Windermere House Independent Hospital

Quality Report

Birkdale Way
Newbridge Road
Kingston-Upon-Hull
Humberside
HU9 2BH
Tel: 01482 322022
Website: wwwbarchester.com

Date of inspection visit: 17 to 19 April 2018
Date of publication: 27/06/2018

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?	**Good**
Are services effective?	**Requires improvement**
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.

Summary of findings

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

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

Overall summary

We rated Windermere House Independent Hospital as good because:

- The hospital had made improvements following feedback from our previous inspection. The hospital environment was clean and well maintained. Staff exceeded the provider targets in key areas for mandatory training, supervision and appraisals. Hospital managers had introduced a robust process to effectively assess and manage the risks identified on the risk register.
- The hospital had systems in place to protect patients from harm. Each unit had an up to date environmental risk register and risk management plans. Staff identified and managed risks appropriately. Risk assessments included monitoring of existing and potential physical health risks. Patients told us they felt safe.
- Patients on both units had detailed, personalised care plans, which included information about physical health needs. Staff gathered information from carers to reflect a patient's history and preferences, which contributed to their care plan. Patients felt involved in decisions about their care. Patients had positive behavioural support plans in place.
- Carers and patients praised the care and treatment the service provided. Staff involved patients in decisions about their care where possible. They engaged with and supported carers where appropriate. Staff contacted carers with updates on patient progress and held regular carers meetings. The hospital was open to visitors throughout the day apart from during mealtimes.
- The hospital had discharged nine patients since 1st January 2017. They considered discharge from admission and actively sought suitable placements that could best meet their patients' needs. Patients visited all proposed placements and made the final decision about their future placement. All units experienced delays in discharging patients due to the lack of availability of suitable placements.
- The organisation's governance structure ensured effective communication from the hospital to board level and vice versa. There were effective systems in place to monitor performance, share good practice and manage risks. The hospital investigated serious incidents, fed back lessons learned to staff, and put in place any identified improvements to practice.

However:

- Staff working on the rehabilitation units struggled to relate best practice to the care and treatment they provided. The hospital was not currently using any recognised rating scales to assess and record severity and outcomes. Not all staff had a clear understanding of the hospital's transcription process for prescription charts, which had the potential to cause errors in administration.
- Patients at the hospital had limited involvement from psychology and currently no access to a qualified occupational therapist. The opinion of the psychiatrist and nursing staff dominated individual patient reviews and these meetings lacked the perspective of other qualified disciplines.
- On Kendal unit, staff did not have a clear understanding of the Mental Capacity Act and its basic principles. They did not distinguish between the Mental Health Act and the Mental Capacity Act and said they treat all patients the same, whether they were detained, informal or had deprivation of liberty safeguards authorisation. Capacity assessments varied in quality on the rehabilitation wards.
- The hospital could not always guarantee a consultant psychiatrist could attend the service within 30 minutes in the event of an emergency.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good	
Wards for older people with mental health problems	Good	

Summary of findings

Contents

Good

Windermere House Independent Hospital

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults; Wards for older people with mental health problems

Summary of this inspection

Background to Windermere House Independent Hospital

Windermere House 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. It provides care and treatment for men with a functional mental health problem (such as schizophrenia or bipolar disorder) or organic mental health problems (such as dementia and brain injuries). The hospital accommodates up to 41 patients and comprises three units:

- Coniston, an 11-bed unit for men that provides complex care and treatment for working age men with either drug induced or treatment resistant functional mental health needs. At the time of the inspection, there were 11 patients on the unit. Eight patients were detained under the Mental Health Act. One patient was subject to a Deprivation of liberty safeguard and one patient was awaiting authorisation of their application by the local authority. There was one informal patient.
- Kendal, a 15-bed unit for men that provides complex care and treatment for men aged 50 and over with either functional or organic mental health difficulties. At the time of the inspection, there were 13 patients on the unit. Three patients were detained under the Mental Health Act, four patients were subject to a Deprivation of liberty safeguard and six patients were awaiting authorisation of their application by the local authority.
- Ullswater unit, a 15-bed unit that provides care and treatment for older aged men with complex dementia and mental health needs. At the time of the inspection, there were five patients on the unit. Two patients were detained under the Mental Health Act. Three patients were either subject to a Deprivation of liberty safeguard or awaiting authorisation of their application by the local authority.

Windermere House Independent Hospital has been registered with the Care Quality Commission since 2011 to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury

A hospital director was in place at the location. The hospital director, along with the registered provider, is legally responsible and accountable for compliance with the requirements of the Health and Social Care Act 2008 and associated regulations. The hospital director was also the controlled drugs accountable officer. The accountable officer is a senior manager who is responsible and accountable for the supervision, management and use of controlled drugs.

The Care Quality Commission has inspected Windermere House Independent Hospital six times. The previous comprehensive inspection took place in December 2015. We carried out an unannounced follow up inspection that took place in November 2016 and found the hospital had breached Health and Social Care regulations. We issued the provider with three requirement notices. These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

Regulation 15 HSCA (RA) Regulations 2014, Premises and equipment

Regulation 17 HSCA (RA) Regulations 2014, Good governance

Regulation 18 HSCA (RA) Regulations 2014, Staffing.

There have also been two Mental Health Act monitoring visits in the past 12 months.

Summary of this inspection

Our inspection team

The team that inspected the service comprised two Care Quality Commission inspectors, one clinical psychologist, a registered mental nurse with experience in older adult care, and one ward manager with experience in rehabilitation.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited all three units at the hospital, looked at the quality of the unit environment and observed how staff were caring for patients
- spoke with five patients who were using the service and six carers
- interviewed the hospital director with responsibility for the service and the divisional director of the hospitals and complex care division
- spoke with the clinical lead for the hospital and managers for each of the units
- spoke with 23 other staff members; including doctors, nurses, occupational therapy assistants, psychologist and trainee psychologist, chef, maintenance, housekeeping, and administrators
- received feedback about the service from care co-ordinators or commissioners.
- spoke with an independent advocate
- attended and observed three multi-disciplinary meetings, three handover meetings and a hospital morning meeting
- observed two meal times and six activities
- looked at 16 care and treatment records of patients
- carried out a specific check of the medication management on the units, including the medication administration records of 29 patients
- reviewed personnel files for five members of staff
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with five patients using the service. Patients told they liked the hospital and felt safe there. They told us there was always staff available to talk to and that staff spoke to them kindly and respected their needs.

Patients told us about activities they had done and outings they had been on, most recently to the seaside for fish and chips. Patients we spoke with informed us staff never cancelled leave and helped them to visit their families.

Summary of this inspection

They were aware of how to complain and happy with the feedback they received.

The carers we spoke with informed us that the hospital was good and that they were happy with the care and treatment the staff provided. They thought staff had a lovely attitude and knew their patients moods and preferences well. Carers confirmed they could visit as often as they liked and felt involved in the care their relative received.

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?

Good

We rated safe as **good** because:

- The hospital was clean and well maintained. Staff followed infection control principles.
- The hospital had sufficient staff to ensure the safe care and treatment of patients. The unit manager could adjust staffing levels daily to take account of patient mix and changes.
- Staff received mandatory training in key skills to enable them to carry out their roles safely.
- Staff effectively assessed monitored and managed patients' risks.
- Use of restrictive interventions was proportionate and minimal.
- Staff knew how to report incidents and learn from them.

However:

- There were blind spots in the bedroom corridors due to the layout of the units and no mirrors to assist with observation.
- The hospital could not always guarantee the attendance of a consultant psychiatrist within 30 minutes in the event of an emergency.
- Qualified nurses were not clear on the process for transcribing prescription charts.

Are services effective?

Requires improvement

We rated effective as **requires improvement** because:

- Qualified nurses and support staff we spoke with struggled to relate the care they provided to best practice guidance.
- The hospital had limited input from psychology and did not have an occupational therapist in post at the time of the inspection.
- Patient reviews lacked input from specialist disciplines.
- Staff did not use recognised rating scales to assess and record severity and outcomes.
- Qualified staff and support staff on Kendal unit did not have a clear understanding of the Mental Capacity Act.

However:

- Patients had up to date personalised care plans.
- Patients had good access to physical healthcare and specialists if required.
- Staff provided a range of care and treatment interventions suitable for the patient group.

Summary of this inspection

Are services caring?

Good

We rated caring as **good** because:

- We observed positive interactions between staff, patients and their carers.
- Staff recognised the importance of patients' privacy and dignity.
- Patients felt staff were available to support them when needed.
- Staff communicated with patients in a way that they could understand.
- Staff involved carers in the patient's care appropriately.

Are services responsive?

Good

We rated responsive as **good** because:

- The hospital considered discharge plans from admission and actively sought suitable placements that could best meet their patients' needs.
- The hospital had a full range of rooms and equipment to support a patient's treatment and care.
- Patients had access to activities seven days of the week.
- Staff ensured patients had access to easy read information for all aspects of their care and treatment.
- Patients and their families knew how to complain and received feedback on the outcome of investigations.

However:

- The rehabilitation wards did not set a goal in respect of the expected length of stay for patients from admission.

Are services well-led?

Good

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

- The hospital had an effective ward to board governance structure.
- The hospital managers had sufficient authority and support to carry out their duties.
- The hospital provided regular information updates for staff, patients, and carers about the service.
- There was clear learning from incidents.

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.

Ninety one percent of staff had received mandatory training in the Mental Health Act and the Code of Practice.

The use of the Mental Health Act 1983 was appropriate; detention documentation complied with the Mental Health Act Code of Practice. The provider had a Mental Health Act administrator who completed audits and scrutinised documentation.

