Arbour 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

Ratings

Overall rating for this location

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

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

This was a focused inspection relating to issues identified at a previous inspection where warning notices were served. Ratings have not been given for this inspection.

The hospital was inspected in July 2016 and an overall rating of inadequate was made, with the hospital placed in special measures. Five warning notices were also issued. These related to safe care and treatment, complaints, care of informal patients, governance and staffing.

At this inspection, we assessed whether issues identified in four warning notices had been addressed. We found improvements had been made in terms of staffing, complaints, care of informal patients and safe care and treatment and that these warning notices had been met.

The service will continue to be monitored closely whilst in special measures and a further comprehensive inspection will take place to inspect and re-rate the service.

Summary of findings

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Summary of this inspection

Background to Arbour Lodge Independent Hospital

Arbour Lodge Independent Hospital is run by Barchester Healthcare Homes Limited. It is a hospital that provides 24 hour support seven days a week for up to 13 patients with early onset dementia and/or mental health problems. The main focus is providing support to people whose behaviour may challenge. The service is for men aged 50 years old and above. At the time of this inspection, there were 10 patients living at the hospital.

The regulated activities at Arbour Lodge Independent Hospital are assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures, treatment of disease, disorder or injury, nursing care and personal care.

A new hospital director had been appointed and had been in post for two months at the time of this inspection.

There have been five previous inspections carried out at this service. The most recent inspection was conducted on 4 and 5 July 2016 and the hospital was rated as inadequate with breaches to six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Warning notices were served for breaches of five regulations and we issued a requirement notice for one breach of regulations. The hospital was also placed into special measures.

Four of the warning notices had compliance dates of September 2016 and these were the four followed up at this inspection. They were for breaches of:

- Regulation 12 Safe care and treatment - in relation to medicines management, including rapid tranquillisation and monitoring, storage of thickening powders, administration records which were not signed. This was also in relation to investigations following incidents.
- Regulation 13 Safeguarding – in relation to informal patients and their rights within the hospital.
- Regulation 16 Complaints – in relation to compliance with the hospital's own complaints procedure and the recording of complaints.
- Regulation 18 Staffing –in relation to staffing numbers and observation levels.

Our inspection team

Team leader: Andrea Tipping, CQC inspector.

Why we carried out this inspection

We undertook this unannounced inspection to find out whether Arbour Lodge Independent Hospital had made improvements since our last comprehensive inspection on 4 and 5 July 2016.

When we last inspected the service, we rated Arbour Lodge Independent Hospital as inadequate overall. We rated the service as inadequate for safe, inadequate for effective, good for caring, requires improvement for responsive and inadequate for well-led.

We issued the provider with five warning notices that affected Arbour Lodge Independent Hospital. These related to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 12 Safe care and treatment
- Regulation 13 Safeguarding
- Regulation 16 Complaints
- Regulation 17 Good governance
- Regulation 18 Staffing

Summary of this inspection

This inspection was undertaken to check whether the service was now compliant with regulations 12, 13, 16 and 18 as the service had to be compliant with these warning notices by 9 September 2016. We will review the warning notice for regulation 17 at a later date.

How we carried out this inspection

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

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

During the inspection visit, the inspector:

- spoke with the hospital director with responsibility for the service
- spoke with one qualified nurse
- looked at three care records of patients
- carried out a specific check of the medication management and reviewed seven prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- examined audits and reports relating to medicines management
- reviewed investigation reports and actions relating to previous incidents
- examined the observation prescriptions, observation records, allocations and staff duty rota
- checked complaint files and records.

What people who use the service say

We did not speak to any patients during this inspection. This was because of the focused nature of this inspection.

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?

Ratings have not been given for this inspection.

We found the following areas of improvement:

Staffing levels were sufficient to manage observation levels safely.

The multidisciplinary team were reviewing observation levels regularly and using an observation prescription authorised by the responsible clinician.

There were systems in place to ensure that rapid tranquillisation was given safely.

Most staff had attended training regarding rapid tranquillisation.

Nurses were managing medicines keys safely.

Nurses had completed medicines competency training.

Patients had their own individual prescription folder.

Are services effective?

Ratings have not been given for this inspection.

We found the following areas of improvement:

Care plans had been completed clearly identifying patients legal status.

A rights leaflet for patients had been devised which explained what informal status is.

Patient involvement was evident within these care plans.

Are services caring?

Ratings have not been given for this inspection.

This domain was not inspected at this inspection.

Are services responsive?

Ratings have not been given for this inspection.

We found the following areas of improvement:

Complaints, whistleblowing and compliments were now being collated.

Complaints were followed up as per hospital policy and evidence of this was stored securely including electronically and in paper form.

Summary of this inspection

Are services well-led?

Ratings have not been given for this inspection.

This domain was not inspected at this inspection.

Detailed findings from this inspection

Mental Health Act responsibilities

We did not review the Mental Health Act key lines of enquiry during this inspection.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the Mental Capacity Act key lines of enquiry during this inspection.

Wards for older people with mental health problems

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are wards for older people with mental health problems safe?

This was a focused inspection relating to issues identified at a previous inspection and where warning notices were served. Ratings have not been given for this inspection.

Safe staffing

Following the previous inspection in July 2016, we served a warning notice in relation to staffing.

At that inspection, it was identified that there were insufficient numbers of staff available throughout the service to manage observation levels safely.

At this inspection, we reviewed the duty rotas for the last month. Completed rotas were clear and easy to understand and shortfalls were easily identified. The level of staffing was for two qualified nurses during the day with six support workers and one qualified nurse at night with three support workers and an additional support worker working a twilight shift up to 10pm.

Patient's observation levels had all been reviewed following the previous inspection. At this inspection, there were three patients nursed on continuous observations, with two of these specifically when in communal areas.

