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

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.

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 Castle Lodge Independent Hospital as **good** because:

- The stages of the admission process were available to referrers, patients and their relatives and staff were involved in a pre-assessment to ensure the hospital could meet the needs of the patient. Following a twelve week assessment period that included two formal review meetings, treatment plans were agreed which showed targets for progression in recovery.
- Assessments completed after admission were comprehensive, timely and informed care planning. Care plans were personalised, recovery focussed and used patients' chosen name. Care plans records were relevant to individually identified needs and showed evidence of regular review.
- Staff engaged with patients in a respectful manner and offered reassurance and support to patients who were showing signs of distress. Patients told us they felt safe at the hospital, that staff were always nearby and treated them well. Carers' spoke of their loved ones being happy and that the care they saw was good.
- Staff were clear about the need to safeguard vulnerable adults in their care and saw safeguarding as everyone's responsibility. We found positive communication between the hospital and the local safeguarding authority.
- Staff knew their responsibility to be open and explain to patients if something went wrong. The carers we spoke with were confident the patients and themselves would be contacted if anything untoward happened. We saw the duty of candour policy followed at the hospital.
- Staff received regular clinical and managerial supervision that they reported as being both challenging and supportive. The staff compliance rate for supervision was 100%.
- The staff we spoke to were committed to their work and wanted to deliver patient care that was the best it could be. Staff spoke of being supported by the hospital manager and the senior managers in the organisation who they knew.
- Staff received regular training and appraisal that supported their development. Against provider target of 85%, the hospital showed staff training compliance of 95% and compliance with appraisal was 89%.
- Staff felt able to raise concerns without fear of victimisation, they knew about the organisations whistleblowing policy, and that they could contact external organisations to report concerns.

However,

- We found issues with safe systems in the management of medicines that were not identified in the hospital's regular medicines audits. Not all staff involved in administrating medication worked to hospital protocols, there were discrepancies in medicine stock levels and medicines were not all disposed in a timely way. Whilst agreed following capacity assessments and best interest meetings, the administration of covert medication did not always follow consultation with a pharmacist, nor was it regularly reviewed in multidisciplinary team meetings.
- Barchester consultant psychiatrists that provided on-call cover for the hospital when the locally based consultant was on leave may not be able to attend in the event of a psychiatric emergency within 30 minutes. The Royal College of Psychiatrists accreditation standards for inpatient older adults mental health November 2014, state that an identified duty doctor should be available to attend within 30 minutes in the event of a psychiatric emergency.
- Whilst wide enough for a wheelchair to pass through, the door into the garden from the female lounge was not wide enough for a patient to propel herself with their hands on the wheels of the chair.
- The hospital had no dedicated space for therapeutic activity. Activities took place in communal lounges, dining areas and the garden.

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	

Summary of findings

Contents

Good

Castle Lodge Independent Hospital

Services we looked at:

Wards for older people with mental health problems

Summary of this inspection

Background to Castle Lodge Independent Hospital

Castle Lodge independent hospital is a specialist independent mental health service based in Kingston-Upon-Hull. It is part of the Barchester hospital and complex care services division. Providing services for men with an organic diagnosis, a type of illness usually caused by disease affecting the brain, and women with a functional diagnosis, a type of illness that has a mainly psychological cause, on an informal and a detained basis. The hospital accommodates up to 15 patients.

The hospital is registered with the Care Quality Commission to carry out two regulated activities:

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

• Treatment of disease, disorder or injury

At the time of our inspection, there was a registered manager who was also the controlled drugs accountable officer for the hospital in post.

The Care Quality Commission has inspected Castle Lodge independent hospital six times; the last inspection was an announced comprehensive inspection that took place in February 2016.

Our inspection team

Our inspection team was led by Christine Barker, Care Quality Commission inspector

The team that inspected these services comprised of two Care Quality Commission inspectors, one assistant inspector and one specialist advisor pharmacist with experience of working in mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Castle Lodge Independent Hospital had made improvements following our last comprehensive inspection which took place in February 2016, where we rated the hospital as requires improvement overall.

This was an unannounced follow up inspection.

At the last inspection, we rated the hospital overall as 'requires improvement'. We rated the service 'requires improvement' for Safe, 'requires improvement' for Effective, 'good' for Caring, 'requires improvement' for Responsive and 'requires improvement' for Well-led.

Following that inspection we told the provider that it **must** take the following actions to improve Castle Lodge Independent Hospital:

- The provider must ensure a risk register is in place, to list, monitor and rate any identified risks across the hospital.
- The provider must ensure sufficient numbers of suitably qualified, competent, skilled and experienced persons are on duty to meet the needs of patients.
- The provider must ensure that medicines management systems are safe, clearly understood by staff and embedded into routine practice.
- The provider must ensure the development of a care pathway for all patients incorporates discharge planning.
- The provider must ensure that staff understand their individual responsibility in relation to the Mental Capacity Act 2005 and apply this in practice. A review of training, policy and application of the Act is required.
- The provider must ensure the systems in place to monitor training are robust so that staff complete mandatory and legislative training in a timely manner.
- The provider must review the systems and training that protect patients and staff from the risk of infection.

Summary of this inspection

- The provider must update both their policy and training to ensure compliance with the Mental Health Act Code of Practice that came into force in April 2015.

We also told the provider that it **should** take the following actions to improve Castle Lodge Independent Hospital:

- The provider should develop a clear evidence-based model of care.
- The provider should ensure the range of disciplines involved in care is wide enough to be effective in meeting the psychological and physical needs of patients.
- The provider should ensure patients receive support to maintain independent living skills.
- The provider should ensure that care plans are reviewed in an appropriate and effective way and the documentation in place is easy for staff to navigate.
- The provider should ensure that any expired medication in appropriate pharmaceutical waste bins is disposed of in a timely way in accordance with current legislation.
- The provider should ensure staff complete equality and diversity training.
- The provider should ensure where possible patients, their carers or an advocate take part in meetings where significant care decisions are made.
- The provider should ensure capacity to consent and best interest decisions are comprehensively completed and documented.
- The provider should ensure cover from the responsible clinician is available when a hospital patient requires admission or detention.
- The provider should ensure the process to agree advanced decisions is transparent, and includes the detail required when recorded.
- The provider should ensure structures are in place so staff and managers learn lessons from incidents or complaints.
- The provider should complete clinical audits to enable staff to learn from the results and make improvements to the service.

We issued the provider with five requirement notices, these related to:

Regulation 9 Health and Social Care Act (Regulated Activity) Regulations 2014

Person-centred care

Regulation 11 Health and Social Care Act (Regulated Activity) Regulations 2014

Need for consent

Regulation 12 Health and Social Care Act (Regulated Activity) Regulations 2014

Safe care and treatment

Regulation 17 Health and Social Care Act (Regulated Activity) Regulations 2014

Good governance

Regulation 18 Health and Social Care Act (Regulated Activity) Regulations 2014

Staffing

The provider submitted an action statement on 22 August 2016 setting out the steps they would take to meet the legal requirements of the regulations. We reviewed the requirement notices at this inspection and found that the hospital had addressed the actions agreed in relation to the specific breaches regulations 9(3)(a) 11(2), 12(2)(b)(g)(h) and 17(1) and 18(1).

However, in relation to regulation 12 (2)(g) whilst the provider had completed the actions previously identified we found other issues relating to the proper and safe management of medicines whilst on site.

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 this service and asked other organisations for information.

Summary of this inspection

During the inspection visit, the inspection team:

- visited both sides of the hospital ward, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with six carers of patients using the service
- collected feedback from eight patients and one carer using comment cards
- attended and observed a multidisciplinary meeting
- observed activities taking place and a mealtime on each side of the ward
- attended and observed the morning hand-over meeting
- interviewed the hospital director with responsibility for the service
- spoke with 15 other staff members; including an activities coordinator, administrators, catering, housekeeping, maintenance, nurses, psychiatrist, psychologist, support workers, the divisional lead nurse and the divisional director
- carried out a specific check of the medication management including all prescription charts
- reviewed seven care and treatment records of patients, including Mental Health Act paperwork where relevant
- looked at a range of policies, procedures and other documents relating to the running of the service
- reviewed three staff records of appraisal, disciplinary, supervision and training
- spoke with an external adult safeguarding social worker and a service commissioner.

What people who use the service say

We spoke with four patients, six carers and received eight comments cards.

The patients able to tell us about the service told us that staff treated them well and that with occasional exceptions when other patients showed distress, they always felt safe at the hospital. They could always see or easily find a member of staff. Patients knew which staff were their keyworkers and spoke with them about their care. Staff supported patients to attend regular meetings to review their care.

Patients liked the activities that took place regularly, and spoke of plenty to do within the hospital; particular favourites were baking and watching films. From patients who liked to go outside, we heard comments that they would like to be able to do this more often, this posed particular difficulties in the winter months for patients at high risk of falls. Carers saw the activities that did take place as enjoyable but commented that they could probably do with a few more. Staff supported specific celebrations, for example birthdays and anniversaries, involving families. Carers saw staff work with patients to ensure they went out when possible.

Comments about food ranged from okay to good, with special diets catered for. We were told they had quite a lot of choice but as the food was brought into the hospital by trolley, its quality varied. Snacks and drinks were available; however, patients told us they were dependent on staff to make these for them and two patients stated they would like to have made their own.

Patients were able to make their room their own. Carers liked the fact each patient had their own space within the hospital ward. Individual rooms were seen as safe and quiet. Each patient had a lockable drawer, when valuable items left by carers had been placed here they had remained secure.

Carers spoke of their loved ones being happy and that the care they saw was good. Staff knew the patients well and were described as being lovely to them. Carers commented that there were always staff always around and there seemed to be enough staff on duty. When agency staff were on duty they were regular so knew the patients, other staff and in some cases the carers.

The hospital kept carers informed of and invited to meetings where care and treatment were discussed. This had helped carers understanding, making them aware of diagnosis, treatment and likely progression. Carers spoke of their involvement in care decisions and best interest meetings. If unable to attend meetings, carers were updated by telephone. When discharge was discussed

Summary of this inspection

carers felt concerned about finding care this good elsewhere. This was exacerbated for carers of patients living with dementia who had an awareness that any change was likely to prompt a deterioration.

We heard from carers that visiting and calls to patients at the hospital were managed well. Visitors were welcomed at the hospital and when visiting was not possible, patients spoke to relatives on the telephone. Sometimes carers felt that the staff delivering immediate care had not listened if they made a suggestion or comment that might improve a situation. However, the nurse in charge and hospital manager had been responsive to any concerns raised. If a patient had fallen, or anything else happened similarly unexpected, carers were confident that they would be contacted.

Those who attended the carers' café meeting held on the last Friday of every month, experienced support from other carers and staff.

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:

- We found issues with medicines management including omissions in medicines record keeping that meant a clear and up-to-date record of medicines administered to each patient was not maintained. We noted a dispensing error that had not been detected by nurses when checking or administering the medication over the last two weeks. Surfaces within the clinical room showed traces of medication which posed a risk of cross contamination and there were discrepancies in medicine stock levels. We also raised concerns where patients were being covertly administered medication following capacity assessments and best interest meetings that in one case there was no evidence that a pharmacist had been consulted or that covert administration had been regularly reviewed as part of multidisciplinary team meetings. The medication safety alerts folder did not contain up to date information and it was not clear how alerts were cascaded to nursing staff.
- Barchester consultant psychiatrists that provided on-call cover for the hospital when the locally based consultant was on leave may not be able to attend in the event of a psychiatric emergency within 30 minutes. The Royal College of Psychiatrists accreditation standards for inpatient older adults mental health November 2014, state that an identified duty doctor should be available to attend within 30 minutes in the event of a psychiatric emergency.
- Trolleys containing dirty laundry were stored in bathrooms that were used by patients.