The administrator ensured patients and staff were aware of timescales for tribunals, renewals of detention and deadlines for reports. Staff informed patients of their rights in an appropriate manner for the patient group and recorded conversations accordingly.

The provider had a contract with an independent mental health advocacy service. All patients were able to access this service. The advocacy service attended the hospital each week and attended relevant meetings.

Mental Capacity Act and Deprivation of Liberty Safeguards

Ninety three percent of staff had received mandatory training in the Mental Capacity Act. Staff on Ullswater unit had a good awareness of the Act and its application. Staff on Kendal and Coniston units were less confident in their application of the Act. Nursing staff we spoke with on Kendal unit did not distinguish between Mental Health Act and the Mental Capacity Act when caring for patients.

Each patient had capacity assessments covering five key areas. These varied in quality and consistency. Staff reviewed capacity assessments within care programme approach meetings every six months. Staff described decisions, which they made in a patient's best interest and documentation showed that staff considered what the patient might want as well as input from family members.

Eight patients had deprivation of liberty safeguards in place and seven were awaiting authorisation. All these patients had received a local authority best interest assessment; however, there was a delay in the process for authorisation.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Requires improvement	Good	Good	Good	Good
Wards for older people with mental health problems	Good	Requires improvement	Good	Good	Good	Good
Overall	Good	Requires improvement	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

The service provided a safe and clean environment. Since the previous inspection, several areas of the hospital had undergone refurbishment. The provider had upgraded and redecorated Coniston and Kendal units. The unit environments had potential ligature points and staff had mitigated the risks adequately. A ligature point is something that a patient can use to tie something to in order to strangle themselves. Unit layout did not allow staff to observe all parts of unit. On both units, patient bedrooms were off a U shaped corridor. There were no mirrors to alleviate blind spots. A blind spot is an area where staff cannot see patients at all times. Patients' who did not require higher levels of observation had unsupervised access to corridors and rooms that had some ligature points, for example window hinges and taps on sinks.

Staff did regular risk assessments of the care environment. Both units had up to date ligature risk audits completed in February 2018. These audits identified that staff managed the risk posed by the ligature points through clinical risk assessment and patient observations. Staff told us that the patient group were at low risk of self-harm. Within patient records, we saw personalised risk assessments and plans were in place. Ligature cutters were available and accessible on each unit.

Within the garden areas, trees, fencing panels, guttering, and a pergola were all potential ligature points. Following a recent incident, staff on Coniston unit had introduced environmental checks every 15 minutes in the garden. On Kendal unit, staff did not carry out routine checks within the garden. Staff could accompany patients or observe them using the garden from the main day area of the unit.

The unit complied with guidance on eliminating mixed-sex accommodation because both units were for male patients only. Patients had their own bedroom with an en-suite toilet and sink. The doors on patients' rooms had viewing panels so when observations were necessary, staff could see patients at night without disturbing their sleep.

There was limited access to communal bathrooms. Each unit had one bathroom and one shower room. The Royal College of Psychiatrists Aims standards for inpatient mental health rehabilitation services identify that units should have at least one bathroom/shower room for every three patients. We saw plans for work to install an additional bathroom on Kendal ward later this year. Patients reported they were always able to use a bathroom when they wanted to.

Staff had easy access to personal alarms and patients had easy access to nurse call systems. Staff received alarms at the start of each shift. Staff provided visitors with alarms when they entered the building and demonstrated how to use them. Following an incident on Coniston ward in December 2017, the provider updated the alarm system to include additional detectors within the garden areas to ensure that staff responded to the right place. During the inspection, we observed staff responding quickly to the location of an activated alarm.

Maintenance, cleanliness and infection control

Long stay/rehabilitation mental health wards for working age adults

Good

During this inspection, we found all unit areas were clean and had well-maintained furnishings. At our previous inspection, we were concerned that the domestic staff did not always clean the hospital in a consistent and comprehensive manner, as there were gaps in the housekeeping rota. The hospital housekeeping team had responsibility for maintaining the cleanliness of public areas and shared facilities, communal areas on each unit, bathrooms and patient bedrooms. They asked for patient consent to clean their bedrooms and liaised with unit staff if a patient repeatedly refused. Cleaning records were up to date and demonstrated that the unit areas were cleaned regularly. We reviewed the housekeeping rota for a three-month period from 18 January until 18 April 2018. During this period, there were 22 days when the provider employed additional cleaning staff to cover annual leave.

Staff carried out regular environmental audits, which included checks on infection control, emergency fire equipment, cleaning rotas, and legionella disease. The maintenance lead had been in post since January 2018 and the hospital had recently appointed a part time maintenance assistant. Staff dealt with maintenance requests promptly and there was a plan for larger works. The provider escalated maintenance issues occurring out of hours to an external company.

Staff followed infection control principles and compliance with infection control training was 95% across the hospital. Above every sink in the hospital were detailed guides on how to wash hands effectively. Each unit completed a quarterly infection control audit, which reviewed the unit environment cleanliness and checked staff awareness and compliance with infection control principles. We reviewed the most recent infection control audits completed on Coniston unit dated 29 January 2018 and on Kendal unit dated 22 February 2018, which identified a few minor issues. The maintenance team had dealt with the actions arising from the audit.

Clinic room and equipment

The clinic rooms were small and equipped to meet patient needs. Neither clinic room had an examination couch. If patients required physical examinations, they visited the local general practice, or had them in their own bedroom. The charge nurse completed weekly clinic room audits and the records of these contained no gaps.

Drugs cupboards and fridges were organised and fridge and room temperatures recorded daily. Records showed temperatures were within safe limits for the storage of drugs. Emergency drugs present, were checked and in date. Resuscitation equipment was available in each unit office.

The equipment we checked was clean, well maintained and had been calibrated within the last year. Electrical items had evidence of portable appliance testing to ensure they were safe to use

Unit staff were responsible for maintaining the cleanliness of the clinic rooms. The clinic room on Coniston unit was clean, tidy and well arranged. When we inspected the clinic room on Kendal unit, we found some small areas needed improvement. We brought this to the attention of the hospital director and staff rectified this during the inspection.

Safe staffing

The hospital had sufficient staff to ensure the safe care and treatment of patients. Windermere House Independent Hospital employed 88 staff; this included qualified nurses, health care assistants, clinicians and ancillary staff. At the time of inspection, there were vacancies for 2.2 qualified nurses and no vacancies for health care assistants.

The hospital managers determined the safe number of staff required for each shift depending on the number of patients on the unit. The rehabilitation units were staffed on a long day shift (12 hours) and a night shift, with an additional qualified nurse on a short day. Staffing of the shifts was organised so there was a minimum of one qualified nurse and three healthcare assistants on duty during the day. For the night shift there was a minimum of one qualified nurse and two healthcare assistants on duty. We reviewed six weeks of rotas and saw the number of nurses and healthcare assistants matched this number on all shifts. Unit managers had one management day per week and worked within the nursing establishment the remaining four days a week.

The unit manager could adjust staffing levels daily to take account of patient mix and changes. The multi-disciplinary team discussed staffing levels at the morning meeting, which occurred four days a week. The hospital director had increased the number of staff required on Kendal above the safe staffing level in response to concern of staff about the acuity of patients on that unit. If patients required

enhanced personal support and needed a staff member to be with them constantly, managers brought in additional staff to enable this to happen safely. When we visited Kendal unit there were two additional healthcare assistants to meet the needs of individual patients who required enhanced personal support. No patients on Coniston unit required enhanced personal support.

When necessary, the hospital deployed agency and bank nursing staff to maintain safe staffing levels. Staff sickness rate on Coniston unit was 2.8% and on Kendal unit was 2.1%. The hospital used mainly bank staff to fill gaps created by sickness and leave but agency staff were used when necessary. There had been an overall reduction in the use of bank and agency staff at Windermere House Independent Hospital from 1200 hours of agency use in April 2017 to 246 hours of agency usage in December 2018. This meant that patients received care from staff with whom they were familiar. When the service needed to use agency staff, they aimed to use regular and consistent agency staff who understood the needs of the patient group.

Information provided by the hospital prior to our inspection showed that in the three-month period 1 November 2017 to 31 January 2018, Coniston unit used bank or agency staff to cover shifts on 43 occasions. Five shifts remained unfilled during this period. In the same time, Kendal unit used bank or agency staff to cover shifts 34 times. No shifts remained unfilled on Kendal unit. When shifts remained uncovered, unit managers or charge nurses who were supernumerary on the staffing rotas, worked more directly to provide cover.

The glass windows of both unit offices were frosted to maintain confidentiality, however there was a member of staff in communal areas at all times. Staff and patients we spoke with said there were sufficient staff to allow patients to have regular one-to-one time with their named nurse. Both units had an occupational therapy assistant or activity organiser who supported patients to engage in meaningful activity. Staff shortages rarely resulted in staff cancelling escorted leave or unit activities.

The multidisciplinary team consisted of:

- a consultant psychiatrist who worked four days a week
- a clinical psychologist who worked 12 hours a week
- a full time occupational therapist (appointed but not yet in post)
- two full time occupational therapy assistants
- an activity coordinator who worked four days (in post until the occupational therapist starts)
- nurses (including unit managers, charge nurses and clinical lead)

Medical staff

The consultant psychiatrist worked at Windermere House four days a week and provided medical cover day and night unless they were on leave. In addition to being responsible clinician for patients at Windermere House, he was also the responsible clinician for patients at another local provider hospital. Staff reported the psychiatrist was available, and did respond, to urgent matters outside the time he was at the hospital.

