to manage comorbidities when needed. Staff reported any changes to patients' health to the multidisciplinary team and could escalate concerns to the ward doctor quickly. The hospital had recently introduced an updated version of the National Early Warning Scores tool (NEWS2) to identify any deterioration in patients' physical health conditions.

Staff reviewed the effects of each patient's medication on their physical health according to national guidance. Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. There was a clear rationale recorded for any patient with dementia who was receiving antipsychotics as part of their overall treatment. Where covert medication had been used there were records detailing why this decision had been made in the patient's best interests and who had been involved. The service provided specific advice to patients and carers about their medicines and responded to any queries they had.

Staff provided a range of care and treatment that was suitable for patients. Although there were no patients engaging in psychological therapies at the time of our inspection, the multidisciplinary team had reviewed individual patients to consider if psychological input would be of benefit and recorded their decisions clearly.

Staff supported patients to live healthier lives. Group sessions were a large component of the treatment programme and focused on maintaining patients' wellbeing. These included groups designed to engage individuals with dementia and some recreational-based activities that promoted physical movement, such as dancing, and seated exercise programmes. The staff provided alternatives for patients who did not enjoy group activities.

Staff met patients' dietary needs. They assessed each patient's nutrition and hydration needs on admission and monitored this daily. Staff could access training on dysphagia management and nutrition awareness and understood how to support patients when eating and drinking.

The clinical development manager attended conferences and other events and cascaded information about clinical best practice to staff. They also followed up with actions.

For example, after attending a conference on pressure ulcers in older people they had made links with a dietician to discuss recipes to improve patients' overall health. Information from the conference had been shared at team meetings.

Skilled staff to deliver care

The multidisciplinary team worked well together to benefit patients. The team consisted of registered general and mental health nurses, healthcare assistants, an activities coordinator, two psychiatric consultants and a GP.

All new staff received a full induction to the service. The provider had recently redesigned its induction process and allocated mentors to new starters to provide coaching and daily support. The service had also improved access to specialist training and worked in partnership with local organisations to provide new learning opportunities for staff. This included face to face training in end of life care at a local hospice. The service had arranged for an external provider to come in and deliver dementia-specific training and provide advice on how to make the overall environment more dementia-friendly for patients.

All staff received regular supervision. Additional group reflective practice sessions were also arranged on a regular basis, led by senior clinical staff. Staff said they found these sessions very useful in developing their knowledge, understanding and skills. All staff had received an appraisal or had been scheduled to receive one by April 2020.

Multidisciplinary and inter-agency team work

Weekly multidisciplinary meetings took place to review every patient's needs. Staff members worked well together to ensure the care and treatment they delivered was effective and that they had considered any changes to, or gaps in, patient care. Patients' risk assessments and risk management plans were also updated. Patients, carers and the independent advocate were invited to input and attend these meetings and care programme approach meetings that took place every six months.

The service had improved access to some allied health professionals since our last inspection, such as speech and language therapy and physiotherapy. An optician and chiropodist now visited the wards routinely. Dental and audiology services were provided through private appointments that staff supported patients to make. Records also showed involvement from tissue viability nurses and community palliative care teams when required.

However, there were still challenges when accessing some allied health professionals. At the time of our inspection there was no routine input from an occupational therapist, and this had delayed access to specialist equipment. The service had purchased standard wheelchairs and other pieces of equipment but there were delays in accessing more specialist equipment that required assessment from an occupational therapist. Managers were diligent in challenging any rejected referrals for additional services and escalated their concerns to commissioners when needed.

Staff shared information about patients' care needs daily. Handover meetings occurred at the beginning of each shift where staff discussed patients' current presentation and any changes in physical and mental health. This included an update on any incidents, concerns, and planned activities for each ward.

Ward teams had effective working relationships with the relevant external teams and organisations involved in patients' care and treatment. They ensured each patient's funding for continuing care was reviewed and coordinated with commissioners.

Adherence to the MHA and the MHA Code of Practice

At the time of our inspection there were ten patients detained under the Mental Health Act 1983. Staff ensured the rights of those detained under the Act were maintained in line with the associated Code of Practice and followed the guiding principles. Information was displayed to tell any informal patients of their rights.

