Sherwood Lodge Independent Healthcare

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Requires improvement
Are services caring?	Good
Are services responsive?	Requires improvement
Are services well-led?	Requires improvement

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

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

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

Summary of findings

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

Overall summary

We rated Sherwood Lodge Independent Mental Healthcare as requires improvement because:

- fixtures and fittings were in need of attention. Floors in some areas were slippery following cleaning during our visit and staff had recorded a high level of slips and trips through incident reporting
- staff documented and monitored risks poorly. This was particularly for patients detained under the Mental Health Act 1983 where a higher level of monitoring and risk management would be expected. There was no systematic means of recording risk or mental state when patients took or returned from daily Section 17 leave as the home had an open door policy
- male and female sleeping areas were not segregated in accordance with Department of Health guidance on same sex accommodation. Although a bathroom separated the genders they were in very close proximity on the upper floor.
- The provider were not providing statutory notifications of abuse or allegations of abuse to the Care Quality Commission
- There was very little acknowledgement of the potential for dignity to be compromised. Some windows facing an outside smoking area had open curtains. This displayed room contents and personal belongings
- the service had not updated all its policies and procedures in line with the revised Code of Practice related to the Mental Health Act 1983 so compliance with the Act was poor, including patients being allowed leave without daily risks or mental state being documented
- there was no formal governance framework or system to make sure staff learned lessons following investigation of incidents of harm or risk of harm.
- the risk register was very limited. It did not address operational or environmental risks.

However,

- we observed staff engaging in warm, caring and kind interactions with patients and staff appeared to be genuinely concerned for the welfare of their patients
- staff showed very good understanding and knowledge of the patients including individual risks
- We were told there was a good relationship with the community and management plans were in place with the police
- patients were able to raise issues and were involved in house meetings. Feedback from patients and carers was generally positive
- there was access to the acute mental health ward if patients experienced deterioration in mental state
- there were efforts made to provide a homely environment and atmosphere. Patients could access quiet areas in the home away from communal areas to relax if they wished
- we saw a full activity programme timetable. During our inspection we saw patients joining in with activities such as foot spas and artwork. Staff we spoke with were enthusiastic about their activity programme
- staff morale appeared good. Staff told us they enjoyed their work and were able to contribute to the service.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Requires improvement 	

Summary of findings

Contents

Requires improvement

Services we looked at
Long stay / rehabilitation

Summary of this inspection

Background to Sherwood Lodge Independent Healthcare

Sherwood Lodge is an independent mental health hospital in Weston-super-Mare, Somerset, which specialises in long-term treatment and management of adults with mental health disorders, some of whom may be detained under the Mental Health Act 1983.

The service is mixed sex and provides 24-hour residential care for up to 24 patients and aims to provide a homely setting. The service believes patients should receive care that focuses on them, emphasises their strengths and promotes their autonomy and independence.

Sherwood Lodge also provides treatment and support for people with long term, complex mental health needs.

Our inspection team

Team leader: Susan Bourne, CQC inspector

The team that inspected the service comprised a CQC inspector, a CQC inspection manager and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this service as part of our on-going 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?

Before the inspection visit, we reviewed information that we held about the hospital and asked a range of other organisations for information.

During the two days of the inspection visit, the inspection team:

- visited Sherwood lodge, looked at the quality of the environment and observed the care being provided for patients
- spoke with five patients using the service
- spoke with the clinical manager
- spoke with five staff members, including staff nurses and healthcare assistants
- received feedback about the service from stakeholders including commissioners, care co-ordinators, advocacy staff and the police
- spoke with two family members
- looked at the care and treatment records of eight patients, seven of whom were detained under a section of the Mental Health Act
- carried out a specific Mental Health Act review of the service
- looked at policies and procedures relating to the running of the service.

Summary of this inspection

What people who use the service say

Feedback from people using the service was generally positive. Patients told us they were happy in Sherwood Lodge and were treated with respect. However, three patients told us they did not feel safe in the environment.