However,

- Individual and robust patient risk assessments were in place and regularly updated.
- Staff knew their responsibility to be open and explain to patients if something went wrong. Carers we spoke with were confident the patients and themselves would be contacted if anything untoward happened.
- The furnishings within the ward were clean comfortable and well maintained.
- Staff awareness of their responsibilities to report safeguarding was high and compliance with annual safeguarding training was 95%.

Summary of this inspection

Are services effective?

Good

We rated effective as **good** because:

- Assessments completed after admission were comprehensive, timely and informed care planning.
- Care plans were personalised, recovery focussed and used the patient's chosen name. Care plans were relevant to individually identified needs and showed evidence of regular review.
- Physical healthcare was a priority with early warning indicators for patients' health completed on a monthly basis.
- The training and development to ensure staff could work safely and effectively was a clear focus at the hospital.
- Staff received regular clinical and managerial supervision that they reported as being both challenging and supportive. The staff compliance rate for supervision was 100%.
- Staff attended regular meetings and felt able to contribute to discussions. Night staff felt informed by the hospital manager and clinical lead that came into work during their shift to discuss significant issues.
- Staff could explain the guiding principles of the Mental Health Act and the five principles of the Mental Capacity Act, and knew where to find further guidance if needed.

However,

- The hospital had had no occupational therapist in post for three months.
- Whilst a patient's capacity to consent was assessed and recorded, in two out of seven sets of notes capacity checklists were present but not fully completed.
- Whilst we saw that carers had been present and they told us they felt listened to at best interest meetings, the minutes within patient files did not always record the views of a patient's family or advocate.

Are services caring?

Good

We rated caring as **good** because:

- Staff engaged with patients in a respectful manner and they offered reassurance and support to patients who were showing signs of distress.
- Patients told us they felt safe at the hospital, that staff were always nearby and treated them well.
- Carers' spoke of their loved ones being happy and that the care they saw was good.
- Staff supported patients to attend their multidisciplinary team meetings.

Summary of this inspection

- Patients gave feedback at the weekly patient meetings and surveys each quarter. We heard about changes made following this feedback.
- Carers' spoke of feeling supported by the staff. A carer's café meeting held monthly offered support from staff and time with other carers.

However,

- Staff did not ensure that patients were offered reading glasses so that they could fully participate in an activity.
- Sometimes carers felt that the staff delivering immediate care had not listened to them.

Are services responsive?

Good

We rated responsive as **good** because:

- The stages of the admission process were available to referrers, patients and their relatives and staff were involved a pre-assessment to ensure the hospital could meet the needs of the patient.
- Following a twelve week assessment period that included two formal review meetings, treatment plans were agreed which showed targets for progression in recovery.
- Discharges involved patients and their relatives; staff planned and managed discharge carefully to ensure this happened as agreed. In the last year, no patient discharged from the service had been readmitted.
- Patients were able to personalise their own room; they had their own belongings in their room and felt their property was safe.
- Staff showed a commitment to patients staying in touch with family and friends. The service had open visiting until 7pm, including at mealtimes. If visiting needed to be arranged at a different time if appropriate for the patient this could happen.
- Activities took place seven days a week within the hospital and where possible, in the community. The activities co-ordinator made activity plans around their knowledge of individual patients; staff specifically linked to an individual patient's care regularly delivered these.
- Drinks and snacks were available 24hours a day, regular liaison between the staff and the kitchen ensured special diets were catered for. The head chef visited the ward once a month to serve from the trolley and chat with patients to get direct feedback about the food.

However,

Summary of this inspection

- Windows overlooking an internal courtyard from the male ward did not have privacy screening, so it was possible that patients in the courtyard of a neighbouring service could look into these rooms. This was resolved during the inspection.
- The door into the garden from the female lounge was wide enough to for a wheelchair to pass through, but was not wide enough for a patient to propel themselves with their hands on the wheels of the chair.
- The hospital had no dedicated space for therapeutic activity space; activities took place in communal lounges, dining areas and the garden.
- Although drinks and snacks were available 24 hours a day, patients were not able to make these themselves and had to rely on staff to facilitate their requests.

Are services well-led?

Good

We rated well-led as **good** because:

- Staff received regular training and effective supervision and appraisal that supported their development. Against a provider target of 85% the hospital had staff training compliance of 95%; staff supervision of 100% and appraisal 89%.
- The hospital had introduced a risk register, and worked to complete some of the actions identified. Senior staff were aware of the register and staff within the wards were clear they would report all risks directly to the hospital director.
- A new internal audit process had been introduced, including 17 different audits. Whilst it became embedded in practice, staff could feedback on the audit tools through clinical and divisional governance meetings.
- Staff were clear about the need to safeguard vulnerable adults in their care and saw safeguarding as everyone's responsibility. We found positive communication between the hospital and the local safeguarding authority.
- Staff could describe their responsibility to inform patients and relatives if something had gone wrong. We saw the duty of candour policy followed at the hospital.
- Staff felt able to raise concerns without fear of victimisation, they knew about the organisations whistleblowing policy, and that they could contact external organisations to report concerns.
- The provider had introduced an employee app that encouraged staff to be part of the organisation. This included completing a survey to reflect on Barchester as an employee.

Summary of this inspection

- The staff we spoke with were committed to their work, and wanted to deliver patient care that was the best it could be. They spoke of being supported by the hospital director and the senior managers in the organisation they knew.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The mental health administrator used the provider's hospital administration system to alert staff when renewals were due. Timely reminders about detention renewals, managers' hearings and tribunals, report deadlines, authorisation of medications and requesting a second opinion appointed doctor visit were received.

Detention documents were scrutinised by the Mental Health Act administrator. Each patient detained under the Mental Health Act had an audit of compliance completed every three months, by the Mental Health Act administrator and the Hospital Director. We were told any actions arising from these audits were completed immediately.

Detained patients had their rights were explained to them on a regular basis; this was documented within their notes. Easy read information about the rights of detained patients was available. Staff made the independent mental health advocate aware of all detained patients in the hospital, some chose to see someone from this external agency.

A full review of all Barchester hospital policies had taken place; these had been re-written to ensure compliance with the Code of Practice. Staff could access these policies through the intranet. Copies of the Mental Health Act Code of Practice were available on the ward.

Annual Mental Health Act training for all staff had been revised following the revision of the Code of Practice. Compliance with this training was100%, the provider target for training was 85%.

Mental Capacity Act and Deprivation of Liberty Safeguards

Patients were given assistance to make a specific decision for themselves before they were considered to lack the mental capacity to make it. People who might have impaired capacity had their capacity to consent assessed on a decision-specific basis. The staff we spoke with had an understanding of the five principles of the Mental Capacity Act and knew where to refer to policy.

Staff supported patients to make their own decisions whenever possible. When they lacked capacity to do so, decisions were made in their best interests. Staff knowledge of patients allowed them to do this in line with their wishes, feelings, culture and history. Best interests meetings included a range of people able to support individual patients.

Eight deprivation of liberty safeguards applications had been made in the last six months, four were in place and four were in the process of being completed. The four that had not been completed were awaiting decisions or assessments from local authority teams. The hospital was aware of these individuals and we saw that repeated representations had been made to the relevant local authority teams. Meanwhile, any care decisions required were made in consultation with relatives and following the principles of the Mental Capacity Act.

The hospital had identified three levels of safeguarding training that included training in the principles of the Mental Capacity Act, Deprivation of Liberty Safeguards and duty of candour. Understanding of training was measured using a self-assessment test at the end of the e-learning module and in the face-to-face update training. Overall compliance with this training was 91% and the provider target for training was 85%.

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

Castle Lodge Independent Hospital was linked via an airlock corridor to Castle Park care home, a separate establishment run by the same provider. The hospital operated as one ward split into two areas one for five female patients and one for ten male patients. Access between the two ward areas was through a closing a door within the main corridor. The door was lockable with access via a key pad. During the day, the door was closed and at night, if patients were all in their rooms it was opened to aid observation. The key code was visible and adjacent to the key pad on the inside of the door. The ward office was centrally based near the entrance to the hospital but this did not allow staff in the office to easily observe either of the communal ward areas. Whilst the bedrooms were off main corridors and could be considered blind spots we found the staff on duty were aware of patients whereabouts at all times.

On the male side of the service, there was a large lounge area with a quiet room at the end of the corridor. The female side had a large open plan lounge containing a dining area. Both sides of the ward had private garden areas. The ward complied with the Department of Health requirement that all hospital accommodation should meet same-sex accommodation guidance. Individual male and female bedrooms each with en suite toilet and shower rooms were in separate parts of the ward. Each of the two ward areas had an assisted bathroom available. The central dining room next to the nursing office was used primarily by male patients, though there was the option for female patients to dine there if they wished to. In addition, we saw a quiet lounge used by male patients, and a relatives meeting room centrally situated opposite the ward office used at different times by all.

Following a recent refurbishment, the furnishings within the ward were clean, comfortable and well maintained. Staff told us the maintenance department were responsive when requests were made to ensure the safety of fixtures and fittings. Maintenance staff told us they felt part of the team and had the equipment required for their role.

There were no seclusion facilities at Castle Lodge Independent Hospital and we found no evidence of seclusion or long-term segregation taking place over the last year.

The environmental audit report on ligature risk from 09 May 2016 identified positive changes had taken place within the hospital environment since our last inspection. A ligature is a fixture or fitting that an item could be tied to in order to attempt hanging. All bedroom doors and en suite bathroom handles were anti ligature in design and each bedroom door was fitted with a privacy panel, in line with Home Office standards so staff could conduct observations without disturbing patients. Pelmets and curtain rails within bedrooms met anti-ligature standards. Most furniture was fixed to the wall and wardrobes had continuous hinges and fixed shelving. Showers were an integral unit to eliminate ligature risk.

Patients who were not on higher levels of observation had unsupervised access to corridors and rooms that had some ligature points. These were monitored by staff vigilance and awareness of individual patients.

Good

Wards for older people with mental health problems

The clinic room was tidy and well arranged. We saw blood pressure monitoring equipment and scales. The clinic room did not have an examination couch. Patients requiring physical examinations had these at the local general practice, or in their own bedroom. Staff recorded clinic room and fridge temperatures on a daily basis. Records showed these temperatures were within safe limits for the storage of drugs. The fridge did contain one item that was not currently in use.

On inspection of the work surfaces within the clinical room, it was clear that the surfaces had not been wiped down after each medication administration round in line with hospital protocol. This posed the risk of cross contamination or infection if medicines were prepared on unclean work surfaces. The clinical lead at the hospital gave a commitment to remind the qualified nurses of the hospital protocol.

Within the locked clinic room medication disposal bins were stored in an unlocked cabinet and one disposal bin was stored outside the cabinet. The principles for the safe and secure handling of medicines: a team approach (Royal Pharmaceutical Society of Great Britain, 2005) identifies that that medicines for disposal should be stored away in a locked cabinet. There had been a delay in the collection of one of the disposal bins because the request for this to happen had not been made. This was resolved during the inspection period. The clinical lead nurses from the hospital and the provider's hospital and complex care division agreed to review the content of the infection control audit for the clinic room to include checks on the appropriate storage of all medicines for disposal.

Resuscitation equipment was available, easily accessible, calibrated and well maintained. We saw evidence of daily checks taking place of the suction machine, portable oxygen and defibrillator. Emergency drugs in the clinic room were checked and in date.