An independent mental health advocate regularly visited the ward and patients' care and treatment records showed frequent input from them. Staff discussed the Mental Health Act status of individual patients during ward rounds and explained their rights to them. Copies of patients' detention papers and associated records were stored correctly, and staff could access them when needed.

Most staff understood their responsibilities under the Act. Senior staff had facilitated group discussions to refresh the nursing team's knowledge and explore topics related to the

Good

Wards for older people with mental health problems

Act. However, some new health care assistants had not yet completed mandatory training relating to the Act and did not know how it impacted on patients' rights or the way they supported them.

Staff could ask for support and advice on applying the Act from a Mental Health Act administrator based on site. The administrator monitored Mental Health Act compliance and liaised with staff to ensure all correct documentation was in place, ensuring patients were lawfully detained. They also coordinated hearings and tribunals for those detained under the Act.

Good practice in applying the MCA

The service acted in line with the guiding principles of the Mental Capacity Act 2005. Staff supported patients to make decisions and always assumed they had capacity in the first instance. When patients lacked capacity, staff made decisions in their best interests, which recognised the importance of the person's wishes, feelings, culture and history.

The capacity of individual patients was assessed at weekly ward round meetings and discussed on a decision-specific basis. Capacity assessments relating to consent to treatment were completed in detail and reviewed.

Staff had a good understanding of the Mental Capacity Act (MCA) and had completed training regarding the Act. They gave examples of how they had supported patients to make specific decisions and were aware of the provider's policy on the MCA and deprivation of liberty safeguards and knew how to access it. The Mental Health Act administrator was also on hand to provide advice to staff about the MCA when requested.

Independent mental capacity advocacy was available to patients. Although the advocate did not visit the hospital regularly, we found evidence that staff had supported patients to access the service when needed and posters were displayed on wards advertising the service.

Are wards for older people with mental health problems caring?

Good

Kindness, privacy, dignity, respect, compassion and support

Patients received care and treatment from staff who protected their dignity and acted kindly towards them. Interactions we observed between patients and staff during our inspection were positive. Staff spoke about patients in an empathic way. Patients said staff were respectful and provided them with support when they needed it. We observed staff calmly support patients who were becoming agitated, they provided reassurance to de-escalate situations compassionately.

Staff understood and respected the individual needs of patients. We found examples of life story work. Life stories included a detailed description of each patient's personal history such as their career, interests and hobbies, dislikes and family and friends. Staff were able to use these stories to engage and interact with patients.

Patients were supported to maintain relationships with those close to them, and the community where possible. The service had access to video calling services to encourage relatives and patients to keep in touch. Staff supported patients to visit the local shops and a pet therapy service had also visited the service.

Patients told us that staff were friendly. Most carers agreed with this but two said they felt staff sometimes behaved in a task orientated way rather than engaging in meaningful conversation with patients and carers. This had been identified at our last inspection and the new management team had acted to improve this. They had conducted reflective group discussions with staff to explore person-centred interactions and delivered training on behaviour and communication. Further time was needed to embed these changes fully.

Staff protected patients' privacy and dignity. Clear guidelines and policies were in place on how to protect patient confidentiality which staff followed. Staff were aware of how to protect patient privacy during team discussions and ensured these conversations took place in an appropriate setting. Patients had sometimes entered other patients' bedrooms by mistake. Staff had put measures in place to minimise this in the least restrictive way possible and patients could lock their bedrooms if they left them unattended.

Staff were comfortable in raising any concerns about disrespectful, discriminatory or abusive behaviour without fear of the consequences.

Involvement in care

Good

Wards for older people with mental health problems

Staff introduced patients to the ward and the service as part of their admission. They had also developed a new patient information pack with details about other helpful services, including telephone helplines.

Where patients were able to contribute towards the planning of their own care, staff involved them in decisions. We observed discussions during ward round that were conducted with the patient in a supportive manner and records reflected patients' personal opinions. Staff supported patients to make advanced decisions about their care, including cardiopulmonary resuscitation, if appropriate. For some patients their involvement in their own care was made more difficult due to the nature of their condition. However, an advocate visited the ward on a regular basis to engage with patients and provide additional representation on their behalf at meetings.