When the consultant psychiatrist was on leave, a regular locum psychiatrist provided cover. Arrangements for annual leave were pre-planned and we saw evidence that staff were aware of whom to contact and when. In the event of unplanned absence, for example sickness, another consultant psychiatrist based two hours away provided cover. The Aims standards for inpatient mental health rehabilitation services state that an identified duty doctor should be available at all times to attend the unit within 30 minutes in the event of a psychiatric emergency.

Mandatory training

At our previous inspection, we found staff were not up to date with mandatory training in key skills. During this inspection, records showed staff had received and were up to date with all appropriate mandatory training. In addition to induction training, there were 18 statutory and mandatory training modules for staff. These included safeguarding, life support, fire training, health and safety, falls, choking, moving and handling, infection control, and pressure care. There were five additional modules for nurses only, which included clinical risk management, unexpected death, anaphylaxis and safe and therapeutic observation. On 15 April 2018, overall, staff in the hospital had undertaken 93% of the various elements of training that the hospital had set as mandatory. This exceeded the provider target of 85%.

Assessing and managing risk to patients and staff

Assessment of patient risk

Long stay/rehabilitation mental health wards for working age adults

Good

During the inspection, we looked at 11 care records within this core service. Staff used a recognised risk assessment tool, the Galatean risk and safety tool, to assess the risk patients posed to themselves, to others and their vulnerability. This meant staff could identify risks and manage these safely.

Staff completed a risk assessment of every patient on admission and updated it every three months or when an incident had occurred. Patient records contained comprehensive and individualised positive behavioural support plans to manage risks. We also saw individual risk assessments and care plans for patients with specific risks such as choking. However, one patient had recently moved units and his risk assessment was not updated to reflect the change of environment.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Handovers included discussion of patient risks. Qualified nurses completed mandatory training in safe and therapeutic observation and training compliance was 89% when we inspected. Nurses could increase observation levels if they felt it necessary. There was a policy for searching however, no staff member could remember a time when it was necessary for them to search a patient.

There was no smoking within the hospital. Patients could smoke outside if they wished to and there were designated areas to do this. Staff supported patients to manage their vulnerability around smoking to ensure that they were safeguarded from abuse. Staff supported patients who wished to stop smoking and there was information about smoking cessation by the activity rooms.

Informal patients knew they could leave at will. From the main hospital reception, patients needed one door code to enter and leave Kendal unit. Patients needed four different codes to enter Coniston unit and two door codes to leave. The other two doors had a button push release to exit. Individual patients knew door codes, or staff would provide them when asked.

Use of restrictive interventions was proportionate and minimal. There were no seclusion facilities at Windermere House Independent Hospital and we saw no evidence of seclusion or long-term segregation taking place.

Staff received training in how to prevent and manage patient aggression. This training included how to calm potentially aggressive situations and the use of physical techniques to restrain a patient if necessary. A restraint happened when staff placed hands on a patient to prevent them from harming themselves or others, or when staff held a patient for a sustained period to provide basic care in their best interests.

There were no incidents of restraint on Coniston unit between 1 July and 31 December 2017. There were 12 incidents of restraint on Kendal unit during the same period. All of these involved standing or seated restraint. Staff did not use prone restraint (where a patient is restrained face down). Patient records contained positive behavioural support plans colour coded green, amber and red. These outlined strategies to use if a patient was becoming increasingly distressed and agitated.

In each incident, restraint had been a last resort following unsuccessful de-escalation. Staff reviewed the use of restraint within the hospital morning meeting, in multidisciplinary team meetings and within care programme approach meetings. Unit managers reviewed trends in the use of restraint within the hospital clinical governance meeting.

Windermere House did not have a restrictive interventions reduction programme. A restrictive intervention is something that restricts a person's liberty and other rights and includes restraint, rapid tranquilisation and wider practices such as blanket restrictions. A blanket restriction is a restriction imposed on a full unit due to the risks of some patients. We did not observe any blanket restrictions in place. During multidisciplinary team meetings, staff considered least restrictive practice and on both units, patients had access to the kitchen based on individual risk assessments.

Qualified staff followed guidance from the National Institute for Health and Care Excellence and the provider's policy in respect of rapid tranquilisation. There were no incidents of rapid tranquilisation between 1 July 2017 and the time of the inspection.

Safeguarding

Staff awareness of their responsibility to report safeguarding was high and 93% were up to date with their annual safeguarding training. All staff we spoke with stated they would tell their line manager or the hospital director if

they felt a safeguarding alert needed raising with the local authority. The hospital had three types of safeguarding training: safeguarding abuse, duty of candour and the Mental Capacity Act. Staff awareness of their responsibility to report safeguarding was high and 93% were up to date with their annual safeguarding training.

Safeguarding referrals were made when appropriate. We saw posters on each unit explaining what abuse is and how to report this. In the last year, the hospital made 17 safeguarding referrals. Staff used an assessment tool provided by the local authority safeguarding team to assess the severity of any concerns. This ensured that safeguarding concerns that needed referring were referred. Staff gave examples of recent safeguarding referrals for example related to medication and financial abuse.

Children did not visit the unit environments. Patients could meet with child visitors off the unit. During the inspection we saw that other visitors visited patients on the unit provided there were no incidents occurring at the time.

Staff access to essential information

Staff used paper patient records and had access to all the information they needed to deliver care to the patients. Patient records were stored securely in the unit office and staff, including bank and agency staff, were able to access them as needed.

The hospital used an electronic clinical governance system, which allowed managers to easily access information related to staff training compliance, supervision attendance, and trends in incidents.

Medicines management

Hospital staff followed a corporate medicine management policy and had a local standard operating procedure for medicine management. Medication was stored securely in a locked clinic room on each unit. The nurse in charge of the shift held the medication key. All registered nurses completed an annual medication competency assessment carried out by a senior nurse. Medication was in order and disposed of appropriately. Staff completed a weekly stock count of medication prescribed for individuals, which they could take as required. During the inspection, we saw the provider had a procedure in place for investigating medication errors and taking appropriate action to prevent a repetition occurring. For example, signing the administration chart incorrectly.

The hospital director was the controlled drugs accountable officer. Access to controlled drugs was restricted and these were stored in a separate cupboard on each unit. Staff regularly checked the balances of controlled drugs held and completed an audit of controlled drugs monthly. Following a recent incident on Kendal unit where the keys to the controlled drugs cupboard were misplaced, a thorough investigation was completed. Staff maintained the security of the controlled drugs at all times. The hospital followed the reporting procedures necessary including duty of candour. Following this incident, each unit carried a spare controlled drug key for another unit.

Patients had individual medication files, which contained their photograph and relevant documentation for example legal documentation, capacity assessments and best interest decisions. There were two medication administration records used: blue for psychiatric medication and white for physical health medication. In all the files, these were neat and orderly. The unit manager or charge nurse carried out a monthly audit of medication files.

All patients who needed covert medication had correct documentation in place, which showed staff had acted in their best interests. Covert medication is when a person unknowingly takes medication disguised in food or drink.

The provider had a policy and a process for transcribing medication instructions. If a medication administration record was nearly full, nursing staff transcribed the medication instructions onto a new record. The doctor then signed this record before nurses gave the patient medication. However, nursing staff were not always clear about when the doctor needed to sign the card and whether the nurse who had transcribed the medication instructions needed to sign the record. This had the potential to cause an administration error.

Staff reviewed the effects of medication on patients' physical health regularly and in line with the National Institute for Health and Care Excellence guidance, especially those patients prescribed a high dose of antipsychotic medication. Staff reviewed the effects of medication on patients' physical health regularly using the Glasgow antipsychotic side-effects scale. We saw evidence of correspondence with GPs and patients received blood tests and electrocardiograms when necessary. Until

recently, the local general practice had undertaken electrocardiograms. The hospital was in the process of acquiring an electrocardiogram to enable staff to complete the tests on site.

Track record on safety

Providers were required to report all serious incidents to the Strategic Executive Information System within two working days of an incident being identified. Windermere House Independent Hospital had no serious incidents that required reporting.

Reporting incidents and learning from when things go wrong

Staff we spoke to knew how to report incidents and gave examples of incidents they had reported. All staff could report an incident by completing an incident form. Unit staff were aware of documenting incidents in patient records and that the multidisciplinary team reviewed these each week.

Staff understood the duty of candour and 93% had completed the mandatory training module. Duty of candour regulations ensure that providers are open and transparent with patients and people acting on their behalf when something goes wrong. Staff had access to guidance and a flowchart on the intranet and when reporting accidents and incidents. Documentation contained a prompt to consider duty of candour.

Staff were open and transparent, and gave patients and families a full explanation if things went wrong. Managers reviewed incidents in the hospital morning meeting and the discussion included whether the incident met the requirements of duty of candour. We saw letters of apology sent to family members and documentation within care records when patients and families had been informed when things had gone wrong.

Staff received feedback from investigation of incidents. All incidents were reviewed in the hospital morning meeting and investigations carried out. Staff told us they received feedback through unit meetings, staff supervision, in the unit communication books and through a monthly newsletter. There was evidence the service made changes because of feedback. Recent changes included additional controlled drugs keys being stored securely, additional support for students and additional alarm sensors within the Coniston unit garden.

Staff debriefed and received support following serious incidents. Staff on Kendal unit spoke about debriefing at the end of each shift and Coniston unit staff described including the patient in a debrief wherever possible. Staff on each unit participated in a team effectiveness meeting on a three weekly basis that included space to reflect on the impact of incidents.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Both units had clear admission criteria. Senior staff completed a comprehensive assessment of a patient's needs and their suitability for the unit prior to an admission. This included an assessment of risk, the physical and mental health needs of the patient. Staff agreed to an admission if they felt they could meet the needs of the patient and the patient would fit into their current patient group on the unit.