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

We rated safe as requires improvement because:

- the environment provided some risks to patients with reduced mobility due to steps leading to some rooms. There were fixtures and fittings requiring attention and floors in three toilets were very slippery following cleaning. Incident forms we saw highlighted a high level of slips and trips. We raised this straight away with staff.
- the provider was not reporting abuse or allegations of abuse to the Care Quality Commission when concerns were reported to the local authority safeguarding team.
- documentation of risk on a day to day basis was poor. Particularly for those patients detained under the Mental Health Act 1983 where a higher level of monitoring and risk management would normally be expected. There was no systematic means of recording or documenting presenting risk or current mental state when patients took Section 17 leave as the home had an open door policy.
- male and female sleeping areas were not segregated in accordance with Department of Health guidance on same sex accommodation. At the top of the right hand staircase some bedrooms used by men were very close to a bedroom for a woman. This was also a breach of the respect and dignity principle of the Mental Health Act revised Code of Practice paragraphs 1.13 to 1.14.

However:

- medicines management within Sherwood Lodge was acceptable. Nursing staff were knowledgeable about administration and storage of medicines.
- all staff knew the patients and their individual risks very well and reported any changes in mood and mental state verbally to the nurses and management daily. Some patients had been in the hospital for a long time and staff were able to predict patterns in behaviour and the location of a patient on leave.
- Sherwood Lodge told us they had a good supportive relationship with the local community. They also had management plans in place with the local police for when a patient went absent without leave.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

Summary of this inspection

- the service had not updated all its policies and procedures in line with the revised Code of Practice related to the Mental Health Act 1983 so compliance with the Act was poor. Patients were taking leave without daily risks or mental state being documented or monitored.
- The service was not ensuring responsible clinicians were undertaking risk assessments or putting in place any necessary safeguards prior to authorising Section 17 leave.
- staff had knowledge of the Mental Capacity Act but were not checking patients' capacity to make decisions about their care consistently. We saw a decision was respected in accordance with principle three of the Mental capacity Act however there was no documentation to show how this decision had been reached.

However:

- all patients had a care plan. We saw physical and mental health needs were being treated equally.
- patients had good access to specialist services outside of the remit of Sherwood Lodge.

Are services caring?

Good

We rated caring as good because:

- we observed warm, caring and kind interactions during our inspection. The staff appeared to be genuinely concerned for the welfare of their patients.
- staff demonstrated a good understanding and knowledge of the patients needs.
- patients were able to raise issues and were involved in house meetings. Feedback from patients and carers was generally positive.

However:

- three patients told us they did not feel they were treated by staff with respect and that they were not spoken to kindly. However we did not observe this at the time of our inspection.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- there were ground floor bedrooms facing the outdoor smoking area. The curtains were open displaying personal belongings compromising privacy and dignity.

However:

Summary of this inspection

- there was access to the acute mental health ward if patients experienced deterioration in mental state.
- efforts were made to provide a homely environment and atmosphere. Patients could access quite areas in the hospital away from communal areas to relax if they wished.
- we saw a full activity programme timetable. During our inspection we saw patients joining in with activities such as foot spa's and artwork. Staff we spoke with were enthusiastic about their activity programme.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- there was no clear clinical governance framework. This meant there was no formal system in place to ensure learning from incident reporting took place or quality of service was improved.
- Incidents and clinical governance issues were discussed between the clinical manager and registered manager. there was no clear documentation or on-going sharing of outcomes of these available.
- the risk register was extremely limited with only one strategic risk and no operational risks.

However:

- staff morale appeared good. Staff we spoke with told us they enjoyed their work and were able to contribute to the service.