Patients were encouraged to input into decisions about the service by attending community meetings to provide feedback. Staff displayed what they had done in response to this feedback on 'you said, we did' posters in communal areas. Easy-read complaints cards had also been designed and placed on all wards to help patients with communication difficulties to raise concerns.

Staff supported and informed families or carers. Most carers and family members we spoke with said they were involved in the care and treatment of patients and were consulted on any changes. Carers could attend ward round meetings or care reviews and we found examples where their input had been used to inform the care planning process. Carers and relatives were able to contact staff to receive updates.

The service monitored carer and patient input through regular audits of patients' care plans. However, some carers gave examples where staff had been abrupt in their manner in the past and said they had not been involved in decisions about patient's care and treatment. The service had made changes to improve carer engagement and to encourage their involvement. For example, the introduction of a bi-monthly relatives' meeting that the patient advocate attended to help facilitate discussion.

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

(for example, to feedback?)

Good

Access and discharge

Access and discharge to the service was well managed and formed part of the local continuing care pathway. Referrals to the hospital were made by the local clinical commissioning group. All admissions were planned and reviewed by the multidisciplinary team to ensure they only admitted patients if the service could meet their needs. A clear admission and exclusion criteria were in place to avoid inappropriate admissions. Most patients required long-term care in a hospital setting, so there were no planned or delayed discharges at the time of our inspection.

The service worked well with other services to arrange more appropriate placements for patients if their needs changed. In the 12-month period before our inspection there had been two discharges in these circumstances.

Staff worked well with other teams if patients required treatment at another service during their stay. This included visits to acute hospitals to address specific physical health needs or concerns. The service had adopted the 'red bag' initiative and provided hospital passports for each patient to take with them. The bags contained important paperwork, medication and personal items and ensured all relevant information was shared with the receiving service. Staff would also accompany patients when needed.

If patients went on leave or were receiving treatment at another service, their bed was protected and always available for them on return. On the day of our inspection there were 40 patients staying at the hospital. One bedroom was unoccupied as it was being refurbished, another was unoccupied as a patient had recently passed away. The average bed occupancy across the hospital was 93%.

The facilities promote recovery, comfort, dignity and confidentiality

The design, layout, and furnishings of the wards supported patients' treatment, privacy and dignity. Each ward was identical in layout and included a nursing office, main

communal area, activity room, dining area and TV lounge. There were three housekeepers employed in the service to carry out tasks including patients' laundry, light cleaning duties and collecting shopping in the community. The interim management team had already made improvements to individual wards and had further plans to enhance the environment. On one ward an activity room had been decorated to resemble a living room complete with table and comfortable chairs and mantelpiece to allow patients to feel more comfortable during ward rounds.

Patient bedrooms were functional and comfortable and had lockable cupboards to store personal possessions. All patients had ensuite bathrooms that were suitable for wheelchair access. Patients were able to personalise their bedrooms by bringing in photos and other private possessions. However, we did find some areas of the ward that had not been well maintained and were in poor decorative state. Some carers raised concerns about the impact of this on the patients' comfort, for example in one patient's bedroom the curtains were stained and had not been cleaned for some time.

Due to the location of the hospital, access to outside space was limited. There were balconies on the first and second floors that patients could access supervised by staff, the service had purchased plotted plants to help make it a 'greener' space. On the ground floor patients could access a patio area. The service had quiet areas, with space available for patients to meet with visitors and make phone calls in private.

Patients had a good choice of food that met their individual dietary requirements. Patients we spoke with said the variety and quality of the food was good. We observed meal times on the ward and found they were calm, and patients were well supported. Staff had a good understanding of the needs of patients who required assistance during meal times and knew the types of foods that individual patients either liked or could not have due to special diets. The clinical development manager completed monthly audits on the quality of food and mealtime support, using spot checks to ensure they were delivered to a good standard. Patients were provided with, and could request, hot drinks and snacks at any time.

Meeting the needs of all people who use the service

The service met the needs of all patients who used the service – including those with a protected characteristic. There had been some improvements made to help make the wards more 'dementia-friendly'. For example, the provider had added some visual aids to help patients navigate their way around their bedrooms. Antique display cabinets had been installed to promote patient engagement with objects that might resonate with them. New activities had also been introduced following advice from an external organisation, including music therapy for people living with dementia.