Staff assessed patients' physical health needs in a timely manner after admission. Staff completed the National Early Warning Score for patients on admission. This score allows staff to track whether a patient is becoming physically unwell by measuring their heart rate, blood pressure, level of consciousness, and temperature. Patients had a physical health check at the local general practice where possible or on the unit if they are not well enough to attend the surgery. Staff regularly assessed patients for risk of developing pressure sores, falls and choking.

Patients were unable to have a formal assessment of their daily living skills for example meal planning, shopping, cooking, laundry, money handling, budgeting and road safety as there was no occupational therapist in post. This meant that their ability to engage fully in rehabilitation was limited.

Care plans were personalised, holistic and most were recovery-oriented. We looked at the care records for eleven patients. Staff regularly reviewed care plans during the

multidisciplinary team meetings. However, one patient had moved units recently and staff had not updated his assessments and care plans to reflect the new environment.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. Staff we spoke to struggled to relate the care they provided to best practice guidance. However, we saw examples of care and treatment based on best practice. For example, staff used physical health measures to make sure they met the physical health needs of patients and some patient files contained positive behaviour support plans. These plans identify proactive strategies that staff can use to support individuals in the event of a crisis. Staff also followed the National Institute for Health and Care Excellence guidance for prescribing medications.

Patients had limited involvement from psychology and no access to a qualified occupational therapist. The Aims standards for inpatient mental health rehabilitation services state that providers should offer patients' evidence based psychological interventions and access to occupational therapy. Occupational therapy assistants provided a wide range of activities. The hospital director supervised them fortnightly in the absence of a qualified occupational therapist. Occupational therapy assistants worked with patients to maintain their function in activities of daily living; however, they had no specialist training for the role. In addition, the service had a temporary activities coordinator to help mitigate the lack of occupational therapist.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. We looked at 11 care records within this core service. We saw evidence of ongoing monitoring of physical health conditions including electrocardiograms and blood test for patients on particular types of medication and diabetes monitoring. Staff had completed assessments for patients with particular physical health risks. For example, the Waterlow score was used to assess the risk of a patient developing a pressure sore. Patients attended the local general practice for an annual physical health check where possible, or the doctor visited them at Windermere House. Staff supported patients to attend specialist health care appointments at the local acute hospital.

Staff supported patients to live healthier lives. Staff weighed patients monthly and used the malnutrition universal screening tool used to identify any patients who could be at risk of malnutrition or obesity. Where staff identified issues, they ensured care plans outlined the steps needed to support food and fluid intake as required. There was variation in how patients received advice on healthy lifestyle. Some care records showed that patients spoke to their named nurse during individual sessions and some patients had completed a document with staff called 'My Physical Health' that included information on healthy lifestyles.

Staff did not use recognised rating scales to assess and record severity and outcomes. The service was currently evaluating a number of potential outcome measures but unit managers wanted assurance that any measure introduced was meaningful for the patients.

Although the patient care records were paper based, staff used the organisations electronic clinical governance system to be able to track trends in incidents, for example an increase in falls. Staff then discussed this information in the multidisciplinary team meeting.

Staff participated in clinical audit for example quarterly clinical notes audit, emergency equipment checks and audits of paperwork related to medication. When we inspected, the hospital did not participate in any nationally recognised clinical audits, benchmarking and quality improvement initiatives. The rehabilitation units were beginning to explore accreditation through the Quality Network for Mental Health Rehabilitation Services.

Skilled staff to deliver care

At our previous inspection, we found the hospital did not provide a range of disciplines required to meet the needs of patients. During this inspection, the staff team included or had access to some input from specialists. For inpatient mental health rehabilitation services that admit detained patients, the Aims standards states that for every 14 patients there should be a 0.5 whole time equivalent consultant psychiatrist, a full time occupational therapist, a clinical psychologist who has four sessions dedicated to psychological interventions for patients and input from an activity organiser. All multidisciplinary team members worked across the hospital covering 26 rehabilitation beds and 15 beds for older adults. The hospital employed a 0.8 whole time equivalent consultant psychiatrist as

responsible clinician and a clinical psychologist who provided three sessions per week, which included time spent providing staff supervision. The hospital previously had an occupational therapist until December 2017. They had recently appointed a full time occupational therapist who was not yet in post.

Staff were experienced and qualified, and had the right skills to meet the needs of the patient group. We reviewed five staff files including clinical and ancillary staff. These files were well-organised and contained appropriate information regarding recruitment process, references, disclosure and barring service checks, qualification checks and where appropriate confirmation of professional registration. The administration department had a robust system of reminders for staff to provide updated confirmation of professional registration and disclosure and barring service checks.

Managers provided new staff with appropriate induction (using the care certificate standards as the benchmark for healthcare assistants). New staff received a comprehensive induction folder, an induction checklist and staff had to complete all their mandatory training before being signed off their probationary period.

At the previous inspection, we found staff did not always receive regular and effective supervision and appraisals. During this inspection, staff had supervision every two months from either their manager or another designated supervisor. Supervision included space to discuss any issues staff wanted to raise, issues raised by the supervisor, and captured details of required actions. The documentation included guidance notes on good supervision that emphasised the employee's experience. The percentage of staff that received regular supervision was 92%. The percentage of staff that had had an appraisal in the last 12 months was 95%.

Managers ensured that staff had access to regular team meetings. In addition to the monthly unit business meetings, a team effectiveness meeting ran once a week. Each unit took it in turns to attend the meeting and staff from other units provided cover so that all unit staff could attend. The psychologist and psychiatrist facilitated this meeting. Staff we spoke with reported this was a helpful meeting.

Following our previous inspection, the hospital director had focused on improving compliance with mandatory training. Unit managers were now beginning to ensure that staff received the necessary specialist training for their roles. The hospital had developed a continuing professional development programme, which included specialist training on brain injury for staff on Kendal unit and rehabilitation for staff on Coniston unit. These training courses were scheduled before the end of 2018.

We saw evidence that hospital managers addressed staff performance promptly and effectively. They worked with staff to develop action plans to address poor performance and escalated issues as necessary through the disciplinary procedure.

Multi-disciplinary and inter-agency team work

Staff shared information about patients at handover meetings. The units had handover meetings from one shift to the next. We observed a handover meeting on each unit. Staff accounted for all patients prior to the start of the meeting. The nurse in charge of the previous shift led the meeting; all staff coming onto the next shift attended. The meeting detailed each patient's activities in the previous shift, any incidents, physical health, diet and fluids and discharge planning. We found that the qualified nurse communicated necessary information.

The hospital held a morning meeting four days a week that included the hospital director, unit managers, housekeeping, maintenance, and administration. Staff followed an agenda and reviewed all incidents in the hospital, considering whether duty of candour was appropriate and reviewed staffing levels across the hospital. Each person had an opportunity to provide feedback within the meeting.

Staff held multidisciplinary team meetings once a week. Patients had regular opportunities to attend multi-disciplinary team meetings to review their progress. We observed multi-disciplinary patient meetings on both units and staff clearly knew the patients and their history well. Staff invited patients to attend their meeting once a month. If a patient refused then the doctor would meet with them after the meeting. Staff invited patients into the meeting after most of the discussion and decisions had been made. There was no feedback form for patients to complete so staff were aware of their views and wishes. Although patients knew what day their multi-disciplinary team meeting was on, they did not know when they could join the meeting.

Long stay/rehabilitation mental health wards for working age adults

Good

The multi-disciplinary team meetings reviewed any incidents that had happened during the week. We attended a multi-disciplinary team meeting on both units with the doctor, nurses, including the unit manager, occupational therapy assistants and a trainee psychologist (for one patient). Psychiatry and nursing opinions dominated individual patient reviews and the meeting lacked the perspective of other qualified disciplines. There was minimal discussion of care plans during the meeting with the exception of medication. The hospital clinical lead reviewed care plans with no discussion of the rest of the team. Similarly, the Glasgow Antipsychotic Side-effects Scale was completed without the presence of the patient.

Both units had effective working relationships with teams outside the organisation, for example, with the district nurses, the local general practice and with care coordinators.

Adherence to the MHA and the MHA Code of Practice

Staff were trained in the Mental Health Act, the Code of Practice and the guiding principles. 91% of staff had had training in the Mental Health Act.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator was based in an office on Coniston unit and was easily accessible to staff. Staff had easy access to local Mental Health Act policies and procedures that reflected the most recent guidance and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. The service had access to an independent mental health advocacy service and clearly displayed information notices about the service in the communal areas. All patients received a referral to the advocacy service and were able to opt out of the referral if they did not wish to see an advocate. The advocate made frequent visits to the hospital and attended care programme approach meetings by request. Staff we spoke with knew who the advocate was, however, the patients we spoke with did not.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. An easy read booklet was available explaining rights under the Mental Health Act for patients and relatives. This was available on the units and displayed in the reception area of the hospital. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff ensured detained patients were able to take any leave granted under the Mental Health Act. On each unit, we saw notices displayed by the exit to tell informal patients that they could leave the unit freely. There was an additional notice by the exit from the activities area to the main hospital reception explaining that informal patients could leave freely. However, staff we spoke with on Kendal unit told us they treat all patients the same, whether they were detained or informal and awaiting deprivation of liberty safeguards authorisation.