Detailed findings from this inspection

Mental Health Act responsibilities

- There were nine patients subject to the Mental Health Act at the time of our inspection.
- Training around the Mental Health Act had been provided for all qualified staff from an external agency. Training records showed that only one member of staff had received training on the revised code of practice. We were told this was due to attendance not being logged prior to staff taking their certificates home.
- Sherwood Lodge had a copy of the revised Mental Health Act code of practice. Staff we spoke with had an understanding of the Mental Health Act and the code of practice. However all the expected new and updated policies required by the revised code of practice had not been put in place within Sherwood Lodge.
- Assessments of capacity to consent to treatment were being completed at regular intervals.
- We could not find sufficient evidence that, before authorising Section 17 leave the responsible clinician was undertaking a risk assessment, or had put in place any necessary safeguards.
- Records showed that rights under Section 132 of Mental Health Act had been presented on admission and re-presented in line with the code of practice guidance.
- There were no approved mental health practitioners reports found in the files of two out of six patients files looked at by the Mental Health Act reviewer. The clinical manager told us these would be located and placed in patients current files alongside the other statutory documents. All other detention documents scrutinised were in order and available.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff received training in the Mental Capacity Act. Staff we spoke with had a knowledge of its five principles. However, in patient records this was not clearly reflected.
- There was one Deprivation of Liberty Safeguard (DoLS) application made on 19 October 2015 awaiting assessment.
- We were told by staff that most of the patients within Sherwood Lodge possessed mental capacity.
- We saw staff supporting patients to make decisions about their day-to-day care and respecting their choices. However, where there was deemed an 'unwise decision', for example, choosing to go outside in slippers in the rain, we could not establish where this decision was assessed under the Mental Capacity Act or documented in a care plan.
- Staff were clear they could access support and information from the local Mental Capacity Act/DoLS office of the local authority. The clinical manager was in the process of liaison with the MCA/DoLS manager regarding the recent DoLS application.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

Are long stay/rehabilitation mental health wards for working-age adults safe?

Requires improvement

Safe and clean environment

- Sherwood Lodge had various blind spots throughout the building and outside area. There were no mirrors to mitigate this.
- There were potential ligature points identified in every room including patients bedrooms and bathrooms, which they had unsupervised access to. there were potential ligature risks on doors, windows, handles, taps, rails and radiators. There was also a bathroom at the top of the stairs with a radiator cover that was broken with jagged edges. We spoke about risk mitigation with the clinical manager who informed us they do not accept high risk patients and that Sherwood Lodge's philosophy was to provide a homely atmosphere and environment for low risk patients.
- The bedrooms did not have ensuite facilities. There were three showers and nine toilets in total. Male and female sleeping areas were not segregated. At the top of the right hand staircase male bedrooms were located very close to a female bedroom.
- There was a female only lounge accessed by the rear courtyard. This was in use throughout our inspection.
- There was a clinic area which was small and acted as a thoroughfare to an office and staff room. There was no examination couch or emergency resuscitation equipment though not strictly necessary. There was emergency oxygen which had been checked regularly. There was a portable suction machine and blood pressure monitor.
- there was no seclusion facility as Sherwood Lodge did not practice seclusion due to the nature of the patient group.
- The communal areas were clean and had new furniture in the lounges. There were three tiled floors in the toilets that were very slippery after cleaning. Three toilet cisterns were poorly maintained and two had missing flush buttons and there was no hot water in the staff toilet. We raised these issues immediately with the manager on the day to be remedied.
- There was no lift, so the upstairs sleeping areas were only accessible by stair. We saw those patients with mobility problems did not have bedrooms in the upstairs area of the home.
- There were a number of trip hazards, The building had some uneven flooring and internal steps. There was also some narrow passageways. Three patients told us they had difficulty moving around the house and did not feel safe. We looked at the last 10 days of incidents reported. Six out of 12 had identified slips or trips.
- There was a cleaning roster in each area with that days date completed. Staff we spoke with were able to tell us infection control principles and demonstrated knowledge about this.
- There were no environmental risks identified on the risk register.
- Each room, toilet and shower had a nurse call system.