Observation allocation was completed by the nurse in charge to ensure that observations were allocated allowing staff breaks and ensuring staff spent no longer than two hours on individual observations with patients.

Observation prescriptions had been introduced to ensure that observation levels were reviewed each week by the multidisciplinary team and that the reason for observations was clearly documented and reviewed. The records for the three patients who were being nursed on enhanced observations had been reviewed each week. The forms clearly stated the reasons for observations and any additional instructions.

Assessing and managing risk to patients and staff

Following the previous inspection, we served a warning notice relating to safe care and treatment, specifically relating to medicines management. This had included the use of rapid tranquillisation which was not monitored, altered medicines administration records, stock medication which did not tally, unsigned for medicines, thickening fluid not being properly stored and safe handling of medicines keys.

At this inspection, action had been taken to address all these issues.

An investigation had taken place regarding medicines keys. All qualified nurses had been sent letters reinforcing their responsibilities in relation to medicines.

Use of rapid tranquillisation in relation to one patient had been reviewed and stopped. An investigation into the circumstances regarding this had taken place. Actions had been identified and undertaken. A letter had been sent to the patient and the patient's next of kin apologising for the errors and explaining what actions had taken place. Staff had gone through this letter with the patient involved and met with the family.

All staff were due to receive training regarding rapid tranquillisation including guidance around monitoring this. Most staff had attended this and there was one more course due to take place.

Qualified staff had completed a medicines competency assessment, with two staff still due to complete this who had dates booked in.

Wards for older people with mental health problems

Daily stock checks were taking place for medicines and we reviewed the audits for the previous four weeks. Where there were discrepancies, actions were noted for this. In one case, several medicines doses were not signed for (at the same time on the same date) and timely action was taken to remedy this.

Thickening fluids were being stored in the clinic and administered as needed with meals and drinks. At the previous inspection, thickening fluids had been stored on the counter in the kitchen with the risk that these may be used mistakenly by patients who did not need thickened fluids and this could lead to an increased risk of choking.

Seven prescription files were reviewed. Each patient had their own slimline prescription file with relevant information in. The hospital stored consent to treatment documents within each file. Capacity assessments had been completed for each patient. The medicines administration charts were stored with the prescription to enable checking of the prescription as needed. There was one handwritten medicines administration record; this had been completed by two nurses from the prescription as the pharmacy had not supplied this sheet in error. All patients had as needed protocols with their medicines records giving information to staff of when and how as needed medication should be given.

Patients receiving medicines covertly had comprehensive plans in place detailing this and nurses were aware of who was receiving medicines covertly and how these were to be administered.

The clinic room was clean and tidy. Medicines were stored appropriately, including refrigerated medicines, and fridge temperatures were checked daily. The room temperature was monitored and air conditioning was used to ensure medicines were stored at room temperatures. There had been building work undertaken recently to convert a larger room into a clinic room. Nurses felt there would be an advantage in terms of space to see patients and for them to receive medicines from the clinic room rather than having medicines taken to them.

Audits in relation to consent to treatment documentation were being undertaken regularly. A monthly medicines administration audit was also being completed with clear actions identified and taken.

A new form had been devised to identify actions needed from the responsible clinician to the GP, for example, when medication doses were changed or medicines stopped.

Reporting incidents and learning from when things go wrong

At the last inspection, there had also been concerns raised regarding investigations following serious incidents, which was highlighted within the same warning notice.

We were able to review completed investigations which clearly identified the scope of investigation, outcomes and actions needed, together with timescales for completion of actions. Actions had been completed within timescales.

One investigation had been undertaken relating to the previous use of rapid tranquillisation in the service and actions identified had been taken. There was evidence within this of compliance with the duty of candour requirements, with letters sent to the patient and family explaining the mistakes and apologising and a meeting held with family to discuss the outcome of the investigation.

Are wards for older people with mental health problems effective?
(for example, treatment is effective)

This was a focused inspection relating to issues identified at a previous inspection and where warning notices were served. Ratings have not been given for this inspection.

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

At the previous inspection, we had issued a warning notice regarding the care of informal patients. We were concerned that informal patients had restrictions placed upon them, including enhanced observations. We were concerned that informal patients were not being made aware that they were not subject to detention despite capacity assessments in their case files. Informal patients were unable to leave the building unaccompanied.

At this inspection, we saw care plans had been reviewed to reflect informal status.

Informal patients were not being nursed on enhanced observations.

Wards for older people with mental health problems

Detailed capacity assessments had been undertaken.

Leaflets had been devised explaining informal status for patients. Informal patients had been given these and staff had gone through them with patients. There were regular discussions regarding informal status recorded in the clinical notes.

We saw evidence in care plans patients had seen these and been involved in these, including comments and signatures.

Are wards for older people with mental health problems caring?

This was a focused inspection relating to issues identified at a previous inspection and where warning notices were served. Ratings have not been given for this inspection.

This domain was not inspected at this inspection.

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

(for example, to feedback?)

Listening to and learning from concerns and complaints

At the previous inspection, we were concerned that the hospital complaints procedure was not being followed; investigations had not been completed and follow up actions had not been completed, the paper records and electronic records were not consistent with information stored. The hospital was not meeting the timescales set out within their policy. At this inspection, we saw evidence that complaints were now being collated centrally, along with whistleblowing and compliments. These were being addressed in line with the policy for complaints. Investigations were being completed and actions achieved within the timescales of the policy.

We were able to look at several complaint files to see how these had been addressed and all expected documentation was available to review.

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

This was a focused inspection relating to issues identified at a previous inspection and where warning notices were served. Ratings have not been given for this inspection.

This domain was not inspected at this inspection.