Staff stored copies of patients' detention papers and forms correctly so they were available to all staff that needed access to them. The Mental Health Act administrator scrutinised Mental Health Act detention paperwork. They did monthly audits to ensure that the Mental Health Act was being applied correctly. The administrator told us they completed any actions immediately and unit staff confirmed this. The Mental Health Act administrator used the providers' administration system to send out timely reminders to alert the medical and unit staff when managers' hearings, tribunals, authorisation of medications, detention renewals, requesting a second opinion appointed doctor visits and report deadlines were due.

Good practice in applying the MCA

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Mental Capacity Act requires that as far as possible people make their own decisions and received help to do so when needed. When they lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and be as least restrictive as possible. The hospital had a Mental Capacity Act policy, which staff could access on the intranet.

Staff compliance with the Mental Capacity Act training was 93% however most staff we spoke to had a limited understanding of the Mental Capacity Act and the five key principles.

For patients who might have impaired capacity, staff assessed and recorded their capacity to consent. They did

Long stay/rehabilitation mental health wards for working age adults

Good

this on a decision-specific basis concerning significant decisions. The hospital undertook capacity assessments in five key areas for all patients: to assess their capacity to consent to treatment, manage their finances, take psychiatric medication, take physical health medication, and whether they could consent to the use of restrictive interventions (such as observations). Two staff who worked across the hospital carried out most of these capacity assessments, which followed the key principles of the Mental Capacity Act. Staff reviewed capacity assessments within care programme approach meetings every six months.

The quality of recording capacity assessments was inconsistent. We saw some examples of capacity assessments where nurses had detailed discussions with patients to assess their capacity. Staff gave patients every possible assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. In one instance, a nurse had concluded that it was not possible to determine the capacity following a detailed discussion with the patient. However, another staff member stated in the documentation that the patient did not have capacity. The documentation included no further information about how the decision was made. Other capacity assessments did not provide any detail of what discussion with the patient had taken place.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history. Best interest meetings involved relevant people and relatives attended either in person or by phone. When advocacy and relatives had not been involved in the best interests meeting, staff invited them to attend the next care programme approach meeting to participate in the review of the decisions. When patients had a Lasting Power of Attorney arrangement for health and welfare and/or finance in place the hospital ensured those representatives had the relevant authority to act on the person's behalf.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised. The procedure for this was to make a deprivation of liberty safeguards application.

Staff made deprivation of liberty safeguards applications when required and monitored the progress of applications to supervisory bodies. Between 1 August 2017 and 31 January 2018, staff made two applications for deprivation of liberty safeguards on Coniston unit and five applications on Kendal unit. On Coniston unit, one patient had deprivation of liberty safeguards in place and one was awaiting authorisation. On Kendal unit, four patients had deprivation of liberty safeguards in place and six were awaiting authorisation. All these patients had received their assessment; however, there was a delay in the process for authorisation. We saw evidence of emails to the local authority on a monthly basis to follow up on the applications.

Nursing and support staff on Kendal unit were not always clear of the legal framework that patients were being treated under. Staff on Kendal unit told us they treat all patients the same because patients were either detained under the Mental Health Act or had deprivation of liberty safeguards in place. One patient whose deprivation of liberty safeguards had expired and was awaiting re-authorisation had seven care plans: one stated he was informal, one stated an application had been made, one stated awaiting authorisation, two stated the deprivation of liberty safeguards had expired (on the wrong date) and two stated that the patient had deprivation of liberty safeguards in place.

Staff sought advice regarding the Mental Capacity Act from each other, or from senior staff such as the unit managers or psychiatrist.

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

Good

Kindness, dignity, respect and support

During our inspection, we observed positive interactions between staff, patients and their carers. Staff offered care that was calm, kind, and promoted people's dignity and were respectful and responsive in their interactions with patients. They recognised the importance of the patient's privacy and dignity. For example, we observed staff encouraging patients to get dressed before leaving their bedrooms and providing discrete personal care when needed.

Long stay/rehabilitation mental health wards for working age adults

Good

Staff were often unable to involve patients in their care in a meaningful way due to their cognitive impairment, particularly on Kendal unit. However, they took time to help patients understand and manage their care and treatment during one to one time and care plan discussions. Staff understood their patients' individual physical, emotional, and social needs and reflected this in the care and treatment they provided. We observed staff engaged in individual patient activities and provided patients and carers with help, support and advice as it was required.

Patients and carers we spoke with reported staff treated them well and were kind, helpful and supportive. They said staff respected their privacy and always had time to talk to them.

Staff were aware of the need to maintain confidentiality of information about patients. The design of the staff office on the units meant that it was not possible for others to see any confidential information as all windows had privacy screening.

The involvement of people in the care they receive

The hospital involved carers and patients in their care and treatment. Records showed patients were involved in their care plans as far as possible and offered them copies. Staff invited patients to attend their reviews. If a patient decided not to attend his review, the consultant met with them afterwards. The independent mental health advocate attended the hospital to meet with patients at least once a week. They supported patients as needed and encouraged the patients to be active partners in their own care.

Patients attended monthly patient meetings. Kendall and Coniston units both displayed the minutes for these meetings in the patient area. The meeting provided patients with the opportunity to discuss any issues and for staff to inform and involve them in hospital changes and decisions. For example, they were involved in discussion around quality of food and meals the service provided. Staff took suggestions made from the meeting to management meetings for consideration. Where possible, patients were involved in decisions about redecoration and refurbishment of their unit. Patients had the opportunity to give further feedback on the care that they received through surveys and feedback forms

Carers and family members of patients were involved appropriately in the care and treatment provided by the hospital. The hospital had open visiting hours for carers, although they ensured protected mealtimes. Where possible, each unit ensured patients were able to take escorted leave to visit their families. For example, support workers regularly facilitated home visits for patients on Coniston unit, whose family live out of area.

Carers informed us that the hospital invited them to all relevant meetings and kept them informed if they were unable to attend. The hospital arranged carers meetings every three months. They had recently sent carers a questionnaire to try improving attendance at the meeting. The hospital director sent carers a monthly newsletter to keep them updated with activities and developments taking place. The hospital sought carers' views through feedback surveys.

Patients invited their carers to attend events held at the hospital. For example, at Christmas time, they invited carers and relatives to join in the Christmas entertainment, which included a carol concert.

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

Good

Access and discharge

The hospital admitted patients following an initial pre assessment and agreement from the multi-disciplinary team. Referral to admission took no longer than seven days, if the patient met the hospital's admission criteria. The criteria ensured the service admitted patients that were suited to the environment and the care and treatment provided. In the six-month period ending 31 January 2018, they assessed three patients who found alternative placements or were not suitable for the unit. The service did not take any urgent admissions. There was a 12-week assessment period from admission to ensure that the patient, their relatives, staff and the commissioners could agree an individual treatment plan for the next six months. Treatment plans showed targets for progression in recovery and discharge.

Long stay/rehabilitation mental health wards for working age adults

Good

The hospital provided information for average length of stay for the period 1 January 2017 to 17 April 2018. Kendal unit reported an average length of stay of 2,466 days. Coniston unit reported their average length of stay as 1147 days. The hospital had existing patients from when Windermere House was a residential care home 10 years ago, who required hospital care. In the last 12 months, the hospital had committed to moving patients on to more suitable environments to aid their recovery. Both Coniston and Kendal units had successfully discharged two long stay patients each, including a patient who had been at the hospital 12 years. However, there was no goal setting on admission for a patient's expected length of stay on the rehabilitation wards.

During this period, 13 patients were from the local area and 11 were out of area placements. Beds were available when needed to people living in the catchment area. Staff did not admit patients into leave beds, which meant that when patients left the unit on leave their bed was always available for them when they returned. The hospital did not move patients between units during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. There was a formal process in place to facilitate this. A patient, who had been with the hospital when it was a care home recently moved so he could access more activities of daily living. As a result, the patient was able to buy and cook lunch for his relatives, which would not have happened had he remained on the previous unit.

Discharge planning commenced on admission and was evident in each of the care records we checked. Staff and patients discussed discharge arrangements at the unit review meetings and care programme approach meetings. In the last 12 months, there were two delayed discharges on Kendal unit and three on Coniston unit. The reasons for the delayed discharge were difficulties in finding suitable alternative placements. Staff arranged discharge times at a time that was convenient to patients, and their families. The hospital did not delay planned discharges for other than clinical reasons.

The facilities promote recovery, comfort, dignity and confidentiality

The hospital had a range of rooms and equipment to support treatment and care and to promote recovery. The reception area of the hospital was friendly and welcoming, with easy read information clearly displayed. There was a small and comfortable café area for people waiting for meetings or visiting patients.

All patients had their own bedrooms. Some patients chose to personalise their bedrooms and all bedrooms provided a lockable safe for patients to keep their possessions safe. Patients could have their own key to their rooms although most patients chose not to have a key. Staff locked these rooms on a patient's request. All patients had access to their rooms during the day.

The hospital had an ongoing plan to update areas of the hospital. They had recently made improvement to the ensuite facilities on Coniston unit and a new bathroom on Kendal unit was being installed in June 2018. One patient on this unit recently had new flooring fitted in his bedroom that was more appropriate to his preferences. The patient and his carers were fully involved in the decision-making process and interim arrangements required while improvements to the room took place.

Staff and patients had access to a range of rooms and equipment to support patients' treatment and rehabilitation needs. On each unit, this included small clinic room, a well-equipped games room, kitchen area, and communal areas. Occupational therapy assistants and the activity coordinator provided patients with a range of meaningful daytime activities and opportunities to socialise. These included visits to places of interest, and at patient request, a disco. Notice boards clearly displayed the activity timetable for each day of the week. Staff focused on maintaining patients function during the period without an occupational therapist.