Safe staffing

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Within Sherwood Lodge there was a total of 22 permanent staff, clinical and non-clinical; with seven leavers over the last 12 months.
- There were 6 qualified nurses and 9.6 nursing assistants.
- There was a 0.7 nursing assistant vacancy.
- There were no qualified nurse vacancies.
- There was 1% staff sickness overall.
- Eight shifts had been filled within the last three months by bank staff. The bank staff were sourced by the permanent staff within the home. Sherwood Lodge had their own well established bank system.
- Staffing levels could be adjusted if needed and agreed through the manager. We observed that patients were provided activities supported by staff. The activities timetable and staffing had been set around this. Core staffing during the day consisted of one registered mental health nurse and three healthcare assistants.
- Staff and management told us that there was always an experienced nurse in communal areas at all times. We saw a nurse present at all times during our inspection, and the staff rotas demonstrated a qualified nurse in the numbers at all times.
- However two family members we spoke with told us they did not feel there was always enough staff on duty. They did not specify a reason for this and we had no concern with staffing levels at the time of our visit.
- All patients were registered with a local general practitioner.
- All staff had received training in safeguarding, first aid, fire marshalling, manual handling, non physical management of aggression training, food hygiene, MCA/ DoLS, Mental Health awareness, medicines management and care certificate. The training was provided by a new provider. We saw there were certificates in staff files.
- The clinical governance meeting minutes dated 5 March 2015 reported that staff training was discussed within the staff development section. It noted that staff were keen on workbooks rather than e-learning. Medicines management was noted as a high profile learning area. This had been an area of concern during the last inspection. Further minutes dated 02 June 2015 noted a new training package had been purchased and a training day had been reported as success. All current staff had completed first aid, non-abusive psychological and physical interventions (NAPPI), fire and manual handling.

Assessing and managing risk to patients and staff

- Sherwood Lodge did not use seclusion or segregation. There were no episodes of restraint.
- All patients records reviewed had a risk assessment.
- Risks assessments within care plans had been updated, although in some cases this only constituted a new date and a tick.
- There was no system for recording the time any patient left the house or for checking on a regular basis who was in the building. We were told by the clinical manager this would be contrary to the 'open door policy' and she could rely on the staff to know when patients left the building. Staff we spoke with told us risk assessments or mental state were not systematically taken or written down prior to any patient taking leave. We saw an entry about risk in the patient record was only made if there was a problem. We saw little evidence that outcome of leave was being assessed or recorded on return by staff.
- We observed that staff were present in communal areas and were able to tell us about individual patients' risks. We were told if they believed the mood of a patient had deteriorated they would offer to accompany them on leave. Staff on the day would be relied on by the senior staff and management to observe when a patient left instead of keeping records.
- Three out of the six of the detained patients' records had up to eight hours unescorted leave per day. This meant that potentially vulnerable patients were able to leave the home without staff knowledge.
- Our Mental Health Act reviewer noted a Mental Capacity Act assessment had been conducted for a patient in June 2015 which concluded they 'lacked capacity to consent to treatment'. The responsible clinician had granted eight hours daily unescorted leave. The patient's records also identified delusional thoughts. Although the term 'lacked mental capacity to consent to

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

treatment' was not specific to Section 17 leave, we would have expected brief decision specific risk and mental state assessment before and on return from any Section 17 leave to be taken and documented.

- We were told that when a patient went absent without leave procedures were followed and the police contacted if required. Sherwood Lodge had a good relationship with the local police missing persons coordinator with whom management plans had been agreed.
- There was a policy for the use of observation however this was not shown to the inspectors at the time of the visit. Staff did not document or have a checklist of patients whereabouts throughout the day or night.
- All staff had received training in safeguarding procedures. Staff we spoke with demonstrated knowledge of what constituted abuse and the correct procedure for making referrals.
- However, following the inspection visit we were advised that between 9 July 2015 and 6 January 2016 there was nine safeguarding concerns raised by police and health staff. The service did not inform the Care Quality Commission of these.
- At our last inspection Sherwood Lodge received a compliance action due to concerns around medicines management. As a consequence we thoroughly reviewed the current systems and were satisfied practice had improved. As a result the action was lifted.
- Staff we spoke with demonstrated knowledge about pressure area management. all patients on admission were assessed for risk of pressure sores and periodically checked and monitored throughout their stay. Sherwood Lodge had access to the local tissue viability service for advice and support.
- A child visiting policy was in place.

