Castle Lodge Independent Hospital

Quality Report

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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

Overall summary

We found

- The clinic room was dirty and the floors were not clean.
- Single use medicine pots were being washed by hand which was not infection control. These were lying dirty in the sink. This was despite the infection control training being at 93%.
- The drug fridge was open with the key in the lock. This was rectified immediately.
- Mandatory training figures were lower than expected.

However

- The ward complied with same sex accommodation guidance. Staff knew the incident reporting process.Pressure ulcer risk assessments were completed on admission. Debriefs for staff occurred after incidents and learning was fed back to them via meetings or supervision.
- The hospital director had sufficient authority to increase staffing numbers should they be required to deliver enhanced nursing care.

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		We found • The clinic room was dirty and the floors were not clean. • Single use medicine pots were being washed up and were lying dirty in the sink. • The drug fridge was open with the key in the lock. This was rectified immediately. • Mandatory training figures were lower than expected. However we found • The ward layout allowed staff to observe all parts of the ward. There were some ligature points but these had been adequately mitigated on the ligature risk assessment. • The ward complied with same sex accommodation guidance and male and female bedrooms and bathrooms were on different parts of the ward. • The hospital director had sufficient authority to increase staffing numbers should they be required to deliver enhanced nursing care. • Staff knew the incident reporting procedure and knew how and when to report a fall or pressure ulcer. A pressure ulcer risk assessment was completed on admission and updated regularly. • Debriefs occured after an incident and any learning was fed back to the staff team via staff meetings or individual supervision.

Summary of findings

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Summary of this inspection

Background to Castle Lodge Independent Hospital

Castle Lodge is an independent hospital registered for the assessment or medical treatment for persons detained under The Mental Health Act 1983. It is registered for a maximum of 15 adults who have either been detained or who have been admitted informally.

The accommodation is purpose built and on one level. There are 15 single bedrooms all having en-suite facilities. There are five bedrooms for female patients and ten for male patients and there is the facility to segregate the two areas.

Our inspection team

The Team Leader was Patti Boden Inspection Manager and two inspectors

Why we carried out this inspection

We inspected Castlelodge because we received some whistleblowing information of concern. This information was received from an anonymous source.

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?

This was an unannounced visit.

Before the inspection visit, we reviewed information that we held about these services, including the last inspection report and Mental Health Act monitoring visit reports.

During the inspection visit, the inspection team:

- Visited the ward environment and did a tour of the ward.
- Interviewed the hospital director.
- Spoke to two relatives.
- Spoke to patients.
- Spoke to five staff.
- Reviewed duty rotas.
- Reviewed five care records.

Looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Castle Lodge Independent Hospital

Castle Lodge Independent Hospital is part of Barchester Healthcare Homes Limited. It was a ward that houses older adults who had mental health problems. There were 15 beds within the unit, 10 for male patients and five for female patients. There was a registered manager and accountable officer.

Summary of this inspection

What people who use the service say

Generally patients were happy with their care and we found that patients were well looked after.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found

- The clinic room was dirty and the floors were not clean.
- Single use medicine pots were being washed up and were lying dirty in the sink.
- The drug fridge was open with the key in the lock. This was rectified immediately.
- Mandatory training figures were lower than expected.

However

- The ward complied with same sex accommodation guidance and male and female bedrooms and bathrooms were on different parts of the ward.
- The hospital director had sufficient authority to increase staffing numbers should they be required to deliver enhanced nursing care.
- Staff knew the incident reporting procedure and knew how and when to report a fall or pressure ulcer. A pressure ulcer risk assessment was completed on admission and updated regularly.
- Debriefs occurred after an incident and any learning was fed back to the staff team via staff meetings or individual supervision.
- The ward layout allowed staff to observe all parts of the ward. There were some ligature points but these had been adequately mitigated on the ligature risk assessment.

Wards for older people with mental health problems

Safe

Are wards for older people with mental health problems safe?

Safe and clean environment

The ward layout allowed staff to observe all parts of the ward. There were some ligature points but these had been adequately mitigated on the ligature risk assessment.

The ward complied with same sex accommodation guidance and male and female bedrooms and bathrooms were on different parts of the ward.

There was a clinic room which had accessible resuscitation equipment and we viewed the records and found they had been regularly checked. However the clinic room was dirty and the floors were not clean. This cleaning duty was attributed to the nurse in charge. Single use medicine pots were being washed up and were lying dirty in the sink despite staff being trained to a high standard (93%) in infection control. The room did not have a couch to enable patients to be examined in the clinic and patients were examined in their rooms. We also found that the drug fridge for which the nurse in charge had responsibility for the key, was open with the key in the lock. This was rectified immediately.