There were quiet areas on and off the units where patients could meet visitors. Patients had access to the gardens allocated to their unit at all times. The gardens were well maintained, with facilities to support patient activities, including designated smoking areas. Throughout the inspection, we saw patients freely access these facilities.

Advocacy services attended the hospital on a regular basis

Staff offered patients the use of the cordless phone so they could make a phone call in private. Some patients had their own mobile phones, which they used to make phone calls in private. There was a computer room, which patients could access with staff support.

Long stay/rehabilitation mental health wards for working age adults

Good

At the time of the inspection, there was an interim head chef. Patients and carers said the food was of a good quality. Catering staff offered patients a daily choice of meals from a menu that rotated every four weeks. Staff ate with and supported patients in the dining room during mealtimes. During the inspection, the weather was unseasonably warm. We saw the chef offer ice creams to those patients enjoying the sunshine. Patients could make hot drinks and access snacks when they wanted.

Patients' engagement with the wider community

Staff ensured that patients had access to opportunities in the local community such as training and work skills. This included enrolment on training courses at the local recovery college. In addition, the hospital offered patients the opportunity to complete accredited programmes of learning through the Award Scheme Development and Accreditation Network. This externally validated learning programme offered courses that build on the strengths and interests of an individual. They included grow skills for learning, skills for employment and skills for life. Hospital staff who had undertaken specific training from the organisation supported patients to complete their programmes of learning.

Staff supported patients to remain in contact with their families and to maintain relationships with other people who were important to them, such as their friends. The service offered flexible visiting arrangements and staff supported patients with their leave requests, which included time with family.

Meeting the needs of all people who use the service

The hospital could accommodate patients and visitors with mobility issues. Coniston unit was located on the first floor and Kendal unit on the ground floor. There was lift access to Coniston unit. All patients who had bedrooms upstairs were fully mobile and able to use the stairs. Staff told us they escorted patients to use the lift if required. The provision of accessible bathing facilities was limited to an assisted bathroom on Kendal unit. Individual patients' ensuites had aids and equipment to assist with the management of continence and all patients' rooms had privacy screens on the windows. Patients who had mobility issues used wheelchairs when appropriate. Where patients had a need, the hospital provided profile beds.

Easy read text about aspects of care and treatment, for example, the rights of detained patients were available. At the time of our inspection, English was the first language for all patients. Each unit had notice boards that displayed a range of information about treatments, local services, the Mental Health Act, and how to complain. Information leaflets in different languages could be requested if there was a need.

Patients had a choice of food available to meet their specific dietary requirements such as vegetarian or diabetic options. They also catered for individual preferences. For example, one patient expressed a preference for no sandwiches. The chef met this request by including alternatives such as omelettes or pasties as an alternative.

The hospital accommodated cultural and spiritual needs. During the inspection, those patients who wished to could attend a church service on site. Staff supported patients to attend a mosque or church using their section 17 leave if this was the patient's wishes

Listening to and learning from concerns and complaints

This core service did not receive any formal complaints in the last 12 months. Patients and carers told us they knew how to complain. Kendal had recorded one concern raised by a carer. Patients we spoke with felt confident to complain or raise concerns either directly with staff or at the weekly community meeting. Staff gave patients and carers verbal feedback regarding these complaints. Staff knew how to support patients to make a formal complaint and ensured patients received feedback.

The hospital displayed its complaints process on notice boards across the service. They also had a 'you said, we did' board, which presented comments made by patients and what actions had been taken. For example, patients complained they did not like rice pudding so the chef amended the menu choice.

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

Good

Vision and values

Long stay/rehabilitation mental health wards for working age adults

Good

The provider had a vision for what it wanted to achieve, which included workable plans to turn it into action. They had recently changed its organisations' values, following a consultation process that included staff input. The values were passion, empowerment, respect, responsibility and integrity. The provider communicated their values through newsletters and posters on communal area notice boards. In addition, staff discussed the values at the beginning of every meeting. Consequently, staff we spoke with had a good understanding of the new values and were able to describe how they applied to the care and treatment they provided.

Staff knew who the most senior managers in the organisation were. All staff knew the service's divisional director, who visited the hospital on a regular basis. Staff were less familiar with the chief executive officer and chief operating officer, and some staff were unaware they had recently visited the service.

Good governance

There was a framework of meetings at unit, hospital and directorate level to enable managers to share and discuss essential information.

At hospital level, the hospital director had systems in place that gave a good oversight of the performance of their units. This included supervision, appraisals and staffing levels.

Staff undertook and participated in a variety of clinical audits such as medicines management, clinic room equipment and care plans at unit level. The audits were sufficient to provide assurance and staff acted on the results when required.

Management of risk, issues and performance

At our previous inspection, we found that although the hospital had a risk register, there was no robust process to effectively assess and manage the risks identified. Staff discussed service risks at team level and could escalate concerns through line management if needed. Hospital managers discussed risks during clinical governance meetings, where they were able to consider inclusion on to the hospital risk register. The hospital risk register clearly identified risks ranging from extreme to low risk. Staff concerns matched those on the risk register.

During this inspection, we found that hospital managers reviewed the existing risks during their clinical governance meeting and updated the risk register to reflect any actions taken or change to the level of risk.

Information management

The unit manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. For example, bed occupancy rates, mandatory training, supervision and appraisal completion. They could easily produce and review specific performance reports, which meant they could discuss their team's performance at the monthly clinical governance meetings with senior management.

Staff had access to the electronic equipment and paper documents they needed to do their work. The electronic systems supported staff to document and update risk. There was sufficient equipment and information technology for staff to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

The service made notifications to external bodies as required.

Leadership, morale and staff engagement

The unit managers for this core service had the skills, knowledge and experience to perform their roles and a good understanding of the units they managed. The hospital director was fully committed to improving the quality of care and treatment and ensuring it met the needs of the patients. They had a good understanding of the systems and processes that gave oversight to the performance and the quality of the service. There had been a number of staff changes, which included the hospital director and the manager for Kendal unit since the previous inspection.

The unit managers had access to leadership training and other management specific training courses. They supported staff with their training needs through the appraisal and supervision process. All the staff we spoke with felt supported by their immediate manager. They told us their managers were approachable and familiar with all the activities on the ward.

This core service planned staffing rotas at least four weeks in advance, which allowed the managers to plan for any

identified gaps in staffing. The hospital director was aware of the importance of using resources effectively and had oversight of the unit budget. They regularly discussed resources and performance issues with senior managers and the provider's financial department. They shared this information with all staff working on the units.

The unit managers and the hospital director appropriately addressed staffing levels and absences. The hospital director was familiar with the learning and development needs of the staff and encouraged them to take lead roles on the unit according to their skills and areas of interest.

Staff reported the hospital director was visible on the unit. All staff knew the service's divisional director. However, some staff were unfamiliar with the senior managers at board level and told us they did not visit the unit.

Culture

Staff morale varied but overall staff reported working in a supportive team. Staff we spoke with mentioned the amount of change the service had been through in the last twelve months was challenging, with changes within the management team and staffing teams. However, staff worked well together and took action to make sure they had enough support when they needed it.

Staff felt confident to use the whistleblowing process and said they would raise concerns without fear of victimisation. They knew about the organisations whistleblowing policy and that they could contact external organisations to report concerns. There were no reported cases of bullying in the twelve months preceding, or during this inspection.

The hospital director dealt with any staff issues such as poor staff performance and long-term sickness. They worked jointly with the provider's human resources department to support staff to address such issues. The overall sickness rate for this core service was low at 2.4%, which was below the national average of 4.2%. The provider had arrangements in place for staff to access support for their own physical and emotional health needs through an occupational health service.

Staff appraisals included conversations about career development and the support available. The provider recognised staff success within the service, with an employee of the month award. Staff working within the hospital nominated an individual each month to receive this award. In addition, the provider held annual care awards across all its services. Previously the hospital had not nominated any staff for an award. However, this year the hospital's Mental Health Act coordinator had been nominated for an award.

Engagement

The hospital provided regular information updates for staff, patients, and carers about the service, the work of the provider and the services they used, through emails, newsletters and a variety of meetings. Staff, patients, and carers could access initial information about the service through the provider's website, although this was not up to date. Staff felt that the hospital managers kept them sufficiently informed of the future of the service and the hospital as a whole.

The service worked closely with external stakeholders such as commissioners, both locally and out of area. Commissioners visited the service and had input into patients' care programme approach meetings. We engaged with commissioners involved with the service and received positive feedback about the service provision.

Everyone had opportunities to give feedback about the service. This could be through staff, patient and carer meetings, surveys or comment cards. We saw evidence that patients were involved in decisions about changes to their unit. For example, at one meeting patients requested a pool table, which was in place at the time of the inspection.

Commitment to quality improvement and innovation

Staff did not take part in any standardised work that supported quality improvement and innovation Nor did they participate in any peer accreditation programmes. However, the hospital director and those heading the different units and services within the hospital met on a regular basis to explore service development and innovations. For example, the psychologist recently used a framework released by the British Psychology Society to help complete formulations for patients on Coniston Unit. The plan was to develop this service wide.

The provider had developed a quarterly peer review system where senior staff visited locations to review the quality of service against a range of standards. Following the most recent peer review visit, the hospital director had

Long stay/rehabilitation mental health wards for working age adults

Good

developed an action plan for those issues identified as requiring improvement. We noted most of these issues either had been resolved or were currently being dealt with.

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

Ullswater unit provided patients with a suitable environment, which was clean and safe. The unit was for male patients only and patients had their own bedroom with an ensuite toilet and sink. The doors on patients' rooms had viewing panels so when observations were necessary, staff could see patients at night without disturbing their sleep.