Track record on safety

- There were no serious incidents recorded in the last 12 months.

Reporting incidents and learning from when things go wrong

- Sherwood Lodge had a paper based incident reporting system. Incidents were reported using an incident and accident book. The clinical manager and registered manager told us they reviewed incidents on a quarterly basis. We asked to see examples of these reviews and were told there were none available at the time of the inspection.
- We looked at the untoward incidents, policies and procedures guidance. This had not been updated since August 2005.
- We looked at incidents recorded in the 10 days leading up to our inspection. We saw there were 12 incidents between 23 October and 3 November 2015, six of which were slips or trips. Two were choking episodes, three were threats or physical aggression and one person slid off a chair in the community.
- We did not see evidence of change being made as a result of learning from incidents being reported.
- However staff we spoke with felt supported by managers following incidents and were offered a debriefing.

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Are long stay/rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

- Patients were assessed prior to admission by the clinical manager. She told us this was to make sure patients met the criteria of low risk rehabilitation for admission to Sherwood Lodge. Once admitted they were monitored over the first three months and the placement reviewed leading to plan of care.
- Sherwood Lodge actively excluded people who were a suicide risk or had a high propensity towards violence at the time of assessment.
- We found a full physical health check was conducted on admission and physical health monitoring was done monthly. In addition an annual health check was undertaken. More complex physical needs were addressed via the local acute hospital.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- Care records were not consistent. Some care records we reviewed lacked detail and some did not have a clear recovery focus. Some did not reflect either the person's individual needs or preferences.
- there were clear gaps in documentation and whether care plans were shared with all the patients reviewed.
- Information was stored using paper records and kept on a shelf in the office which could be locked.

Best practice in treatment and care

- Medication was prescribed by either the patients' general practitioner or the responsible clinician. Neither was employed by Sherwood Lodge. Three consultant psychiatrists from the mental health trusts shared responsibility for patients. A local pharmacist attended the home fortnightly and offered advice.
- Patients had to access specialist nursing services when required. For example tissue viability, bladder and bowel services and district nursing. This also included specialist support and advice from dieticians if required.
- We did not see any evidence of recognised rating scales used to assess and record outcomes. In the last six months we did see a medication management audit and clinical notes audit had been undertaken.

Skilled staff to deliver care

- Sherwood lodge only employed qualified nurses or nursing assistants. In order for patients to access other mental health disciplines, these would be arranged through the Sherwood Lodge.
- Staff received a local induction organised by the clinical manager. This included accessing training from an external provider.
- Staff received formal supervision every three months. They could access informal supervision outside of these times if they requested it.12 staff had commenced employment in the last year so only ten staff had received appraisal.
- Staff had monthly team meetings.

Multi-disciplinary and inter-agency team work

- Care co-ordinators from the two mental health trusts would attend Sherwood Lodge to review their patients. Staff told us attendance by consultant psychiatrists was variable throughout the year. Care co-ordinators would be from Somerset Partnership NHS trust or Avon and Wiltshire Partnership NHS trust.
- Handovers occurred each morning and evening when staff worked day long shifts. We saw a handover log which detailed patient activity during the previous shift. Handovers would be three times a day when working shorter shifts. However during inspection staff were on long day shifts.
- There were relationships with teams outside of Sherwood Lodge. For example quarterly liaison meetings with the police where relevant Mental Health Act and safety issues were discussed.