The equipment we checked was clean and well maintained. Throughout the hospital, we found electrical items showed evidence of portable appliance testing. However, annual calibration certificates for electrical diagnostic equipment, blood pressure machines, the blood glucose monitor and the weighing scales could not be located. Once alerted to this the hospital manager put in a request for this to take place.

The hospital had a clear system that showed evidence of cleaning that was the responsibility of the care staff, for example, bathroom hoists. We saw signed checklists recording the name, date and time that cleaning had taken place after each use of the assisted bathroom. Individual patients equipment, for example wheelchairs, were cleaned a minimum of once a week. We saw a checklist with signatures indicating this took place in a timely way.

The housekeeping staff had responsibility to clean patient's rooms and the communal areas. These staff told us they had the resources to keep the environment clean. They also commented on feeling valued and part of the hospital team. We saw cleaning records that indicated all rooms on the schedule had been cleaned.

We checked the cleaning rotas for individual patients rooms and found that each room had had a daily clean and that 12 out of the 15 rooms had been spring cleaned, involving cleaning the inside of drawers and wardrobes the previous month. We asked about those that had not had a spring-clean and were told two rooms had not been occupied, both having had a deep clean following discharge and prior to an admission. The patient using the other room had a rehabilitation care plan that involved cleaning their room alongside care staff, which we saw. The housekeepers did not record this on their schedule.

The hospital had purchased trolleys to avoid putting dirty laundry on the floor, however; we saw these trolleys containing dirty laundry stored in bathrooms. Staff explained that this was due to lack of storage for the trolleys elsewhere on the ward, and that they were wheeled elsewhere when a bathroom was in use. We raised concerns about this practice with the hospital manager and by the end of the inspection period, the storage arrangements had been changed to allow storage within a designated dirty linen cupboard.

Training in infection control took place annually for all staff; current compliance with this training was 100%. We saw information next to every sink about handwashing and staff understood its importance. The clinical lead nurse completed and documented spot checks with staff to ensure the correct handwashing procedures were used.

In addition to the monthly infection control and health and safety audits, the hospital environment was assessed bi-monthly as part of the provider's quality first visits. Outstanding actions identified in previous reports were

reviewed, with any new actions identified and included on a central action plan for the service. We reviewed the most recent environmental audit that took place on 4 January 2017. This included checks on equipment, utility rooms, waste disposal including clinical waste, the clinic room and all patient areas. We saw an action plan from January 2017 with four problems identified, three of which were already resolved, the fourth involved re-training which had been booked for 20 January 2017.

Every staff member had an individual alarm with a call button to use for assistance; these were signed out at the beginning of each shift. Staff felt this system worked well and colleagues were responsive to alarm calls. Visitors to the hospital, including our inspection team, were required to wear an alarm at all times when within the service.

Safe staffing

Barchester hospital and complex care services division used a target-operating model, a system to identify the roles and numbers of people in each role and skills, capabilities and knowledge required to determine core-staffing levels. From this, based on the ward patient group and the number of beds, core staff numbers and skill mix were determined and reviewed annually.

Core staffing agreed in September 2016 based on this model were one hospital manager not included in the staffing numbers, one clinical lead; five registered nurses; 22 support workers, with an activities co-ordinator 30 hours a week (supernumerary).

Establishment levels at the time of inspection (whole time equivalent):

- 1 clinical lead nurse holding a mental health registration
- 4 qualified nurses holding a mental health registration
- 26 nursing assistants

Vacancies (whole time equivalent):

- 1 registered mental health nurse (nights)

Staff turnover rate was 22% in the 12 months prior to 31 December 2016; this represented eight staff leavers from a small team in the last twelve months. The staff sickness rate in the same 12 month period was 4.22%. In the three months from 01 October to 31 December 2016, the number of shifts to cover sickness, absence or vacancies was 137.

The core staffing during the day was two nurses Monday to Friday, with one nurse at the weekend. From the rotas over the three months from 01 October to 31 December 2016 we found that all but three week day shifts which had one nurse on duty met this. At night, every shift had the required qualified nurse on duty. With the exception of three shifts over 13 weeks, four nurses known to the patients and staff did the cover provided through an agency. Support workers employed within the service often provided cover through overtime; in addition, the service used three regular agency support workers. Carers and patients commented that they knew agency staff at the hospital.

The core staffing for support workers was four during the day, three at night and all shifts met this minimum. Additional support workers to provide individual support were required during the daytime. Across the three months from 01 October to 31 December 2016, the hospital required eight support workers on each daytime shift. From the rotas, we saw this had been achieved on all but three days when there had been seven support workers on duty. On each of these days, the hospital manager had been on site. Staff had told us that when there were additional needs on the ward the hospital manager would help.

The hospital manager was able to adjust staffing levels to take account of patient need. Patients' requiring additional support outside the core staffing were individually assessed. Extra staffing required to support individuals was based on this assessment of need. Usually funded by the clinical commissioning group, this required regular reporting and reviews to ensure the objectives and outcomes identified for the patient continued to be met. Staff confirmed that when a patient required one to one observation additional staffing was available.

There had been an increase in qualified nursing since our last inspection. In addition to this, the clinical lead half of whose time was on the rota boosted the qualified nurse presence at key times, for example whilst meetings took place. However, during most evenings, at night and weekends the qualified nurse on duty held responsibility and oversight throughout their shift, with a manager on call system in place.

The rotas for support workers showed new shift times had been trialled so one staff member worked their long shift 6am to 7.45pm and another 10am to 10pm to give higher

staff numbers at busy times. This helped ensure there were enough staff on duty to safely carry out care interventions. Whilst under review at the time of inspection, the feedback we heard from staff was positive.

Staff told us there were enough staff members on duty so that patients had regular one-to-one time with their named nurse and support worker. Patients knew which staff were their keyworkers and spoke with them regularly about their care.

The activities co-ordinator was not included in the shift numbers and worked a set pattern, including some time on the ward at weekends. Their role included planning specific activities in the ward areas or with a patient's key worker. Support workers primarily offered escorted leave and ward activities. Although there was an acknowledgement that patients went out less often in the winter than any other season there had been no cancellation of community escorts or planned activity in the previous three months.

Multidisciplinary team establishment (whole time equivalent):

- 0.2 consultant psychiatrist (based locally at sister hospital in Hull provided two sessions on site each week, and responsible clinician cover for the hospital across 24 hours)
- 0.2 psychologist
- 0.2 occupational therapist (recruited, due to commence in February 2017)
- 0.8 activities co-ordinator

All patients were registered with a local general practitioner who provided out of hours on call cover. Physical health care emergencies were dealt with through the general practitioner, the national health service 111 telephone advice line, or in a medical emergency by calling 999.

The consultant psychiatrist, the responsible clinician for all patients, would respond to crisis or urgent matters for patients unless on leave. They could be contacted outside of their hospital based session times for mental health emergencies or support. We heard from staff that the psychiatrist had been responsive in such situations. For periods when the locally based consultant was on annual leave, Barchester consultant psychiatrists provided cover for the hospital; this was across the geographical area of the north east of England. Arrangements were pre-planned so staff knew whom to contact. Whilst staff could discuss their concerns immediately with a consultant psychiatrist, it was unclear how long it would take for the on-call psychiatrist to attend the hospital should the need arise. The Royal College of Psychiatrists accreditation standards for inpatient older adults mental health November 2014, state that an identified duty doctor should be available to attend within 30 minutes in the event of a psychiatric emergency.

As the registered manager, the hospital director held 24-hour responsibility for the service and would be available on call unless on annual leave. In this circumstance, a nominated person was identified, for example the hospital director from the sister hospital in Hull, to provide additional support.

All staff had completed their common induction standards training. In addition to this, there were 17 legislative and mandatory training modules for staff with five additional modules for nurses only. Staff had received and were up to date with appropriate mandatory and legislative training. The average legislative training rate was 93% and mandatory training rate was 97.5% Giving an overall for staff training compliance of 95% against a provider target of 85%. No mandatory or legislative training was below 75%.

Assessing and managing risk to patients and staff

There had been no reported incidents of use of seclusion, long-term segregation or rapid tranquilisation at the hospital from 01 January to 31 December 2016, and we found no evidence of these taking place. The hospital had seclusion and rapid tranquilisation policies that referenced the Mental Health Act Code of Practice and followed National Institute for Health and Care Excellence guidance.

There were 151 recorded episodes of restraint in last six months. All had been recorded as level two holds, standing only. The staff we spoke with were clear that if a situation needed any physical intervention they recorded this as restraint. The hospital manager and the staff we spoke with confirmed that no prone (in a face down position) restraint, was used within the hospital.

Practice within the hospital complied with the National Institute for Health and Care Excellence guidance, principles for managing violence and aggression. Six different patients had been restrained all on the older male side of the ward. Staff were clear that restraint was used to

manage aggression and this was as a last resort following unsuccessful de-escalation. In most of the cases reviewed, we saw that restraint involved patients guided elsewhere to avoid an incident escalating.

Since our last inspection, the hospital had changed its system to manage challenging behaviour of patients to the management of actual or potential aggression. Staff completed training annually, at the time of inspection this training showed 97% compliance. Although initially this caused staff some concerns, the new training had been delivered to ensure the change between systems had happened successfully. In addition, to support staff in the implementation of the training, a physical restraint recording form was introduced to reflect the Mental Health Act Code of Practice. This form asked if all staff who took part in physical restraint had received the management of actual or potential aggression training and if a debrief session had been held.

To monitor the use of restraint and check staff compliance with the new system, in addition to incident reporting, physical restraint was a standing item on the hospital clinical governance agenda.

We examined seven patient care records. In each, we found up to date risk assessments, commenced on admission and regularly reviewed using the Galatean risk and safety tool. This validated and nationally recognised risk assessment tool was reviewed a minimum of every three months and immediately after any incident or identified change in the patients wellbeing. It was also discussed in each patient's multidisciplinary team meeting and referred to at their care programme approach meeting. Detailed risk management plans drew on staff knowledge of individual patients. In addition to the Galatean risk and safety tool we saw individual risk assessments, care plans and reviews for patients where specific concerns had been identified, for example falls, choking and pressure ulcers.

Staff told us that the patient group within the hospital were at low risk of self-harm. Over a twelve month period, no incidents of self-harm had been reported at the hospital. Staff knowledge of individuals and their whereabouts assisted in the management of risk. The staff on duty during the inspection knew patients well and understood risk. In patients notes we saw individualised risk assessments and plans that were regularly updated.

We saw key codes next to key pads on internal doors that allowed informal patients and visitors to leave the hospital at will. We found the bathroom doors on the corridors locked. When we asked about this we were told by staff that it was to prevent patients wandering into the bathrooms where laundry was stored. We were assured that patients could access bathrooms at any time following a request to staff and one of the patients who liked to have regular baths confirmed this. Patients had unrestricted access to toilet and sink facilities in their bedrooms. Patients could access kitchen areas to make their own drinks with staff awareness. Patients did not have room keys but could have access to lockable cabinet drawers within their room to store personal belongings.

Patients, who chose to, could have a mobile phone following an individual risk assessment. We spoke with one patient who had their own telephone. The hospital manager told us that within the hospital there had been an emphasis on working with staff to consider least restrictive practice in all their interventions with patients. This was being done through update training, discussions in the multidisciplinary team and staff meetings. Support staff were aware of this aim and recognised that sometimes they could be overprotective of patients doing things for themselves if it might involve a risk.

Searching was not routine practice at Castle Lodge hospital, and the staff we spoke with had never known a search take place. A leaflet was available to staff, patients and visitors explaining why there might be concerns about specific items brought into the ward area. This gave a clear explanation about what might trigger a concern, what an individual would be asked in such circumstances and how any search would take place if agreed to.