The unit layout did not allow staff to observe all parts of the unit. Patient bedrooms were off a U-shaped corridor. There were no mirrors to alleviate blind spots. A blind spot is an area where staff cannot see patients at all times. The environment had potential ligature points; however, staff had taken steps to manage these risks. A ligature point is something that a patient can use to tie something to in order to strangle themselves.

Patients who did not require higher levels of observation had unsupervised access to corridors and rooms that had some ligature points for example window hinges and taps on sinks. Staff did regular risk assessments of the care environment. The unit had an up to date ligature risk audits completed in February 2018. This audit identified that staff managed the risk posed by the ligature points through clinical risk assessment and patient observations. Staff told us that the patient group was at low risk of self-harm and within patient records; we saw personalised risk assessments and plans were in place. Ligature cutters were available and accessible on the unit.

Within the garden areas, trees, fencing panels, and guttering were all potential ligature points. Ullswater unit was located on the ground floor and access to the garden area was through the lounge. Staff could accompany patients or observe them using the garden from the main day area of the unit. During the inspection, we saw that the door to the garden was open most of the time.

The unit had one bathroom and shower room. The Aims standards for inpatient older adults mental health services recommends that units should have at least one bathroom/shower room for every three patients. When we inspected there were five patients on Ullswater unit. The bathrooms were in need of decoration and the staff were trying to involve patients in the choice of colour for the rooms.

Staff had easy access to personal alarms and patients had easy access to nurse call systems. Staff received alarms at the start of each shift. Staff provided visitors with alarms when they entered the building and demonstrated how to use them.

Maintenance, cleanliness and infection control

During this inspection, we found all unit areas were clean with well-maintained furnishings and fittings. At our previous inspection, we were concerned that gaps in the housekeeping rota meant domestic staff did not always cleaned in a consistent and comprehensive manner. The hospital housekeeping team had responsibility for

maintaining the cleanliness of public areas and shared facilities, communal areas on each unit, bathrooms and patient bedrooms. Cleaning records were up to date and demonstrated the team cleaned the unit regularly.

Staff carried out regular environmental audits, which included checks on infection control, emergency fire equipment, cleaning rotas, and legionella disease. The maintenance lead had been in post since January 2018 and the hospital had recently appointed a part time maintenance assistant. Staff dealt with maintenance requests promptly and there was a plan for larger works. The provider escalated maintenance issues occurring out of hours to an external company.

Staff followed infection control principles and compliance with infection control training was 95% across the hospital. Above every sink in the hospital were detailed guides on how to wash hands effectively. The unit completed a quarterly infection control audit, which reviewed the environment cleanliness and checked staff awareness and compliance with infection control principles. We reviewed the most recent infection control audit completed on Ullswater Unit on 22 February 2018. The audit identified an issue with spot cleaning that staff reported to housekeeping. The subsequent action plan addressed this issue.

Clinic room and equipment

The clinic room was small and equipped to meet patient needs. It was clean, well maintained and equipment had been calibrated within the previous year. The clinic room did not have an examination couch. If patients required physical examinations, they visited their local general practice, or had them in their own bedroom. The charge nurse completed weekly clinic room audits and the records of these contained no gaps.

Drugs cupboards and fridges were organised and fridge and room temperatures recorded daily. Records showed temperatures were within safe limits for the storage of drugs. Emergency drugs present, were checked and in date. Resuscitation equipment was available in the unit office. There was no controlled drug cupboard on Ullswater.

Safe staffing

The unit had sufficient staff to provide safe care and treatment to patients. The unit manager determined the safe number of staff required for each shift depending on the number of patients on the unit. Ullswater Unit worked a shift pattern of a long day shift (12 hours) and a night shift. Staffing of the shifts was organised so there was a minimum of one qualified nurse and two healthcare assistants on duty during the day, with an additional support worker on a short day. For the night shift there was a minimum of one qualified nurse and two healthcare assistants on duty. We reviewed six weeks of rotas and saw that the number of nurses and healthcare assistants matched this number on all shifts. The unit manager had three days to carry out additional duties in management and leadership each week and worked within the nursing establishment the remaining two days.

The unit manager could adjust staffing levels daily to take account of patient mix and changes. The multidisciplinary team discussed staffing levels at their morning meeting, which occurred four days a week. If patients required enhanced personal support and needed a staff member to be with them constantly, the unit brought in additional staff to enable this to happen safely. When we visited Ullswater unit, there were two additional healthcare assistants on duty until midnight to provide enhanced personal support.

When necessary, managers used agency and bank nursing staff to maintain safe staffing levels. The staff sickness rate was 3.1% with one staff member being sick for a long time. The hospital used mainly bank staff to fill gaps created by sickness and leave but employed agency staff when necessary. When managers had to use agency staff, they tried to use those who worked at the hospital regularly and understood the needs of the patient group. Information provided by the hospital before our inspection showed that, in the period 1 November 2017 to 31 January 2018, Ullswater unit used bank or agency staff to cover shifts on seven occasions. Four shifts remained unfilled during this period. When shifts remained uncovered, the unit manager or charge nurse provided cover.

The glass windows of the unit office were frosted to maintain confidentiality. This meant that staff could not see out. However, there was a member of staff in communal areas at all times. Staff we spoke to said there were sufficient staff to allow patients to have regular one-to-one time with their named nurse and nurses were creative in how they spent time with patients. The unit had an

occupational therapy assistant two days a week who supported patients to engage in meaningful activity. Staff shortages rarely resulted in staff cancelling escorted leave or unit activities.

Medical staff

The consultant psychiatrist worked at Windermere House Independent Hospital four days a week and provided medical cover day and night unless they were on leave. In addition, they were also the responsible clinician at another local hospital run by the provider. Staff reported the psychiatrist was available, and did respond, to urgent matters outside the time they were at the hospital.

When the consultant psychiatrist was on leave, a regular locum psychiatrist provided cover. Arrangements for annual leave were pre-planned and staff knew who to contact and when.

In the event of unplanned absence where the locum psychiatrist was unavailable, another psychiatrist based two hours away provided cover. The fundamental standards for inpatient older adults mental health services states an identified duty doctor should be available at all times to attend the unit within 30 minutes in the event of a psychiatric emergency and within an hour during normal working hours.

Mandatory training

At our previous inspection, we found staff were not up to date with mandatory training in key skills. During this inspection, records showed staff had received and were up to date with all their mandatory training requirements. In addition to induction training, there were 18 statutory and mandatory training modules for staff. These included safeguarding, life support, fire training, health and safety, falls, choking, moving and handling, infection control, and pressure care. There were five additional modules for nurses only, which included clinical risk management, unexpected death, anaphylaxis and safe and therapeutic observation.

Assessing and managing risk to patients and staff

Assessment of patient risk

During the inspection, we looked at five care records within this core service. Staff used a recognised risk assessment tool to assess the risk patients posed to themselves, to others and their vulnerability. This meant staff could identify risks and manage these safely.

Staff completed a risk assessment of every patient on admission and updated it every three months or when an incident occurred. Patient records contained comprehensive and individualised positive behavioural support plans to manage risks. We also saw individual risk assessments and care plans for patients with specific risks such as choking.

Management of patient risk

Staff identified and responded to changing risks to, or posed by, patients. Handovers included discussion of patient risks. Qualified nurses completed mandatory training in safe and therapeutic observation. They could increase observation levels if they felt it necessary. There was a policy for searching patients; however, staff we spoke with said they could not remember a time when it had been necessary to search a patient.

There was no smoking allowed within the hospital. Patients could smoke outside if they wished to and there were designated areas to do this. Staff supported patients who wished to stop smoking and there was information about smoking cessation by the activity rooms. At the time we inspected, none of the patients on Ullswater unit smoked.

There was a notice by the door, informing informal patients who wished to leave that they could ask a nurse to open the door. At the time of our inspection, there were two patients detained under the Mental Health Act and three patients subject to the Deprivation of Liberty Safeguards.

Use of restrictive interventions

The unit had no seclusion facilities and the provider reported no incidents of seclusion or long-term segregation taking place. Staff received training in how to prevent and manage patient aggression. This training included how to calm potentially aggressive situations and the use of physical techniques to restrain a patient if necessary. A restraint happened when staff placed hands on patients to prevent them from harming themselves or others, or when staff held a patient for a sustained period to provide basic care in their best interests.

Good

Wards for older people with mental health problems

There were 34 incidents of restraint on Ullswater Unit between 1 August 2017 and 31 January 2018 involving five different patients. This was an increase in comparison to the number of restraints reported during the previous year. However, all of these restraints were either standing or seated restraint. Staff took action to identify the underlying need of a patient who required restraining on several occasions. The learning from this resulted in restraint no longer being necessary with this patient. Staff did not use prone restraint (where a patient is restrained face down). Patient records contained positive behavioural support plans, which included a graded plan outlining strategies to use if a patient was becoming increasingly distressed and agitated.

In each incident, restraint had been a last resort following unsuccessful de-escalation. Staff we spoke to described a variety of techniques they use to deescalate which demonstrated they knew the patients well. Staff reviewed the use of restraint within the hospital morning meeting, in multidisciplinary team meetings and within care programme approach meetings. Managers reviewed trends in the use of restraint within the hospital clinical governance meeting.

Windermere House Independent Hospital did not have a restrictive interventions reduction programme. A restrictive intervention is something that restricts a person's liberty and other rights and includes restraint, rapid tranquilisation and wider practices such as blanket restrictions. A blanket restriction is a restriction imposed on a full unit due to the risks of some patients. We did not observe any blanket restrictions in place. For example, bedroom doors on the unit were unlocked unless a patient requested that staff lock theirs. Staff managed patients' wandering into other people's bedrooms on an individual basis, rather than a locking all bedroom doors. During multidisciplinary team meetings, staff considered least restrictive practice and patients had access to the kitchen based on individual risk assessments.