However, further work was needed to make the service more dementia-friendly to minimise disorientation of patients. For example, some furnishings did not have clear contrasting colours to help patients orientate and the floor surface was damaged in areas which was a potential fall hazard. Information displayed on ward notice boards was difficult to read and could have been presented in a more accessible format. Senior managers were aware of this need and had arranged for further input from an external organisation to re-review the environment and provide additional dementia related training for staff.

Patients had access to appropriate therapeutic activities. Each ward had a dedicated activities coordinator to led recreational activity sessions, including chair-based exercise and sessions designed for patients with dementia. The hospital had also purchased an electronic projector which included several games and puzzles that patients could use. The service was considering expanding its offer of activities to help patients retain skills and cognitive abilities, and further input from occupational therapy to assist with this. For patients who did not wish to engage with group activities, staff delivered one-to-one sessions as an alternative. Staff tailored these activities to engage with patients based on their personal interests. For example, staff printed off material related to one patient's life-long interest and used this in conversation with them as part of their care plan.

The service made adjustments for disabled people and those with other specific needs. All wards were accessible to patients and visitors using wheelchairs via a lift. Ensuite bathrooms had also been fitted with extra hand rails and other fixtures.

Patients had access to spiritual, religious and cultural support. Staff who spoke other languages provided care to patients in their own language where possible. Staff could

also request interpreters to attend meetings when required. Food menus reflected patients' cultural and ethnic backgrounds and their personal choices. The service could arrange for members of local faith communities to attend the hospital when requested by patients. Staff were also aware of patients who had protected characteristics and protected their rights, for example, patients from the LGBT+ community.

When possible, staff supported patients to access local facilities. For patients who could not leave the hospital, staff arranged for local services to visit the wards, including a hairdresser, chiropodist and dentist. Staff had also facilitated social outings for patients in the wider community to the seaside. For patients who could not travel long distances staff had organised afternoon tea at a nearby care home.

Listening to and learning from concerns and complaints

The service had a clear complaints policy in place and treated concerns seriously. Four complaints had been received in the 12 months prior to our inspection. Two of these were upheld and related to staff attitude and staff conduct. The service had investigated complaints, identified changes that needed to be made and communicated any learning to staff. We reviewed complaint response letters that had been written in a thoughtful and open way and provided people with advice about what to do next if they still were not satisfied. The service had received 11 compliments from 1 December 2018 to 12 December 2019. The clinical development manager analysed all feedback from complaints and compliments to highlight areas for improvement and any emerging trends or themes.

Some relatives and carers we spoke with did not know how to complain. However, the service had recently refreshed posters on how to complain on all wards and created easy-read complaint cards to encourage people to complain when necessary. Staff had also been provided with a flow chart of the complaint process and reminded at team meetings to make relatives aware of this process and encourage them to share their concerns.

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

Good

Leadership

Leaders had the integrity, skills and abilities to run the service. After the previous registered manager and deputy manager had left the service in August 2019, an interim management team had been put in place. This included an experienced clinical development manager. The group's director of nursing provided senior management input and had responsibility for the operational performance of the hospital. Clear efforts had been made throughout this time to appoint a new registered manager and the provider had successfully recruited into the post. However, the candidate had not yet started at the time of our inspection.

Managers were visible in the service. Staff we spoke with had noted positive improvements since the introduction of the current leadership team and said they could access support from them whenever needed. The senior nurses on each ward also supported their teams well. They were aware of the ward level risks and challenges and were open in sharing them with the team.

Staff were encouraged to develop their skills and take on more senior roles. As well as recruiting to the registered manager post the service had reviewed the current management structure and decided to introduce ward managers for each floor, supporting staff members to apply and step-up into these roles.

Vision and strategy

Butterworth Centre was the only hospital service operated by Sanctuary Care at the time of this inspection. The provider understood the unique challenges and differences a hospital service may face. The management team had identified areas for improvement and brought in additional expertise from internal teams to support this, including quality assurance, learning and development and health and safety.