Staff awareness of their responsibilities to report safeguarding was high and compliance with annual safeguarding training was 95%.The staff we asked knew how to raise a safeguarding alert with the local authority safeguarding team. We saw information leaflets available in the staff room explaining what abuse is and how to report this.

The severity of any adult safeguarding concern was measured against a matrix given to providers by the local authority safeguarding team, which gave a consistency of

reporting to safeguarding. Hospital staff attended a quarterly meeting for providers of services with Hull adults safeguarding protection board. At these meetings, staff shared experiences and discussed benchmark reporting.

Ahead of inspection, the local authority team told us the hospital had systems in place to capture safeguarding incidents, and their understanding was that staff appropriately reported and followed through safeguarding concerns. There had been six safeguarding referrals made to the local authority in the twelve months prior to inspection. Aside from the direct reports from the hospital, neither families nor any professional staff going in to review patients had raised any safeguarding concerns in the last six months.

The controlled drugs accountable officer was the registered manager. She was involved in meetings with the local intelligence network for controlled drugs. Controlled drugs within the hospital were stored in a separate cupboard. Access to these drugs was restricted and the keys held securely. Staff routinely checked the balances of controlled drugs held in line with hospital policy.

Medicines were stored securely in the locked clinic room and the keys held by the nurse in charge. Each patient had their own-labelled supply of medicines. The cabinets used to store medication were adequate for the number of patients and well organised. Records of fridge temperatures showed these to be within safe limits for the storage of drugs. Medicines that were disposed of were recorded in a separate book and signed by two individuals. Consignment notes for collection of medicines disposed were evidenced.

Each patient had a separate medication file; we reviewed the prescription charts of all patients. The hospital operated a system in which the consultant psychiatrist prescribed psychiatric medication. The general practitioner prescribed medication for physical health symptoms. As the responsible clinician it was clear that the consultant psychiatrist held overall responsibility for patient medication. Communication about medication with the patient's general practitioner who generated prescriptions to the pharmacy was undertaken primarily via fax and records were kept.

Changes to medicines made by the psychiatrist were faxed to the patients' general practitioner who produced a prescription that was then supplied to the hospital through an external pharmacy contractor. This pharmacy also provided the medicine administration cards. Staff told us both the general practitioners and the pharmacy were responsive to requests for changes and urgent medicines. However, the hospital had no immediate access to medication on site.

We found a discrepancy between the system in which the responsible clinician prescribed psychiatric medication and the medicine administration record charts on two occasions. These related specifically to changes to medication prescribed to be taken as needed. This was a complication of having two systems running simultaneously that were not entirely synchronised.

The nurses we spoke with had a detailed understanding of the medicine ordering and receiving process, using repeat medication forms issued by the patient's general practitioner. Medication was ordered on a monthly basis and should last for a 28 day cycle. However, there was evidence of the hospital requesting a further supply of medication because it was not sufficient for the month. We completed random quantity checks on medicine stock levels for two patients and found discrepancies. These linked to patients bringing medication into hospital on admission, then not having sufficient medication ordered to remain synchronised within the 28 day cycle. It was the responsibility of the hospital staff to ensure the correct quantities of all medications were available so each patient had sufficient to meet their needs.

Where patients were being covertly administered medication care plans were in place but there was no evidence that covert administration had been reviewed as part of regular multidisciplinary team meetings. In some instances, the covert care plan lacked detail regarding method of administration for nurses to follow. Nursing and Midwifery Council medicines management guidance, standard 16 states that care plans should provide specific details of how to administer the medication covertly, for example, is it with food items or beverages, does the tablet dissolve in drinks if it is administered through this way. Without this detail, nurses could be administering medications in ways that are not suitable or compatible for that particular medication. Lack of such detail could also create difficulties for new or agency nurses dispensing medication.

In one instance, the covert care plan did not document whether a pharmacist had been consulted. The Royal

Good

Wards for older people with mental health problems

College of Psychiatrists statement on the covert administration of medicines, section 9 states that proposed treatment should be discussed with a pharmacist to ensure that medication may be mixed with food and will not be affected by procedures such as crushing.

On the medicine administration record charts, we saw several instances where staff had missed signatures, or where a patient had refused medication with no reason recorded. These had not been reported as a drug error. The Nursing and Midwifery Council medicines management guidance, standard 8: administration, states that you must make a clear, accurate and immediate record of all medicine administered, intentionally withheld or refused by the patient, ensuring the signature is clear and legible. Where medication is not given, the reason for not doing so must be recorded.

We also found where medication was to be administered weekly or fortnightly, the next due date was not clear on the medicine administration record chart, posing a potential risk of a dose being missed. We found an example of this in a two day delay in the administration of a depot injection. Medicines delayed or missed could affect patient presentation and health.

We found a medication error made originally by the pharmacy provider who had supplied a different strength of medication and not changed the medicines administration record chart instructions. The nurses dispensing the medication would have realised the error had they checked both the medicines administration record chart and the original prescription. This error continued for over two weeks. We raised this with the hospital director and hospital clinical lead; they checked with the responsible clinician and contacted the pharmacy immediately. The medicines error was reported, and the hospital followed its duty of candour responsibilities.

In this case, the dose the patient received was 10% of that originally prescribed. This had had no obvious impact on the patient's wellbeing and led to a multidisciplinary team discussion the outcome of which was to reduce the prescribed dose. However, Nursing and Midwifery Council medicines management guidance, standard 4 states that dispensing includes such activities as checking the validity of the prescription, the appropriateness of the medicine for an individual patient, assembly of the product, labelling in accordance with legal requirements and providing information leaflets for the patient which had not been done.

A folder for medication/devices safety alerts was located in the clinic but did not contain all up to date medication/device alerts. It was not clear how new safety alerts were cascaded to nursing staff.

The hospital had introduced monthly medication records audit, weekly clinic room checks, monthly medication stock checks, daily defibrillator checks and daily clinic room temperature checks.

These were completed by the clinical lead assisted by the qualified nurses. Given the medication issues found during inspection a commitment was given by the hospital and divisional lead nurses to review the efficacy of these audits and where necessary undertake additional training for staff.

Child visiting procedures were in place and these visits took place in a separate accessible room off the ward. Other visitors were able to visit patients on the ward either in their own room, or a separate lounge.

Track record on safety

There had been six serious incidents requiring investigation reported in the twelve months prior to inspection. The hospital had followed internal procedures including investigation, reported these to the local authority and where relevant notified the Care Quality Commission.

Evidence of safety improvements following incidents included:

- Following incident involving error in administration of medication, qualified nurse medication competencies were renewed.
- The introduction of personal alarms on all units and for visitors to the hospital with an agreed protocol that all staff, visitors and allied professionals within the service are required to wear these at all times when on duty with the service.
- A new protocol introduced around the way in which the team respond to the activation of a personal alarm and in an emergency situation.

Good

Wards for older people with mental health problems

- New enhanced observation prescriptions introduced with observation records reviewed at least once by the nurse in charge on each shift, in conjunction with review at the multidisciplinary team meetings on a weekly/ monthly basis.
- Door keypad codes changed a minimum of six monthly on all entry doors to main building entrance, staff only areas and units to prevent patients accessing other units without support from staff.
- Clinical governance database upgraded to improve diligence around clinical effectiveness. Clinical governance meetings now held every month at hospital level, quarterly at divisional and strategic levels.

Reporting incidents and learning from when things go wrong

The staff we spoke with knew how to report and record incidents. From incidents reported to the Care Quality Commission, we saw that families were kept informed, patients de-briefed and where relevant local safeguarding teams were informed.

We reviewed the incidents reported over two months in November and December 2016. All were reported in detail using the accident/incident form and were reported in brief using the electronic incident reporting system. Staff linked the two systems by indicating that they had made a report using the electronic incident reporting system by writing the incident reference number on the accident/incident form. Incident reports included examples of near misses and of the 33 incidents documented in these two months, most were low-level.

All reported incidents were reviewed by the clinical lead and signed off by the hospital manager daily. These were then reviewed at the multidisciplinary team meeting each week. Lessons learned relating to individual patients were discussed as part of their multi-disciplinary team review, with care plans updated accordingly. Any changes to care because of these discussions were shared with staff at daily handovers.

Following incidents, feedback was given to staff at morning meetings and at regular monthly staff meetings. At times when specific individual feedback was appropriate, clinical or managerial supervision was utilised. The hospital clinical governance meeting looked at all incidents each month. Through the governance structure, learning from incidents across the sector took place at divisional and strategic meetings.

A form was available to support debrief following an incident. Individual staff spoke to us about supportive debrief, led by the nurse in charge, clinical lead or hospital manager.

Duty of Candour

There was a policy in place to support duty of candour and this was available centrally to staff through the intranet. Information on the noticeboard in the staff room referred staff to this.

Staff told us they were aware of their responsibilities to be open and explain to patients if something went wrong. The qualified nurses talked about initiating discussions within the staff team, testing out what would need to happen in specific scenarios. Support workers told us duty of candour was something they talked about a lot. Staff awareness of their responsibilities seemed high and we found 97% were in date with this legislative training.

The hospital manager was clear that patients or/and their relatives received explanations verbally and in writing if something had gone wrong. We saw an example of this during the inspection following a medication error. The carers we spoke with were confident they would be contacted if anything happened that was unexpected.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

We reviewed seven patients' care records, which were stored securely in a lockable cabinet in the nursing office. All clinical team members and visiting professionals involved in the care and treatment of the patient had access to these records. Patients, relatives and their representatives could access records under the access to medical records policy guidelines. Care records were

paper-based and well organised. However, the files contained a considerable amount of information and we noted that in two records, papers in the file had torn and had the potential to fall out of the file.

Most patients had a pre-admission assessment completed that had informed the decision to admit them to Castle Lodge. In all records, we saw a timely assessment completed after admission that informed care planning. Care plans showed assessments completed following discussion with patients and/or people who knew the patient well. Care plans had a capacity to consent to photographs section we found five out of seven completed.

We found physical health checks had been undertaken and ongoing monitoring of physical health problems that were comprehensive. Delivery and review of physical health care involved a number of external practitioners.

The care records we saw contained a series of individual care plans designed to meet a patient's needs. Patients had individual care plans to address communication needs; physical health needs; personal hygiene needs; nutrition and fluid needs; mobility and falls; mental health; and managing aggression. We saw that care plans were personalised, recovery focussed and used the patient's chosen name. Whilst each care record was organised in a similar way we saw that records had been individualised and that care plans were only implemented if a need or risk was apparent. This meant, for example, whilst every patient had a personalised care plan to meet their communication needs or nutritional needs, not every patient had a risk associated with continence and so not every patient had a care plan for continence needs. Individual care plans had evidence of regular review at least monthly and staff indicated whether a change was or was not required following review.

The only area in the care records that did not show evidence of regular review were observation levels. We saw that three records had an observations prescription chart completed by the consultant psychiatrist. In these records, the chart stated that patients required one to one observations. All three charts were completed in either September or October 2016 and we saw no evidence of a review of these observation levels. On one chart we saw that the consultant had stated that observation levels were to be reviewed 'when observation levels change' which did not provide clarity for how often the staff should review observation. When raised with the psychiatrist, they explained this was an error and would be corrected. On another chart we saw that observation levels were to be reviewed 'when (the patient's) presentation changes'. From the multidisciplinary team meeting notes we saw observation levels reviewed weekly. However, this information was not always transferred into the individual patient's observation care record.