Adherence to the MHA and the MHA Code of Practice

- There were nine patients subject to the Mental Health Act 1983 (MHA) at the time of our inspection.
- Training around the MHA had been arranged for all qualified staff from an external agency.
- Sherwood Lodge had a copy of the revised Mental Health Act code of practice. Staff we spoke with had an understanding of the Mental Health Act and the code of practice. However training records showed only one member of staff had received training around the revised code of practice. The clinical manager told us she did not believe the new and updated policies required by the revised code of practice had been put in place within Sherwood Lodge.
- Assessments of capacity to consent to treatment were being completed at regular intervals. We were unable to check in three out of six files whether the responsible clinician had recorded their assessment of consent.
- We could not find sufficient evidence that before authorising Section 17 leave the responsible clinician from the admitting NHS trust was undertaking a risk assessment or had put in place any necessary safeguards.
- Records showed that rights under Section 132 of the Mental Health Act had been presented on admission and re-presented in line with the code of practice guidance.
- There were no approved mental health practitioner reports found in the files of two out of six patients files looked at by the Mental Health Act reviewer. The clinical

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

manager told us these would be located and placed in patient's current files alongside the other statutory documents. All other detention documents scrutinised were in order and available.

- There was no evidence to show that all existing policies had been updated or new policies related to the new code of practice were put in place.

Good practice in applying the MCA

- All staff received training in Mental Capacity Act 2005 (MCA). However within the patient records we saw a lack of time or specific decisions documented.
- There was one Deprivation of Liberty Safeguard (DoLS) application made on 19 October 2015 which was awaiting assessment. Whilst waiting for the DoLS assessment there was no clear management plan in place.
- We saw people were supported to make decisions around their day to day care and choices were respected. However where there was deemed an 'unwise decision' for example, choosing to go outside in slippers in the rain, we could not establish where this decision was assessed under the Mental Capacity Act or documented in a care plan.
- Staff were clear they could access support and information from the local Mental Capacity Act/DoLS office of the local authority. The clinical manager was in the process of liaison with the MCA/DoLS manager regarding the recent DoLS application.

Are long stay/rehabilitation mental health wards for working-age adults caring?

Good

Kindness, dignity, respect and support

- We saw staff demonstrated kindness and concern for the welfare of their patients at all times. We observed interactions between staff and patients that were respectful and discreet.
- We spoke with five patients receiving care at Sherwood Lodge. Four of whom were detained under the Mental Health Act. Three of the patients were very positive about their care and the staff at Sherwood Lodge. The negative comments made were they felt they should be moving on more quickly to the community.
- Three out of five patients we spoke with complimented the food and menu choices.
- Patients we spoke with told us they enjoyed trips out to the community. They also told us they had been supported to access courses run at the local education and training centre.
- However three patients we spoke with told us they were not spoken to with respect, were sometimes ignored and sometimes staff were not kind. however we did not observe this during our inspection.
- Staff we spoke with demonstrated a good level of understanding of the individual needs and preferences of the patients in Sherwood Lodge. Staff spoke warmly and positively about them at all times.
- We received feedback from a share your experience form prior to inspection from a relative. They highlighted the high quality care for their relative and stated that their relative had been involved in their plans of care and had choice in activities.
- Sherwood Lodge carried out a staff survey in June 2015. Action points identified ways resident experience could be optimised by monitoring of staffing levels, more efficient use of the rota and training. We also saw a community meeting action plan. This demonstrated that resident wishes had been actioned with regard to access to drinks and increased activities.

The involvement of people in the care they receive

- We were told by the clinical manager that Sherwood Lodge aimed to provide a least restrictive environment which focussed on the strengths of patients. We saw care plans which focussed on the individual. However no patient we spoke with could tell us they had been offered a copy of their leave or care plan.
- Community meetings took place monthly. Patients could express their views and suggest improvements. We saw minutes which identified improvements made. Copies of the minutes were available in communal areas.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- We saw that files contained 'about me' leaflets. Four out of the files we looked at contained patients own views and in their own words.
- Sherwood Lodge told us they had access to two advocacy providers, SWAN advocacy and 1in4 People. We saw leaflets on display for both.
- When we spoke with both services 1in4 people told us they were funded through the North Somerset council supporting people programme. they had only been asked to provide support on a few occasions. SWAN support one patient in Sherwood Lodge.
- We spoke with two family members of patients using the service. They reported they were generally happy with the support given to their relatives, and felt they were involved in their care.