Senior staff implemented the collective values of the wider organisation which were ambition, sustainability, equality, diversity and integrity. The management team led by example in implementing these values at ward level and

operated a values-based recruitment process. During supervision and annual appraisal, the organisational values were reviewed with staff and they were each set objectives in line with the strategy for the service.

The service was connected to the work of the wider company. Managers attended an annual management conference and other events to remain involved in wider organisational changes. Sanctuary Care also kept all staff updated about changes via an online intranet portal and through discussion at team meetings.

Culture

The interim management team were working to make positive changes to the culture of the hospital. They modelled and encouraged supportive relationships amongst staff and were passionate about improving the quality of the service for patients and their families.

The service supported overall staff development and career progression. New training opportunities were now available to staff including the Nursing Associate programme linked to universities. The service had also engaged with NHS organisations to provide clinical training on specific topics such as safeguarding and venepuncture. More time was needed to fully demonstrate the impact of these changes as many of the staff we spoke with were in the progress of completing this training or due to start it in the future.

Staff were supported and felt respected and valued. They said they were positive about the future of the service. Staff who had been affected by changes to their contracts during 2019 said they had been well supported and managers had handled the situation well. The provider had revised the rewards schemes for staff to provide more opportunities for them with greater access to employment linked rewards. Staff could also access occupational health services and an employee advice service for further support.

Teams across the hospital worked well with one another to provide care and treatment. Staff felt able to raise concerns at team meetings or with managers and felt that incidents were treated as learning opportunities. Reflective practice sessions had been introduced amongst all staff to promote skill sharing and cohesion.

The sickness rate for the service was 7.6% which was higher than when we last inspected. However, there was no evidence that suggested this was linked to staff morale or working conditions. The service managed sickness and performance issues in line with internal policies and procedures and accessed help from the human resource team when needed.

The hospital promoted equality and diversity and policy and procedures were in place to support this, including those relating to recruitment of new staff. Patients and staff with protected characteristics were supported and protected from harassment.

Governance

A governance framework was in place across the hospital but had not always been implemented effectively to ensure all issues on the ward were identified and rectified in a timely way. For example, the audits completed by the pharmacy service, management team and spot check completed by nursing staff had not ensured that every piece of equipment in the clinic rooms was properly maintained or stored. We found a nebuliser and suction pump that had not been checked since 2016 in one clinic room. When we raised this with managers, they rectified the issue immediately but could not explain how this had been missed or guarantee that staff had not been using this equipment.

The governance system did not work well prior to the arrival of the current leadership team as they had identified many issues within the hospital and had worked hard to resolve them. However, the governance framework was now more effective. It ensured most information flowed from board to ward and there were clear lines of accountability.

Each ward had a team meeting every month to identify areas for improvement and there was a whole hospital meeting monthly, attended by senior managers. Information from these meetings was collected and discussed at quarterly clinical governance meetings which were attended by senior clinical staff, the clinical development manager and the director of nursing. The director of nursing reported on the hospital's performance to the senior leadership team at Sanctuary Care during board meetings. Safeguarding issues were scrutinised by the provider's safeguarding committee.

Management of risk, issues and performance

Aspects of performance had been impacted by the recent high turnover of staff and the departure of the previous

registered manager and deputy manager. For example, delivery of mandatory training had not matched the pace of recruitment and some new staff were delivering care and treatment without the necessary training. The service had also been slow in developing its dementia-specific offer to the patient group.

Despite this, the interim management team had clearly made improvements and were in the process of making further changes to address the issues we identified. For example, at the previous inspection we found staff had variable knowledge of safeguarding procedures. The service had brought in extra support from Sanctuary Care's learning and development team to provide additional face to face training, which had clearly improved staff knowledge and understanding of safeguarding.

Managers were transparent and open with commissioners about the hospital's overall performance and understood challenges within the wider healthcare system. For example, staff were assertive in following up on requests for additional equipment and services if patients needed them. The service used key performance indicators to track the quality of clinical care and shared these with commissioners on a regular basis.

Risk was generally well managed. A local risk register was in place for the hospital which fed into the wider Sanctuary Group combined risk map so that there was oversight at the appropriate level. For example, issues regarding the maintenance of the ward environment had been raised to the Health and Safety team at Sanctuary Care, who had met with the landlord's estates team to devise an action plan with clear timescales for improvement.