All patients had a discharge planning care plan in their care records. It was clear when relevant, that relatives had been involved in discussion about discharge. The care plan addressed four long-term goals: accommodation, medication, occupation and physical health. Two discharge planning care plans stated in the accommodation long-term goal that 'alternative placement was not appropriate at this stage' giving little indication of when this may change.

Best practice in treatment and care

We saw 24 examples of evidence-based practice across the hospital that referred to guidance from the National Institute for Health and Care Excellence. These included: older people independence and mental wellbeing; supporting people with dementia and their carers; transition between inpatient mental health settings and community; falls assessing risk and prevention; the management of pressure ulcers; urinary incontinence and medicine adherence.

To understand and manage challenging behaviour, the hospital had adopted the Newcastle Support Model. Following initial information gathered from a range of places, this was put together to identify both the triggers and the needs of an individual patient. This then allowed staff to consider the most appropriate interventions for an individual patient.

All patients were registered with local general practitioners. Those able to attended appointments at the surgery did so, usually supported by staff. For individuals unable to attend the practice, the general practitioner saw patients on the ward. Staff told us the general practitioners were responsive to requests from staff to see patients at the hospital. If required, either staff or relatives supported patients to attend specialist appointments at the general hospital for example, chest clinics.

A series of initial physical healthcare assessments took place following admission. Each patient had a nutritional and falls assessments completed and care plans reflected

specific individual needs. Following this, care plan reviews took place at an interval to suit individual patient needs. In addition, we saw early warning indicators for patients' health completed on a monthly basis.

Assessment of nutrition was completed using the Malnutrition Universal Screening Tool, to identify any adult, who could be malnourished, at risk of malnutrition, or obese. Where high risks had been identified, referrals were made to a dietician to assess the patient on the ward. We saw care plans to guide staff to support food and or fluid intake for patients with nutritional risk, and these were updated regularly. Staff monitored special diets and /or prescribed food supplements. All patients being nutritionally monitored were entered onto the clinical governance database, which was reviewed monthly at hospital meetings.

The qualified nurses completed falls risk assessments. These assessments informed care planning and reviews. A referral to the falls team was made for any patient where a high risk of falls had been identified. Where a patient was considered at high risk of falls this was entered onto the clinical governance database, which was reviewed monthly at hospital meetings.

Staff completed a Waterlow pressure ulcer risk assessment, to identify patients who may require support in relation to their tissue viability. Where a risk was found, a specific care plan was written to ensure consistency of care and reviewed regularly. All patients at risk of pressure ulcers were entered onto the clinical governance database, which was reviewed monthly at hospital meetings.

A podiatrist visited the hospital each month and attended to patients as required. Speech and language therapy and physiotherapy could be arranged for individual patients by appointment. Patients attended private community based opticians and dentists however, for those unable to do so, arrangements were in place for patients to see an optician or dental practitioner at the hospital.

Clinical staff used the Health Of the Nation Outcome to rate the progress of patients. These documented individual ratings and were repeated after a course of treatment or intervention, to monitor change and progress.

Barchester hospital and complex care services division did not participate in any nationally recognised clinical audit at the time of inspection. However, in the last year, clinical staff had been involved in audits of medication, clinic rooms, emergency equipment, patients' care records and Mental Health Act compliance.

Skilled staff to deliver care

At the time of inspection, the mental health disciplines in the multidisciplinary team were limited to nursing, psychiatry and psychology. An occupational therapist had been appointed and was due to take up the post in February 2017.

Nursing staff on the wards held relevant qualifications and experience to work within the hospital. The consultant psychiatrist was the responsible clinician for all patients and was employed full time across Castle Lodge and another Barchester hospital in Hull. This had been a significant increase in the clinical availability of a psychiatrist at the hospital. The staff, patients and carers we spoke with felt positive about this change. An experienced psychologist had recently joined the team and was available to see patients individually following a multidisciplinary team discussion. They also had a role supporting staff in their thinking and understanding about interventions with patients. The activities co-ordinator with extensive knowledge of many of the hospital patients planned specific activities individually, or for groups within the ward areas. There had been a gap of three months without an occupational therapist in the team. Recruitment had been successful and once in post, in addition to their clinical work the occupational therapist would offer clinical supervision to the activities co-ordinator. At this point, training for the activities coordinator as an occupational therapy assistant would be considered.

The hospital had an induction for new starters that incorporated the care certificate for support workers. Face to face and online training formed part of staff induction. The support workers we spoke with about the induction said it contained a lot of useful information to do the job with a booklet to keep and to refer back to. A new nurse spoke of receiving additional support and an on-site induction from the clinical lead and their colleagues.

The hospital manager had a clear focus on ensuring staff received the training required to do their work safely and effectively. The manager and administrator were responsible for monitoring training compliance. They sent prompts and reminders to staff, verbally, by email or using

the provider's app. The provider had made a decision to alter the delivery of most mandatory training from hospital level to a uniform approach across the directorate. The transition to the new system took place in October 2016. Although there were some teething problems with the centralised systems, its introduction had been successful at Castle Lodge where a high mandatory training compliance had been achieved.

As part of the hospital meeting the needs of its patients more fully, twelve staff including nurses, support workers and housekeeping had recently attended dementia training. The hospital manager had plans for more staff to undertake specific dementia training when this could be organised.

Support was available for staff to train externally if gaining a specific qualification would enhance their role, for example; the Mental Health Act administrator was undertaking a Mental Health Act law and practice certificate at Northumbria university.

The hospital worked to Barchester's staff supervision and appraisal policy. We reviewed four staff files, all clearly showed regular attendance dates for managerial supervision and a record of the staff member's last appraisal.

Staff received managerial supervision every two months. The records of this supervision showed that staff regularly discussed their mandatory training compliance, performance and development. In addition, we saw that during individual supervision staff members had received debriefs following incidents; additional supervision following a medication error and issues raised following an internal quality first visit. Staff told us they found supervision both supportive and challenging.

In addition, staff accessed clinical reflective supervision, with the aim of developing skills, knowledge and behaviours to improve care to the patients they supported. The responsibility to deliver clinical supervision was with the clinical lead and other registered practitioners. The aim was for staff to receive this every month. The staff we spoke with reported feeling supported by their supervisor. The compliance rate for staff supervision in the last twelve months was 100%.

Staff appraisal took place annually, with a six monthly review of progress on individual targets. From staff files, we saw individual goals alongside more standard company expectations relating to their role. The appraisal matrix recorded 33 out of 37 staff members as having their appraisal completed when planned. This showed a compliance rate for the last twelve months for appraisal as 89%.

Team meetings took place monthly for all staff with the hospital manager. We saw minutes of the three most recent team meetings where between 13 and 15 staff, out of a workforce of 30 had attended. Agenda items had been followed, with clear actions for each and who held responsibility for these actions going forward. It was clear from the 'any other business' section of the meeting that staff contributed their ideas and views on the service. Staff told us they felt able to contribute to discussion at meetings, and minutes were received promptly. Night staff told us that the hospital manager or clinical lead came into work during their shift to meet with them, to discuss significant issues arising from staff meetings.

In addition, each week the hospital manager met with heads of department to discuss any concerns, issues or achievements. Hospital clinical governance meetings chaired by the hospital manager took place monthly, attended by the responsible clinician, clinical lead, psychologist and the activities co-ordinator. Bi-monthly health and safety meetings were held on site chaired by the site health and safety officer.

There was regular monitoring of staff attendance, timekeeping, sickness and absence, training compliance, appraisal and supervision. Poor performance was initially addressed through managerial supervision and where relevant, additional training. Human resources procedures triggered increased action for persistent poor attendance and/or timekeeping. Management of poor attendance was done through return to work interviews. When these processes were not sufficient to address an issue, more formal performance management took place; this referenced the provider's framework to set improvement targets and expectations. Disciplinary action was used when all other actions had been exhausted, or a performance issue was of sufficient seriousness to require this, for example, staff misconduct.

Multidisciplinary and inter-agency team work

Multidisciplinary meetings took place twice a week on Tuesday and Thursday. Unless something unexpected had happened requiring discussion about additional patients, a

pre-planned agenda ensured every patient had a multidisciplinary team meeting at least every three weeks. This meant carers and external professionals could be invited to the meeting for a particular patient. Staff planned care programme approach meetings to ensure maximum attendance by care co-ordinators for patients both from the locality and from out of area.

Meetings were normally attended by a nurse, the clinical lead, consultant psychiatrist, activities coordinator, hospital manager, the patient's support worker, the patient (if they were well enough to attend, if not they were seen prior to the meeting by the consultant) and carers (if appropriate, and they wanted to attend). For patients where a specialist practitioner was involved, for example, the psychologist or a speech and language therapist, they were also included.

During inspection, we attended a multidisciplinary meeting for two patients. A nurse, the clinical lead, consultant psychiatrist, hospital manager, the patient's support worker and the mental health administrator were present. We heard staff speaking about the patient with care and understanding. It was clear from the discussions that those present had extensive knowledge of the patients concerned. Reference was made to ensuring patient's legal status was in date and their most recent risk assessments. Positive and thorough reviews of progress towards goals took place with decisions made about the need for specific referrals.

The meetings followed a set agenda, standing items included: incidents; observation levels; physical health; legal status, medication and any other issues. We saw notes for each individual taken against each item during the meeting. The service kept a file of all previous multidisciplinary meetings and care programme approach meetings for each patient. Staff referred to these minutes when clarification of previous decisions was required.

We saw and heard about positive relationships within the multidisciplinary team. Whilst acknowledging the gap in occupational therapy, the practitioners we met on site worked together for the good of the patients. Having experienced a period of time when they did not go into multidisciplinary team meetings, support workers were pleased to be back there and to be part of the team. Those we asked felt their contribution and knowledge of patients was increasingly acknowledged by the qualified staff.

We attended handover from night to day shifts, this lasted 15 minutes, during which the nurse in charge used a handover sheet from which she gave verbal information about all patients on the ward. Information shared included key details from the previous handover, patients' mood, risk, and levels of observation. The short length of time meant staff could not easily reference patient care plans, however, the staff coming on duty knew the patients well and seemed clear about what they needed to do. The immediate focus following handover was to allocate duties to the staff arriving on shift that enabled patients to receive continuity of care between the change of staff.

There were links with the local general practitioner surgery where patients were registered. When possible, staff supported patients to arrange and attend appointments in the community. For patients who could not do this we heard general practitioners were responsive to staff requests for them to visit the hospital. Other professionals involved in delivering care, for example district nurses, saw patients on the ward and liaised directly with staff to update them of a patient's progress.

Staff at the hospital and a social worker from the local safeguarding team reported positive communication about safeguarding concerns.

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

At the time of inspection, there were six patients detained under the Mental Health Act at Castle Lodge independent hospital. The Mental Health Act administrator scrutinised detention documents. The detention paperwork was filled correctly, in date and stored appropriately. We checked treatment forms attached to medication charts for the six patients detained under the Mental Health Act, certificates of consent to treatment known as T2 forms and confirmation of authorised medication certificate of second opinion known as T3 forms were accurate and in accordance with Mental Health Act guidance.

Detained patients were given information about their rights on admission and at least monthly. This was the responsibility of the key nurse; we saw evidence of this documented in patient's notes. Patients who could tell us confirmed they were aware of their rights and were informed of these regularly by staff. Easy read information leaflets about the rights of detained patients were available.

Good

Wards for older people with mental health problems

Section 17 leave forms were signed by patients who had the capacity to do so. Leave conditions were specified and a record was made of how leave had gone. Systems to ensure leave took place worked well. In the last three months, no Section 17 leave had been cancelled for patients at the hospital.