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Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?

(for example, to feedback?)

Requires improvement

Access and discharge

- There was a mean bed occupancy of 92% for the period between 06 April and 05 October 2015. At the time of our inspection there were 22 residents out of 24 beds. Nine residents were subject to the Mental Health Act (1983) and one was on overnight leave. When a patient was on leave their bed was always available on return.
- The clinical manager told us some detained patients were discharged on to a community treatment order. Discharge would be straight into community accommodation. We saw only limited active discharge planning in the records.
- Deterioration in a patient's mental state would result in admission to a mental health acute ward. Sherwood Lodge did not admit patients requiring a high level of risk or acuity. In the last year two patients had required admissions to the local acute admission ward.

The facilities promote recovery, comfort, dignity and confidentiality

- The outdoor space had a covered smoking area plus table tennis, and a barbeque. It was paved with no grass or flower beds. There were ground floor bedrooms looking to the outdoor area. If the curtains were open personal belongings could be seen. We raised this at the time of inspection, and were told it was patient choice not to close their curtains. However, despite this no safeguards had been considered for the potential of any compromise patient's of dignity.
- Sherwood Lodge had quiet areas where patients could be alone or sit with visitors. There were two large lounges at the front of the house. One with a pool table and an electronic game machine and one with a television.
- There was a payphone for residents use in a hallway. This was not working on the day of inspection however we were told patients were able to use the office phone.
- There were positive comments in regards to food hygiene at Sherwood Lodge by patients. In June 2012 they were awarded a Food Hygiene Rating of 5 (very good) by North Somerset Council.
- We saw bedrooms were personalised. There were two double bedrooms separated by a partition. One room was occupied by one patient, whilst the other was shared by two patients who the clinical manager told us had shared a room for a long period of time.
- We saw a full activity programme timetable. During our inspection we saw patients joining in with activities such as foot spa's and artwork. Staff we spoke with were enthusiastic about the activity programme and their contribution to it.

Meeting the needs of all people who use the service

- Sherwood Lodge had been converted from two large Victorian houses. Although we were told by staff each was mainly used by women or men, we found they were mixed. a woman's bedroom was on the same corridor upstairs as some men. Patients with identified mobility problems had been given bedrooms on the ground floor.
- There was no disabled access however an adjustment had been made to lower one of the high steps to allow access. There was no risk assessment or contingency plan in place in case of any further deterioration of patients with already reduced mobility.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- We saw several notice boards displaying information for patients and carers. This included information on how to access an advocate.

Listening to and learning from concerns and complaints

- Sherwood Lodge had reported to us prior to the inspection that they had an 'open culture in managing complaints and concerns and aim to learn from any'. They further described a culture of clarity, openness, review and monitoring of any complaints.
- We were informed there were no formal complaints made against Sherwood Lodge. However in the clinical governance meeting minutes dated 05 March 2015 one complainant was identified in the complaints section. It was noted as a written complaint of 'delusional content' which was shown to the care co-ordinator and responded to politely in writing.
- A 'friends and family survey' was being carried out. All the results were not available at the time of our inspection.

Are long stay/rehabilitation mental health wards for working-age adults well-led?

Requires improvement

Vision and values

- Staff we spoke with knew the values and vision of Sherwood Lodge. They were clear on the aims and objectives, particularly around promotion of independence and autonomy day to day.
- We looked at staff meeting minutes which reflected these values.