The ward was clean and tidy and free from odours and we could see they were being regularly cleaned there was a cleaning schedule available. The main day area was bright and airy and all furniture was in a good state of repair.

Environmental risk assessments were available for us to view.

Safe staffing

The number and skills of staff that were required to manage the unit on both night and day shifts was as planned on the rota. We reviewed the rota and this was seven staff during the day, one twilight and three waking night staff. There were enough staff to undertake nursing care. We viewed the rotas for a two week period prior to our inspection and we could see that there were consistently the numbers of staff required available. Agency staff were used on occasions but these were regular agency staff and every month they used between 48-96 hours.

The hospital director had sufficient authority to increase staffing numbers should they be required to deliver enhanced nursing care.

Patients were often taken off of the unit and into the community. These outings were planned and staff we spoke to told us they were rarely cancelled.

There were always two qualified nurses present in the clinical area. There was appropriate medical cover and they could respond quickly. There had never been a time when doctors could not respond.

There were enough trained staff in the clinical area to carry out control and restraint. Staff we spoke to told us they always engaged in de-escalation and tried to avoid using physical interventions. There had not been an incident that required use of this in the last two months.

Mandatory training

Mandatory training was completed by all staff and this compliance was at a variable level. With Mental Health Act and Mental Capacity Act being lower figures than the rest. Figures were cardiopulmonary resuscitation(CPR) 60%, equality and diversity 80%, fire 80%, infection control 93%, management of aggression 97%, Mental Health Act 1983 20%, safeguarding 77%, Mental Capacity Act 2005 /Deprivation of liberty safeguarding 43%.

Assessing and managing risk to patients and staff

The unit did not have a seclusion facility and physical interventions happened rarely. We found no incidents of rapid tranquilisation in the last 2 months.

Staff undertook a risk assessment on admission and these were regularly updated. Tools such as the malnutrition universal screening tool (MUST). MUST is a five-step screening tool to identify adults, who are malnourished or at risk of malnutrition (under nutrition), or obese. It also included management guidelines which could be used to develop a care plan and referrals to the speech and language therapist as well as dieticians were common. Occupational therapists also visited the units weekly to undertake assessments as required.

We found no examples of blanket restrictions.

Wards for older people with mental health problems

Staff were trained in safeguarding and knew how to make such a referral. Such referrals could have included neglect, financial abuse or unexplained bruising. and a body map would usually accompany such a referral.

Staff knew the incident reporting procedure and knew how and when to report a fall or pressure ulcer. A pressure ulcer risk assessment was completed on admission and updated regularly.

We found that the clinic was dirty and single use medicine pots were washed up in the sink, we also found that the drugs fridge was unlocked and the key was in the lock. This was rectified immediately, the fridge was locked and the key was removed. Controlled drugs were stored, checked and administered appropriately. If there were only one qualified staff on duty then a second nurse would be called from the unit next door to ensure that two staff were available for controlled drug checking and administration. There were two drug cards for each patient, one for physical health medication and one for psychiatric medication, there was also a signature list of all qualified staff on the ward. We found that T2's and T3's were stored with the medication card (authorisation under the Mental Health Act to prescribe medication). Other documentation such as the covert pathway for administration of medication, a best interest checklist, Mental Capacity Act checklist, any section 62 paperwork (emergency treatment under the Mental Health Act) and guidance on palliative care drugs, were also stored with the medication cards.

Track record on safety

Since August 2014 there had been 24 recorded incidents. Of these incidents 16 of these related to incidents of aggression and had required the use of approved physical interventions. These incidents were detailed and clearly showed that de-escalation had been attempted before they employed management of actual and potential aggression (NAPPI) techniques. Most of these interventions were passive holds to keep the aggressive patient safe and only one of them had resulted in rapid tranquilisation. None of these restraints were in the prone position.

Other incidents recorded related to applications for Dols (Deprivation of liberty safeguarding) under the Mental Capacity Act and two of them were expected deaths.

Reporting incidents and learning from when things go wrong

Staff knew what to report and how to report it. There was a clear process in place. Staff completed incident forms and these were then given to the manager to log on to the computer system. A more in-depth analysis of the incidents took place if physical intervention had been used. This information was then sent back to the service to understand what they did and to improve future practice. Debriefs occurred after incidents and learning was fed back to the staff team via staff meetings or individual supervision. Immediate debriefs following an instance where physical interventions or rapid tranquilisation were used was undertaken by the staff nurse in charge.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (Regulated activities) Regulations 2014 Safe care and treatment Staff did not have the required mandatory training in all areas This was a breach of regulation 12 (2)(c) Staff did not have regard for the proper and safe management of medicines This was a breach of regulation 12 (2)(g) Staff did not assess the risk of and prevent infection control This was a breach of regulation 12 (2)(h)