Although there were issues with completion of mandatory training which were still in the process of being resolved, the service had responded well to other risks associated with the large turnover of staff in October 2019. A recruitment plan had been put in place and use of agency staff was closely scrutinised by the senior leadership team and had reduced. At the time of our inspection there no agency staff being used to cover unfilled shifts and staffing had stabilised across all wards.

Information management

Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect. The new electronic reporting system, that had been introduced since our last visit, provided managers with most of the information they needed to monitor the quality of the service. The system captured data about incidents, safeguarding, local care audits and provided managers with a data dashboard. The provider was looking to invest further in the hospital's technology infrastructure and was at the final stages of developing a new electronic system for care records, which was due to be launched in the months following our inspection.

However, some areas of information management needed refining to ensure managers had access to accurate, real time data. For example, some actions identified through internal audits had not been updated to show the most recent progress. Data used to track the completion of training had not been kept up-to-date due to delays in administrative processes. The provider was aware of this and was completing ongoing work to embed the new systems and processes that had been introduced.

Engagement

The service worked collaboratively with other external partners to improve the quality of care and treatment. The hospital had worked with other providers to introduce new training for staff and there were plans to bring in further external consultancy to improve the quality of the service.

The service engaged well with staff. Staff attended regular team meetings and team leaders provided information for those who could not attend. All staff we spoke with said that the provider had engaged well with them during changes to terms and conditions of employment and they had been given clear information. Results from a recent staff survey had been analysed and reviewed at team meetings and had led to action plans to address any areas of concern. In the most recent staff survey over 90% of staff said they enjoyed their role and would recommend the provider as a place to work.

The service had improved engagement with patient and carers. Patients, carers and relatives were encouraged to provide feedback on the service to nursing staff and at the bi-monthly carer's meeting. Any feedback raised at these meetings was reviewed by the clinical development manager and raised at the quarterly clinical governance meetings when needed.

Good

Wards for older people with mental health problems

The clinical development manager operated an open-door policy and regularly received phone calls from carers and family members. Training in communication and behaviour was also being delivered to staff to improve engagement with patients and their family or carers.

However, it was too soon to assess the impact of these changes and some carers and relatives we spoke did not know who managed the service or how to complain. They also raised concerns that nursing staff had sometimes been abrupt in their manner and seemed task orientated when delivering care and treatment.

Learning, continuous improvement and innovation

The interim management team had a focus on continuous learning and were enthusiastic about improving the service. For example, the service had worked with an external pharmacy provider to pilot a new electronic prescribing system which had reduced the number of medication errors across the hospital. Nursing staff said this new technology had made medication management more efficient and they had enjoyed introducing this change.

The service had also introduced the 'red bag' initiative for patients who needed to visit other hospitals. The bags contained important paperwork, medication and personal items to ensure patients had these essential items during their hospital stay.

The interim management team had ongoing improvement plans in place to develop the quality of the service. Once a new registered manager was in post it was expected they would take greater ownership of this work and implement further quality improvement initiatives across the hospital, for example, the introduction of acoustic monitoring that uses sound to detect patient falls. The service had previously held a regular quality improvement group at the hospital which had been paused whilst a new registered manager was found.

The service did not take part in any national accreditation schemes. Participation may have been beneficial given that this service was the only hospital within the provider's portfolio and accreditation normally involves peer review.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure all staff complete and keep up-to-date with their mandatory training so they can carry out their roles safely and effectively.

Action the provider SHOULD take to improve

- The provider should ensure all maintenance of ward areas is completed in a timely way so that it does not impact the safety or comfort patients.
- The provider should ensure that all medication storage cupboards are locked when not in use.
- The provider should ensure all nurse call alarms in patient bedrooms are within easy reach.
- The provider should ensure staff can access daily cleaning records to check what has been cleaned and when.
- The provider should ensure there is adequate space for staff to store their belongings safely.
- The provider should ensure actions from audits are consistently followed through.
- The provider should improve engagement with carers and relatives of patients, so they are kept informed of changes within the service and know how to raise concerns.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider had not ensured all staff delivering care and treatment had received the mandatory training to do so safely.**