A Mental Health Act administrator worked 20 hours a week at the hospital and held a key role in supporting the staff. If needed, the administrator could access additional support, advice or information by telephone or email from a peer at Barchester's sister hospital in Hull, or the mental health lead administrator based at a different hospital within the Barchester group.

The provider's hospital administration system was used to alert staff when renewals were due. The administrator sent out timely reminders about detention renewals, managers' hearings and tribunals, report deadlines, authorisation of medications and requesting a second opinion appointed doctor visit.

Each patient detained under the Mental Health Act had an audit of compliance completed every three months by the Mental Health Act administrator and the hospital manager. We were told any actions arising from these audits were completed immediately. The audit processes for Mental Health Act documents fed into Barchester hospital and complex care services division. The Mental Health Act lead administrator reviewed these to improve the application of the Mental Health Act across the sector.

A full review of all Barchester hospital policies had taken place. New policies had been written for the hospital and complex care services division to ensure compliance with the revised Code of Practice. Staff could access these policies through the intranet. Since the introduction of 45 new policies, a schedule was in place to ensure staff became familiar with each one. Specific sessions and discussions to support staff in their understanding were taking place at staff meetings. Copies of the Mental Health Act Code of Practice were available on the ward.

Detained patients had access to advocacy. Information about access to an independent mental health advocate was displayed on the ward and in reception. Where patients could not self-refer to advocacy because of capacity issues, staff made the independent mental health advocate aware of detained patients in the hospital. Whilst some patients chose to see someone from this external agency and others chose not to, it was not always clear if a best interest meeting had been held ahead of referral.

The independent mental health advocate assisted patients to prepare for attendance at hospital mangers meetings and mental health review tribunals. They could attend these meetings, care programme approach and multidisciplinary team meetings to support patients.

Annual Mental Health Act training for all staff had been revised following the revision of the Code of Practice. Compliance with this training was 100% the provider target for training was 85%. Staff that worked in the clinical areas were able to explain the guiding principles of the Mental Health Act and knew where to find further guidance.

Good practice in applying the Mental Capacity Act

The hospital had identified three levels of safeguarding training that included training in the principles of the Mental Capacity Act, deprivation of liberty safeguards and duty of candour. Understanding of training was measured using a self-assessment test at the end of the e-learning module and in face-to-face update training. Following training, staff were given pocket sized reference leaflets explaining what the Mental Capacity Act is and what the five principles are. Overall compliance with this training was 91% the provider target for legislative training was 85%.

We spoke with eight staff on the ward who all had received training in the Mental Capacity Act, they all had an awareness of the five principles of the Mental Capacity Act and followed these. We found staff particularly focussed on least restrictive practice with staff supporting patients to make their own decisions where appropriate. Whilst having an awareness of both the Mental Capacity and the Mental Health Act, two support staff became confused between the principles of both Acts. Qualified nurses described the principles of the Mental Capacity Act in detail. Support staff described how they would notify the nurse in charge, clinical lead or the hospital manager if a patient's capacity changed. All staff understood and could explain the Mental Capacity Act definition of restraint.

The hospital made eight deprivation of liberty safeguards applications made in the six months prior to our inspection. Four were in place and four were in the process of being completed. The four that had not been completed

Good

Wards for older people with mental health problems

were awaiting decisions or assessments from local authority teams. The hospital was acutely aware of these individuals and we saw that repeated representations had been made to the relevant local authority teams. Meanwhile any care decisions required were made in consultation with relatives and following the principles of the Act. All staff we spoke with knew which patients had deprivation of liberty safeguards in place.

In addition to information in individual patient notes, the hospital had a separate system that logged all submitted urgent and standard applications on the corporate clinical governance database. This was regularly updated with set reminder dates flagged to re-contact local authorities about outstanding applications.

Policies were in date and provided hyperlinks to detailed information such as current legislation and guidance. We reviewed the provider's Mental Capacity Act policy. This had been updated and was available in the nurse's station and electronically on the provider's intranet. In October 2016, the service had introduced a new policy and procedure 'choosing between the Mental Health Act and a Deprivation of Liberty Safeguards Authorisation'. Staff spoke of finding this helpful when navigating legislation.

We saw capacity to consent assessed and recorded within the patient records we viewed. However, in two sets of notes capacity checklists were present but incomplete. Patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. People who might have impaired capacity had their capacity to consent assessed on a decision-specific basis.

Staff supported patients to make their own decisions whenever possible and provided patients who might have impaired capacity with assistance to make a specific decision for themselves, before they were assessed to lack the mental capacity to make it. When a patient lacked capacity to make their own decision, this was made in their best interests. Staff knowledge of patients allowed them to do this in line with their wishes, feelings, culture and history; this followed the principles of the Act.

Best interests meetings included a range of people able to support individual patients. Carers were invited to take part and told us in this forum their knowledge of the choices their loved one would make was heard. Patients without family, who did not have capacity to choose this, could be referred following a best interest discussion by staff to an independent mental capacity advocate as their representative. Best interest meetings were recorded. However, family or advocate opinions could not always be seen when reviewing best interest meeting notes in patient files.

Staff sought advice on the Mental Capacity Act from each other, the wider multidisciplinary team, managers and the external advocacy service. We saw regular monitoring of practice relating to adherence to the Mental Capacity Act within the monthly care records clinical audit which included checks on completion of capacity assessments; six weekly reviews and if relevant, deprivation of liberty safeguards authority in place and in date.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

We observed staff and patient interaction and saw genuine caring communication between staff and patients. Staff engaged with patients in a respectful manner, offered reassurance and support to patients who were showing signs of distress. We also observed positive engagement with patients at mealtimes. Staff had a good understanding of each patient's needs, preferences and dietary requirements.

When observing a session with a number of patients reading with staff we saw that the literature had been carefully chosen to match the interests of the individual. However, staff did not ensure that patients were offered reading glasses so that they could fully participate in the activity. Age-related long sightedness (presbyopia) affects people from around the age of forty. The age of the patients engaged in the activity meant that most would have required reading glasses in order to focus on close work. When we raised this following the session we were told some patients had glasses prescribed, and others had glasses on order.

We spoke with four patients, who told us that staff treated them well and felt safe at the hospital. Patients told us that staff were always nearby and usually visible. We saw that patients received dedicated one to one time with staff. This

involved either talking or engaging in an activity. When staff administered medicines to individuals; they took time and completed this with support and care. Patients knew which staff were their dedicated key workers and spoke with them about their care.

Patients liked the activities that took place regularly; particular favourites were baking; watching films and going out. Carers commented that they felt the variety of activity on the ward could be greater.

Patients who liked to go outside could use the garden facilities daily, however, going on local community visits such as going to the shop, posed more difficulties in the winter months because paths were slippery increasing the risk of falls. Most patients understood why staff needed to accompany them to go out and whenever possible, staff ensured this happened.

We heard comments from patients about going out on trips more often. Trips and visits into the wider community, needed to be pre-planned as part of care. The hospital had access to a minibus, and a number of drivers within the staff team. Staffing levels meant that external activities and planned trips did take place. A comment card spoke of staff supporting patients who liked to go out of the hospital.

Carers spoke of their relatives being happy and that the care they saw was good. Staff knew the patients well and were described as being lovely to them. Carers commented that there were always staff always around and there seemed to be enough staff on duty. When agency staff were on duty they were regular so they knew the patients, staff and in some cases the carers.

Sometimes carers felt that the staff delivering immediate care had not listened if they made a suggestion or comment that might improve a situation. However, carers said that the nurse in charge and hospital manager had been responsive to any concerns raised.

Comments cards mentioned patients being treated with respect, liking the staff, being happy about care, and feeling looked after. The hospital was described as clean, tidy and lovely. One card spoke of staff supporting patients who liked to go out of the hospital.

The involvement of people in the care they receive

The hospital manager and a staff member completed a pre-admission assessment, which meant they had met patients and sometimes carers ahead of admission.

Admissions were planned and staffing adjusted to accommodate orientation and time with patients and carers. Whenever possible patient's designated workers were on duty for their admission. Information about the hospital was available in leaflet form.

Each patient had a named nurse who worked with them and their relative to write care plans that met their individual needs. We heard from staff that in an effort to be least restrictive they focussed on what a patient could do, as well as their difficulties, in order to support patients to maintain their independence. We saw care plans discussed and updated at least monthly. We also saw one to one sessions with both patient and relative involvement documented in the patient care profile. All patients were offered their care plans to sign, if they were unable to sign or refused to in most cases this was documented.

Patients attended their multidisciplinary team meeting, usually with the support of their key worker. If a patient needed support due to capacity issues, a best interest decision was documented to involve either an advocate or relative to be present, to offer support if the patient agreed to this. The standard agenda that was followed encouraged patients to contribute to important discussions about any incidents they had been involved in; their mental and physical health; relevant detention under the Mental Health Act; medication changes; levels of staff observation and anything else of importance at the time of the meeting.

The hospital kept carers informed of and invited them to meetings where care and treatment were discussed. This had helped carers understanding, making them aware of diagnosis, treatment and likely progression. Carers spoke of their involvement in care decisions and best interest meetings. If unable to attend meetings, carers were updated by telephone.

We heard from patients and carers that visiting and calls to patients at the hospital were managed well. Visitors were welcomed at the hospital, which had open visiting during the day. If families requested evening visiting after 7pm this was considered depending on the individual patients pattern of rest and sleep. When visiting was not possible, patients spoke with relatives on the telephone. When carers had telephoned the hospital, they experienced a polite and quick response. If a patient had fallen, or anything else happened similarly unexpected, carers were confident that they would be contacted.

Good

Wards for older people with mental health problems

Carers spoke of feeling supported by the staff. A carer's café meeting was held on the last Friday of every month. This offered support from staff and time with other carers. The sessions were used to share information and experiences informally. The carers we spoke with that attended found support in this meeting.

An external advocacy service provided access to both an independent mental health advocate and an independent mental capacity advocate. Patients were made aware of the advocacy service on admission to the hospital and regularly reminded that if they require an advocate the service was available.

The hospital manager had a regular presence in the ward areas where individual patients spoke openly with her about the service. Service feedback from patients was given at the weekly patient meetings and surveys each quarter. We were told the last patient survey had an 87% response rate and the feedback was mainly positive. Issues raised by patients around food had elicited a response from the head chef who had visited the ward to observe the quality of meals and speak directly with patients about choices they would like.

Carers spoke of the manager's office door being open and receiving a positive response to issues they had raised. Carers gave feedback about the service at the monthly carers meeting. At the time of the inspection, patients had not been involved in staff recruitment.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

The average bed occupancy rate at Castle Lodge independent hospital over the period 01 July 2016 to 31 December 2016 was 93%. At the time of our inspection, the hospital had no empty beds. The hospital never admitted patients without a vacancy so there was always access to a bed should a patient go on leave and return.

The number of out of area placements at the hospital in the last six months was eight. These were made up of six patients from the adjacent local authority East Riding whose border was two miles away, and two from North East Lincolnshire. The other seven patients were from Hull. At the time of the inspection, the hospital did not have beds available if needed for people living in the catchment area.

The hospital referral criteria described the ten bedded male side of the ward as a service providing slow stream recovery based care and treatment to older men aged over 55, with either functional and/or an organic mental health issues. The five bedded female side of the ward described a service providing care and treatment to older women aged over 50, with complex dementia and mental health needs.

The referral criteria also specified patients must:

- suffer from mental health problems
- be liable to detention under the Mental Health Act 1983 or subject to depravation of liberty safeguards
- be compliant with prescribed medication
- Incident free for a minimum period of 3 months (with no episodes of serious physical assaults to people or property)
- be able to contract with the unit's alcohol and substance misuse policy
- be able to engage with services and therapeutic programmes
- require rehabilitation prior to community and/or a less restrictive residential placement.