Good governance

- Mandatory training had been arranged by the Sherwood Lodge management team. We saw a training matrix with completion dates of training. However there was evidence of attendance of only one member of staff for the Mental Health Act training. We were told the staff had taken their certificates home before attendance was logged. The clinical manager had not ensured these were logged prior to staff taking them home.
- 10 appraisals had been completed in the last year out of a workforce of 22. 12 of the staff were new starters and not yet required an appraisal.
- Staffing levels were managed well and all shifts covered. There was always a registered nurse on duty, day and night.
- We saw incident reporting was taking place using a paper based system. However we saw there was no formal governance framework in place to ensure learning from incident reporting took place. Incidents and clinical governance issues were discussed between the clinical manager and registered manager and we saw some documentation of these meetings. However, there was no action plans or dissemination of outcomes identified from these meetings.
- We were shown a quality assurance framework outlining Sherwood Lodge's approach to quality monitoring. This included use of audit, hearing views of people using the services, reporting, visits and meetings. However, from the evidence we saw we could not see how this was measured or managed.
- We were shown a medicines management audit from June 2015, a general clinical audit from April 2015, a food audit from September 2015. We also saw staff meeting minutes from June 2015 and a house meeting minutes from July 2015. Although this was good practice it lacked the quality of measurement expected for monitoring people detained under the Mental Health Act 1983.
- Policies and procedures had a review date indicated but had not been amended or updated. There were no new policies associated with the updated MHA code of practice which was introduced in April 2015.
- Staff were clear on safeguarding procedures and were able to tell us what constitutes abuse.
- We were shown a strategic risk register. This identified action to be taken in the event of loss of buildings or loss of contracts/commissioning or funding cuts. There were no risks containing he environmental or personal risk to patients. Staff told us they were able to raise risks but did not contribute to a risk register.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Leadership, morale and staff engagement

- We were told by there were no concerns around sickness and absence rates in Sherwood Lodge. Staff we spoke with told us they felt able to raise concerns without fear, and all reported good staff morale. We saw the staff team working together well during our inspection.
- Staff we spoke with told us they knew the whistleblowing process.
- We saw in staff meeting minutes that staff were able to contribute to the service and offered suggestions for improving patient care.

Commitment to quality improvement and innovation

- Sherwood Lodge did not use improvement methodologies. There were no examples of innovative practice or involvement in research.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

The provider must ensure that:

- action takes place to ensure all rooms are private and privacy and dignity is maintained at all times
- all statutory notifications of safeguarding concerns or alerts are made to the Care Quality Commission
- they meet the Department of Health same sex accommodation guidelines.
- the hospital is safe for all patients, particularly those with reduced mobility, and that fixtures and fittings are in good working order
- risk management is robust, risks are reviewed regularly, and risk and capacity assessments of patients are conducted and recorded in relation to Section 17 leave
- policies and procedures under the Mental Health Act revised code of practice are current and available
- a current and relevant register of operational risks is kept, with clear timeframes for actions.

Action the provider SHOULD take to improve

The provider should:

- All care records reflect patients' individual views and preferences, including recovery and discharge plans
- all staff have a good knowledge and understanding of documentation around the Mental Capacity Act and its principles.

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 15 HSCA (RA) Regulations 2014 Premises and equipment Patients and others were not being protected against risks associated with unsuitable premises. There were fixtures and fittings in need of maintenance, including flooring and toilets. This was in breach of Regulation 15(1)(c)

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 Patients detained under the Mental Health Act 1983 were not being protected against the risks associated with unsafe care and treatment. The provider was not ensuring risk or mental state of patients taking daily Section 17 leave were monitored or documented before or after return from leave. This was in breach of Regulation 12 (1)(a)(b)

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 17 HSCA (RA) Regulations 2014 Good governance The provider was not creating or maintaining an up-to-date risk register with clear actions. The hospital did not have all policies related to the Mental Health Act amended code of practice. This was in breach of Regulation 17 (1)(2)(a)(b)(f)(

This section is primarily information for the provider

Requirement notices

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 10 HSCA (RA) Regulations 2014 Dignity and respect Patients were not being protected against the compromise of their dignity and respect. Some patients' rooms and belongings were clearly on display and could be seen from the outside. Patients upstairs were in very close proximity and not segregated by gender. This was in breach of Regulation 10(2)(a)(b)

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 18 CQC (Registration) Regulations 2009 Notification of other incidents The service was not notifying the Care Quality Commission of abuse or allegations of abuse in relation to service users This was in breach of Regulation 18 (1)(e)