Referral to admission of a patient to the hospital took around two weeks; the hospital had a target time of 14 days. This involved a pre-assessment to ensure the hospital could meet the needs of the patient. We saw an information document that set out the stages of the admission process available to referrers, patients and their relatives.

From admission to the hospital, patients had an assessment period of 12 weeks. Pre-planned reviews took place at six and twelve weeks to ensure any potential issues were addressed. External agencies, relatives and commissioners involved with the patient were invited to attend to share their views regarding services, patients' progress and agree an individual treatment plan. The treatment plans we saw showed targets for progression in recovery and discharge planning was evident in each of the seven care records we checked.

Good

Wards for older people with mental health problems

Following agreed placements the patient and hospital continued to work within a care programme approach framework, with planned formal reviews at a minimum of six monthly intervals. The average length of stay on the male side of the ward was 41 weeks; the female side was 47 weeks.

A patient requiring a move on clinical grounds would need to access services elsewhere. Whenever possible when planning discharge, consideration was given to how a patient would maintain contact with their family and friends. Planned discharges happened at an appropriate time of day. Discharges involved patients and their relatives; staff planned and managed discharge carefully to ensure this happened as and when agreed. In the last year, no patient discharged from the service had been readmitted.

We heard from staff that one difficulty in working towards discharge was finding suitable alternative placements. When discharge was discussed carers felt concerned about finding care as good elsewhere as their relatives had received at Castle Lodge. This was exacerbated for carers of patients living with dementia who had awareness that any change was likely to prompt deterioration.

In the last six months, the hospital reported three delayed discharges from Castle Lodge. A delayed discharge occurs when a patient judged clinically ready for transfer or discharge continues to occupy a bed in the service. For two patients suitable step down placements had been difficult to identify. For the other a plan had been made with funding agreed however, the relative preferred an alternative service. The commissioners worked with the hospital team to ensure delayed discharges were minimal.

The facilities promote recovery, comfort, dignity and confidentiality

At our last inspection, the provider was looking at plans to relocate the hospital. However, since this time, a decision had been made to invest in the décor and facilities to improve the ward environment in its existing building. This meant the rooms within the ward were brighter, with furnishing replaced in the lounge and dining room areas clean, comfortable and well maintained.

Patients had their own belongings in their rooms and they told us they felt their property was safe. Patients were able to personalise their room to their own taste. One patient told us they would like a key to their room, and had asked, but had not received one. Staff explained that whilst lockable spaces were available within patient's rooms, it was not hospital practice to give individuals room door keys. Carers liked the fact each patient had their own space within the hospital ward; they saw individual rooms as safe and quiet. When carers had left valuable items these had remained secure.

Each side of the ward had an assisted bathroom. The clinic room did not have an examination couch. If a patient required a physical examination, this took place in their own bedroom, where privacy windows were standard on each door.

The bedroom windows overlooking public areas all had privacy screening. However, we found the windows overlooking an internal courtyard from the male ward did not have this screening so it was possible that patients in the courtyard of a neighbouring service could look into these rooms.

Once raised with the manager, we saw privacy screening fitted during the inspection.

Each side of the ward had access to its own lounge area. Patients on the male side could use a different, quieter lounge at the end of the corridor. Female patients who wanted a quieter indoor lounge were required to check that the 'visitors meeting room' was available.

Access to the separate gardens was through doors from the ward lounges. We found the door to the male garden locked with no notice of the door codes. We asked about this and were told that the codes should have been in place by the door however, they had been taken down for cleaning and not put back up. The door into the garden from the female lounge had its door code in place. An upgraded ramp allowed easier access for patients using a wheel chair from the female lounge into the garden. However, the exit door whilst wide enough to for the wheelchair to pass through was not wide enough for patients to propel themselves using their hands on the wheels of the chair. Whilst staff proactively supported patients in chairs through this door, it meant patients were not able to be as independent as they may have liked.

The service had open visiting until 7pm, including at mealtimes. If friends or family needed to visit after this time, this could be arranged with staff, depending on the needs of the individual patient concerned. We saw two

spaces, a separate room off the ward and a separate lounge with a door linking to the ward for visiting. In addition, some relatives visited the patients in their own room.

Patients could make a phone call in private. We saw patients with their own mobile phone. Other patients had access to a portable ward phone that they could use in their own private room or used a large button phone in the visitors' room. A carer told us that staff had ensured they could speak with their relative on the ward when unable to visit.

The hospital had no dedicated space for therapeutic activity; activities took place in communal lounges, dining areas and gardens. The activities co-ordinator had worked in this role for two years and worked with the support workers to deliver activities. The activities took place seven days a week within the hospital and where possible, in the community.

When possible the activities co-ordinator made activity plans around their knowledge of individual patients. In gaining this understanding, both patients and their families were important. Every patient had a 'My Life Story' folder covering holidays, hobbies and interests, education, family and other special people, home, work, faith, likes and dislikes, daily routine, favourite recipes, important dates, family memories and funny stories. This information helped plan meaningful activities. We saw two examples of these folders, one that a carer had completed and one that a patient had completed themselves.

Regular activities in the community included shopping or going to a café or pub. The hospital had three mini-bus drivers, which meant patients could go out further afield. When specific trips had been organised, for example to a museum, information was collated and used as prompts to remind patients where they had been and what they had seen. Support workers knew patients well and were confident and comfortable going out into the community with them. Carers told us staff worked with patients to ensure they could go out when possible.

Support workers told us within their shifts they were able to spend time doing individual activities with patients. We heard from patients on the female side of the ward they liked watching films; arts and crafts; quizzes and having pampering sessions. On the male side patients liked listening to music; reading; woodwork and in the better weather using the garden to grow vegetables, for bird watching or just to be outside. No activities had been cancelled at the hospital in the three months prior to our inspection.

Carers saw the activities that did take place enjoyable but commented that they could probably do with a few more. Staff supported specific celebrations, for example birthdays and anniversaries and involved families. Recent group activity sessions on the ward included entertainment from a piano player and 'tickle my taste buds' a session using lots of different foods.

Comments from patients about food ranged from okay to good. We heard about regular liaison between the staff and the kitchen to ensure special diets were catered for. The head chef visited the ward once a month to serve from the trolley and chat with patients to get direct feedback about the food. Patient feedback had resulted in some changes, for example buying the ingredients to make a specific pudding a patient asked for. On Saturdays, take away nights were particularly popular with patients.

The menu was on a four week cycle, patients had two choices of main meal. We were told that patients had quite a lot of choice but as the food was pre-ordered, sometimes when it arrived it was no longer what the patient wanted. Whenever possible staff responded to patient requests to alter their meal. Food was cooked on site by a team of appropriately trained staff. Meals arrived on the ward in a heated trolley. Staff used probes to check the temperature of the food before leaving the kitchen and when being served on the ward.

We observed lunch on both sides of the ward. The staff serving the food understood patient's dietary requirements, likes and dislikes. Staff sat on each side of the ward to eat their lunch with the patients. Support workers were friendly and made sure the patient's they supported had what they wanted. We saw a lot of positive interaction with patients being supported to eat appropriately, this included the use of specialist feeding aids. However, particularly in the main dining room, staff made noise that was distracting with dishes being cleared into the sink whilst patients were still eating.

Snacks and drinks were available 24 hours a day; however, patients told us they were dependent on staff to make these for them and two patients would like to have made their own.

Good

Wards for older people with mental health problems

Meeting the needs of all people who use the service

Patients had access to assisted baths and toilets with handrails on each side of the ward. The hospital was on one level with ramps in place where needed into the gardens. With the exception of doors to the garden from the female lounge, the hospital was easy to navigate for people requiring disabled access. Each patient had an en suite toilet and shower; however, not all showers had aids and equipment in place to assist patients to maintain their independence.

Noticeboards for patients displayed a range of information on the Mental Health Act, how to complain, activities, menus, how to raise a safeguarding concern to the local authority and the advocacy service.

We saw large print and hand signed information for the explaining of rights to detained patients. We saw no leaflets translated into different languages but were assured that if there was a need, this would be done. The service had access to interpreters and an online translation service, staff were confident that interpreters or signers would be found if required.

The head chef was clear that a choice of food to meet dietary requirements of religious and ethnic groups would be available if needed. In the last six months, none had been required. Where specific diets were required for medical reasons, for example, diabetic patients', the chef received direct requests and feedback from the dietician when on site. The staff held a monthly nutritional meeting to check the dietary needs of all patients were met. In addition, pre-arranged themed events included specific related menus, and special events for birthdays including buffets and cakes chosen by patients.

Staff told us they would support individuals to meet their spiritual needs if requested to do so. Links to local churches for individual patients had been made. The quiet room or visitors lounge was available to visiting chaplains. Patients who chose to attended community church services and a gospel choir had visited the hospital.

Listening to and learning from concerns and complaints

Patients tended to raise concerns verbally to the staff or directly to the hospital manager who had a regular presence on the ward. Informal discussions took place to resolve concerns, with verbal feedback given to patients. We were assured that if something could not be resolved in this way, it would be registered as a complaint.

We saw a hospital leaflet explaining how to complain, that contained both internal and external contact details. The provider had a complaints policy in place which staff were aware of. Barchester Healthcare Limited had an on-line complaints handling system for formal complaints with standardised stages, letters and follow-up requests for managers investigating the complaint. The director of care quality at a provider level oversaw the complaints system.

We reviewed the complaints summary for Castle Lodge from 01 January 2016 To 31 December 2016:

- Total number of complaints in last 12 months – 4
- Total number complaints upheld – 3 (partially upheld, one with a response)
- Total number complaints referred to Ombudsman in last 12 months – 0
- Total number complaints upheld by Ombudsman in last 12 months – 0

We reviewed these and saw the provider had responded appropriately to investigate and resolve these complaints. Formal responses in the form of letters or emails stating the outcome of investigations had been sent.

Staff told us complaints from patients or their relatives were very unusual. Following a complaint they understood that lessons learned would be shared at the monthly team meetings but no-one could recall this happening.

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

Good

Vision and values

The hospital had adopted Barchester's vision, mission and values statements.

The provider's vision statement was:

By putting quality first into everything we do for individuals we support, their families and our teams, we aspire to be the most respected and successful care provider.

Good

Wards for older people with mental health problems

The mission was to always focus on improving and developing the quality of:

- the care, hospitality and choice we offer the people we support
- our employees, their experience, development and behaviour
- the environments we create and the buildings we operate
- our systems and our financial performance.

The values were:

- We work together to make quality our way of life.
- We respect, support and strive to improve the communities we serve.
- We are honest, fair and ethical in everything we do.
- We recognise and appreciate individuality.
- We accept responsibility for our actions.
- We make life and work meaningful and enjoyable for all.
- We support and encourage initiative and creativity.
- We focus on an individual's ability and aspirations.

The vision, values and mission statements were visible during our inspection at the hospital. Some staff could refer to these; others spoke about their work at the hospital in terms of being honest, working with integrity and supporting patients to have the best quality of life they could.

Staff knew who the senior managers in the organisation were. They spoke of senior managers visiting the wards and offering support. The hospital director was very involved in care on the ward and patients and carers all knew who this was.

Good governance

We saw effective systems and oversight through monthly hospital clinical governance meetings, attended by the hospital director, registered clinician, clinical lead, registered mental health nurses and mental health administrator. These linked to divisional clinical governance meetings, which took place every three months. We saw a follow through of key agenda items, including serious untoward incidents, safeguarding of vulnerable adults, patient and public involvement, medication management and learning and development. We saw action plans with timescales and individuals responsible for actions recorded.

The provider ensured staff had access to appropriate mandatory and legislative training commencing with common induction standards. The hospital had an overall staff training compliance of 95% against a provider target of 85%. No mandatory or legislative training had less than 75% compliance. The provider had introduced a more standardised approach to training across the hospital and complex care services division. This involved both face-to-face and e-learning delivery. The hospital had managed this change successfully. We heard positive feedback from staff about both the emphasis on and access to training. Online training courses could be completed using hand held devices purchased by the hospital. Staff felt supported by managers and peers to learn, high training compliance figures reflected this.

The hospital worked to Barchester's staff supervision and appraisal policy. Staff received managerial supervision every two months and an annual appraisal. The compliance rate for the last twelve months for appraisal was 89%. The compliance rate for staff supervision in the last twelve months was 100%.

The staff files reviewed clearly showed regular attendance dates for managerial supervision and a record of their last appraisal. Records of supervision showed that staff regularly discussed their mandatory training compliance; performance and development. In addition, records showed that during individual supervision staff members had received debriefs following incidents; additional supervision following a medication error and issues raised following an internal quality first visit. In addition, staff accessed clinical reflective supervision, with the aim of developing skills and knowledge and behaviours to improve care to the patients they support. The responsibility to deliver clinical supervision was with the clinical lead and other registered practitioners.

Staff turnover in the period between December 2015 and November 2016 was 22%.The hospital risk register noted in October 2016 that patients could not receive consistent care due to the use of different agency staff. The hospital then recruited to all support worker vacancies, so at the time of the inspection only one qualified nurse vacancy was outstanding. This improved consistency in care. The hospital had recently recruited an occupational therapist and psychologist to the multidisciplinary team, which had also been noted as high risk and recorded as actioned on

the hospital risk register. Catering, housekeeping and maintenance told us they had no concerns about staffing and were able to fulfil their roles and responsibilities within their team.

Whilst the hospital was keen to develop a culture of learning and innovation, the focus of managers and care staff was to deliver quality care to patients. To ensure this happened the staff maximised their time on shift on direct care activities.

The hospital did not participate in any nationally recognised clinical audits into the procedures used for diagnosis, care and treatment. Local clinical governance minutes noted that staff completed audits on care records and medication charts on a monthly basis, the last audit on ligature risks was completed in May 2016.

A new internal audit process was introduced in January 2017. This gave staff the opportunity to give feedback on the audit tools through clinical and divisional governance meetings. All changes and updates to audits and most recent completed audits were readily available on the intranet. We saw evidence of the introduction of the latest audit schedule, including a list of 17 different audits for the hospital across twelve months; all identified both the frequency and the month for completion.

The pharmacy provider had agreed to complete quarterly audits and to attend the hospital clinical governance meeting quarterly to share their findings. We saw completed audits of medication, prescription cards and controlled drugs which took place on a monthly basis and the clinic room, which were completed weekly.

Staff knew what and how to report incidents and complaints. We saw investigations and learning from both. Following investigation, staff understood that lessons learned would be shared at daily meetings and monthly team meetings. We saw evidence of this happening in regular monthly staff meetings minutes, and in individual supervisions when appropriate. The service also kept a log of compliments; these were shared with staff in a similar way. All staff we spoke with could describe duty of candour and we saw the policy adhered to within the hospital.

Staff saw safeguarding as everyone's responsibility and were clear about the need to safeguard vulnerable adults in their care. We found positive communication between the hospital and the local safeguarding authority.

Staff had an understanding of the five principles of the Mental Capacity Act and followed these. We found staff particularly focussed on least restrictive practice with staff supporting patients to make decisions where appropriate.

Detained patients were given information about their rights on a regular basis and had access to advocacy. The detention documents we saw were in order. The mental health administrator was key in supporting the staff. If needed, Barchester had a mental health lead administrator they could access for support and information.

Staff performance was measured using feedback from supervisors and mentors as well as peers. This included key worker responsibilities and patient outcomes. Managers measured performance by referring to: attendance and timekeeping, sickness and absence, training compliance, appraisal, and supervision.

Managers would address poor performance through supervision and additional training prior to more formal framework of performance management where critical improvements targets and expectations would be set. With high compliance figures for supervision and appraisal it was evident that these systems were robust.

Following absence from work, attendance was managed through return to work interviews. These may trigger increased action in line with procedures from human resources for staff with persistent poor attendance and timekeeping. Disciplinary action was used when all other actions had been exhausted.

The hospital director felt they had sufficient authority to undertake their role. They spoke of being supported within the division and had recently increased administrative support within the hospital to assist in the collation of data. The hospital had its own key performance indicators to gauge performance, alongside a budget review these were discussed at every divisional meeting.

The hospital introduced a risk register in October 2016, senior staff were aware of this register and staff within the wards were clear they would report any risks directly to the hospital director. A new format had been introduced by Barchester hospital and complex care services division which followed national patient safety agencies frameworks and risk assessment matrix, in line with NHS guidelines.

Good

Wards for older people with mental health problems

We were told the risk register was updated at hospital governance meetings each month, with items taken to divisional clinical governance meetings quarterly. During the inspection, we saw the risk register was a documented standing item in the meeting minutes; it contained 12 items and showed reviews twice since its introduction these reviews had taken place in November and December 2016.

Leadership, morale and staff engagement

Barchester healthcare had recently introduced an employee app that encouraged staff to undertake a survey to reflect on Barchester as an employee, their working conditions and experience. Staff were also offered the opportunity to give feedback on services and input into service development in regular general staff and unit meetings.

The most recent staff survey was completed in November 2016, which had 17 responses. The survey data showed that:

- The percentage of staff that would recommend the hospital to a family member was 78%
- The percentage of staff that would recommend the hospital as an employer was 84%
- The percentage of staff that felt they had positive working relationships with their colleagues was 86%
- The percentage of staff that were positive about communication was 80%
- The percentage of staff that felt they were fairly rewarded for their work was 78%

Staff sickness rate in the 12 months 1 January – 31 December 2016 was 4.22%.

The staff we spoke with felt able to raise concerns without fear of victimisation. In the last twelve months there were no reports of bullying and harassment cases and we received no evidence to suggest any bullying or harassment had taken place. There was a bullying and harassment policy in place, which was last reviewed in November 2015.

We were also assured that all staff were made aware of the whistle-blowing process during their induction. It was evident when speaking to staff that they knew what whistle-blowing was and how to use this process. We saw posters in the ward office, staff room and in the main reception area. These related both to Barchester's internal whistle-blowing process and to that of the care quality commission. In the previous year, staff had used both. In each case, processes had been followed and investigations by someone external to the hospital had taken place.

The staff we spoke with were committed to their work, and wanted to deliver patient care that was the best it could be. Staff felt encouraged to develop and spoke of being supported to take on additional responsibilities as their competence and confidence grew. Staff who had been within the service a number of years reported that staff morale had improved since the appointment of the current hospital director.

Most staff reported they felt supported by their supervisor and team. The provider offered opportunities for staff to develop and extend their roles. The mental health administrator had recently enrolled on an externally validated learning programme, paid for and supported by Barchester.

The staff we spoke with were aware of their responsibilities to be open and transparent and explain if something went wrong with patients and relatives. We saw an example of this during inspection. Staff received Duty of Candour training on an annual basis, 91% of staff were up to date with the training. Barchester healthcare had a policy in place that was last reviewed on 1st May 2015. The policy was available on-site and on the intranet for staff.

Staff communication took place on the ward at handovers, in daily stand up and monthly team meetings. General staff meetings chaired by the hospital director took place on a monthly basis for all staff. The staff we spoke with felt able to express their views. Senior management team meetings were held weekly and attended by all heads of department. Staff could give input and feedback into the service through these forums.

There was a suggestion box in the reception area with slips for both staff and patients to complete. The hospital director told us they had an open door policy so staff and carers could raise issues and suggestions within the service. Staff told us they would feel comfortable approaching the hospital director with issues or suggestions. The night staff commented that they had the opportunity to have direct dialogue with managers as both the hospital director and the clinical lead nurse came into the hospital during their shifts.

Good

Wards for older people with mental health problems

Staff knew and felt able to speak to the divisional director and divisional lead nurse when at the hospital. The operational director for the division emailed a weekly update report out to staff.

Commitment to quality improvement and innovation

Castle Lodge's housekeeping assistant won Barchester divisional award for housekeeping 2016. The mental health administrator won Barchester divisional ward for apprentice of the year 2016. Castle Lodge also won the Barchester green award for energy efficiency in 2016.

Since our last inspection, processes had been reviewed and new divisional forms had been introduced to the hospital to ensure consistency of reporting, for violent incident/restrictive intervention; complaints/concerns/whistleblowing; observation and medication balance discrepancies.

Patients had been involved in meetings with Hull commissioners. Hospital staff attended a quarterly meeting for providers of services with Hull adults safeguarding protection board, at these meetings staff shared experiences and discussed benchmark reporting. The hospital director was on Hull and East Riding safeguarding board.

Staff had received training in an initiative to deliver improved dementia care using a collection of measurement tools, to support interventions that improve the quality of patients' lives. This included the involvement of the patient and their family, improving an individual's well-being, help after diagnosis, meaningful activity, orientation within the ward environment, medication, legislation and end of life care.

Castle Lodge were preparing for participation in accreditation for inpatient mental health services for wards for older people within the next twelve months.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure safe systems in the management of medicines. All staff involved in dispensing medication must be familiar with and work to hospital protocols. Pharmacy systems must be robust and the provider must ensure that medication audits are effective with learning from these shared. Hospital staff must ensure the correct quantities of all medications are available so each patient has sufficient to meet their needs. The provider must ensure that the administration of covert medication is only agreed following consultation with a pharmacist and regularly reviewed in multidisciplinary team meetings. The provider must ensure that medicines for disposal are appropriately stored and disposed of in a timely way. New medication and device safety alerts must be cascaded to nursing staff in a timely manner.

Action the provider SHOULD take to improve

- The provider should ensure enough qualified, competent and skilled staff to meet the needs of the patients. This includes sufficient qualified nurses on duty to complete the professional oversight required, a consultant psychiatrist is able to attend the hospital in the event of a psychiatric emergency within 30 minutes and gaps in the appointment of key staff are kept to a minimum.
- The provider should ensure that following assessment of a patient's capacity to consent the documentation available to record this is fully completed and that the opinions of a patient's family or advocate are recorded in best interest meeting notes within patient files.
- The provider should ensure that patients maintain as much independence as is possible. This includes having everything they need to participate fully in an activity, for example reading glasses, to be able to access all areas of the ward and gardens independently and when possible being able to make their own drinks and snacks.
- The provider should ensure that dirty linen trollies remain stored away from patient areas.

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 How the regulation was not met: Not all staff involved in dispensing medication worked to hospital protocols. Staff dispensing medication did not clean the surfaces after each medication administration round. This posed the risk of cross contamination or infection if medicines were prepared on unclean work surfaces. Omissions in medicines record keeping that meant a clear and up-to-date record of medicines administered to each patient was not maintained. We noted a dispensing error that had not been detected by nurses when checking or administering the medication over the last two weeks. There were discrepancies in medicine stock levels. Covert administered of medication did not include consultation with a pharmacist. Nor did we see it regularly reviews within multidisciplinary team meetings. Medicines for disposal were not all appropriately stored. There were two disposal bins in use when only one was required. A medicines audit recently completed did not pick up the issues found on inspection. Medication safety alerts were not in date, nor was it clear how these were cascaded to nursing staff in a timely manner. This was a breach of regulation 12 (2)(g)