Qualified staff followed guidance from the National Institute for Health and Care Excellence and the provider's policy respect of rapid tranquilisation. There were no incidents of rapid tranquilisation between 1 July 2017 and the time of the inspection.

Safeguarding

Although staff received training in safeguarding most unqualified staff were unaware how to raise a safeguarding alert with the local authority safeguarding team. All staff stated they would tell their line manager or the hospital director. The hospital had three types of safeguarding training: safeguarding abuse, duty of candour and the Mental Capacity Act. Staff awareness of their responsibility to report safeguarding was high and 93% were up to date with their annual safeguarding training.

The hospital made safeguarding referrals when appropriate. We saw posters explaining what abuse is and how to report this. In the previous year, the hospital made 17 safeguarding referrals. Staff used an assessment tool provided by the local authority safeguarding team to assess the severity of any concerns. This ensured that safeguarding concerns that needed referring were made. Staff gave examples of different types of abuse; however, they could not recall any recent safeguarding alerts that had been necessary.

Children did not visit the unit environment. Patients could meet with child visitors off the unit. During the inspection, we saw that visitors visited patients on the unit provided there were no incidents occurring at the time.

Staff access to essential information

Staff used paper patient records and had access to all the information they needed to deliver care to the patients. Patient records were stored securely in the unit office and staff, including bank and agency staff, were able to access them as needed.

The hospital used an electronic clinical governance system that allowed managers to easily access information related to staff training compliance, supervision attendance, and trends in incidents.

Medicines management

Hospital staff followed a corporate medicine management policy and had a local standard operating procedure for medicine management. Medication was stored securely in a locked clinic room. The nurse in charge of the shift held the key. All registered nurses completed an annual medication competency assessment carried out by a senior nurse. Medication was in order and disposed of in

Good

Wards for older people with mental health problems

line with the law. Staff completed a weekly stock count of medication that patients took as required. Staff investigated medication errors, and took action to prevent mistakes re-occurring.

The hospital director was the controlled drugs accountable officer. However, there was no controlled drugs cupboard on Ullswater Unit and no patients were prescribed controlled drugs.

Patients had individual medication files, which contained their photograph and relevant documentation, for example, legal documentation, capacity assessments and best interest decisions. There were two medication administration records used: blue for psychiatric medication and white for physical health medication. In all the files, these were neat and orderly. The unit manager or charge nurse carried out a monthly audit of medication files.

All patients who needed covert medication had correct documentation in place and staff had acted in their best interests. Covert medication is when a person unknowingly takes medication disguised in food or drink.

Staff reviewed the effects of medication on patients' physical health regularly and in line with National Institute for Health and Care Excellence guidance, especially when the patient took a high dose of antipsychotic medication. Staff used the Glasgow Antipsychotic Side-effects scale to monitor the effects of medication on patients' physical health. We saw evidence of correspondence with GPs, and patients received blood tests and electrocardiograms when necessary. The hospital was in the process of acquiring an electrocardiogram machine to enable staff to complete the tests on site.

Track record on safety

Providers are required to report all serious incidents to the Strategic Executive Information System within two working days of an incident. Ulleswater unit had no serious incidents that required reporting between 1 January and 31 December 2017 or at the time of the inspection.

Reporting incidents and learning from when things go wrong

Staff we spoke to knew how to report incidents and gave examples of incidents they had reported. All staff could report an incident by completing an incident form. Unit staff were aware of documenting incidents in patient records and that the multidisciplinary team reviewed these each week.

Staff understood the duty of candour and 93% had completed the mandatory training module. Duty of candour regulations ensure that providers are open and transparent with patients and people acting on their behalf when something goes wrong. Staff were open and transparent, and gave patients and families a full explanation when things went wrong. Managers reviewed incidents in the hospital morning meeting and the discussion included whether the incident met the requirements of duty of candour.

Staff received feedback from investigation of incidents. All incidents were reviewed in the hospital morning meeting and investigations carried out. Staff told us they received feedback through team meetings, staff supervision, in the unit communication books and through a monthly newsletter. Staff met to discuss that feedback and the hospital director pre-populated meeting agendas with lessons learnt from incidents and complaints.

Staff debriefed and received support after a serious incident. Staff described including the patient in debriefs wherever possible and coming back to discuss it later if they initially refused.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Ullswater Unit had clear admission criteria. Senior staff completed a detailed assessment of a patient's needs and their suitability for the unit prior to admission. This included an assessment of risk, the physical and mental health needs of the patient. Staff agreed to an admission if they felt they could meet the needs of the patient and the patient would fit into their current patient group on the unit.

Staff assessed patients' physical health needs in a timely manner after admission. Staff completed the National Early

Good

Wards for older people with mental health problems

Warning Score for patients. This score allowed staff to track whether a patient was becoming physically unwell by measuring their heart rate, blood pressure, level of consciousness, and temperature. Patients had a physical health check at the local general practice where possible or on the unit if they are not well enough to attend the surgery. Staff regularly assessed patients for risk of developing pressure sores, falls and choking.

Nursing staff knew the patients well and were able to identify activities that were meaningful to them although patients were unable to have a formal assessment of their current level of ability to engage in activities. In 2016, a previous occupational therapist had completed the Pool Activity Level Instrument, as recommended by the National Institute for Clinical Excellence Clinical Guidelines for Dementia. However, staff had not updated this to reflect any changes in patient abilities.

We looked at the care records for five patients. Care plans were personalised, holistic and identified patients' interests and previous activities. However, they did not identify what support the patient needed was to engage in activities. Records showed staff regularly reviewed care plans in multidisciplinary team meetings.

Best practice in treatment and care

Staff provided a range of care and treatment interventions suitable for the patient group. Some staff we spoke with struggled to relate the care they provided to best practice guidance. However, we saw examples of care and treatment based on best practice. For example, staff used physical health measures to make sure they met the physical health needs of patients. There was a variety of dementia friendly activities available within communal areas that reflected the history of the patient group. Patient files contained positive behaviour support plans. These plans identified proactive strategies that staff used to support individuals in the event of a crisis. Staff also followed the National Institute for Health and Care Excellence guidance for prescribing medications.

Patients received no involvement from psychology and the service currently had no qualified occupational therapist. The Aims standards for inpatient older adults mental health services state that patients should be offered evidence based psychological interventions and have access to occupational therapy.

An occupational therapy assistant worked on the unit two days a week and provided a range of activities. They worked with patients to maintain their function in activities of daily living. However, they had no specialist training for the role. The hospital director supervised them fortnightly in the absence of a qualified occupational therapist.

Staff ensured that patients had good access to physical healthcare, including access to specialists when needed. We looked at five care records within this core service. We saw evidence of ongoing monitoring of physical health conditions including electrocardiograms and blood test for patients on particular types of medication. Staff had completed assessments for patients with particular physical health risks. For example, staff used the Waterlow score to assess the risk of a patient developing a pressure score. Patients attended the local general practice for an annual physical health check where possible, or the doctor visited them the Hospital. Staff supported patients to attend specialist healthcare appointments at the local acute hospital.

Staff supported patients to live healthier lives. Staff weighed patients monthly and used the malnutrition universal screening tool used to identify any patients who could be at risk of malnutrition or obesity. Staff could refer patients for speech and language therapy if they were concerned about their ability to swallow food and drink. When staff identified a patient had physical health concerns, they included a guide for staff to follow in the care plan to support food and fluid intake as required

Staff did not use recognised rating scales to assess and record patient outcomes. The service was currently evaluating a number of potential outcome measures as the hospital director wanted assurance that any measure introduced was meaningful for the patients.

Although the patient care records were paper based, staff used the organisation's electronic clinical governance system to be able to track trends in incidents, for example an increase in falls. They would then discuss this information in the multidisciplinary team meeting.

Staff participated in clinical audit for example a quarterly audit of care records, emergency equipment checks, and audits of paperwork related to medication. The hospital did not participate in any nationally recognised clinical audits, benchmarking and quality improvement initiatives.

Skilled staff to deliver care

Good

Wards for older people with mental health problems

The multidisciplinary team consisted of:

- a consultant psychiatrist who worked four days a week across the hospital
- a full time occupational therapist (appointed not yet in post) to work across the hospital
- an occupational therapy assistants 2 days a week
- nurses (including unit manager, charge nurse and clinical lead)

At our previous inspection, we found the hospital did not provide a range of disciplines required to meet needs of patients. For inpatient older adults mental health services, the Aims standard states that the unit should have an occupational therapist four days each week, a psychologist who works 20 hours each week and a consultant psychiatrist who works half a day a week per three patients and a minimum of two days a week. All multidisciplinary team members worked across the hospital covering 26 rehabilitation beds and 15 beds for older adults. The hospital had a clinical psychologist, who provided 12 hours each week to the rehabilitation service. They had recently appointed a full time occupational therapist who was not yet in post.

Staff were experienced and qualified, and had the right skills to meet the needs of the patient group. We reviewed five staff files including clinical and ancillary staff. These files were well-organised and contained information regarding recruitment process, references, disclosure and barring service checks, qualification checks and where necessary confirmation of professional registration. The administration department had a robust system of reminders for staff to provide updated confirmation of professional registration and disclosure and barring service checks.

The unit manager provided new staff with an induction (using the care certificate standards as the requirement for healthcare assistants). New staff received a comprehensive induction folder, an induction checklist and staff had to complete all their mandatory training before being signed off their probationary period.

At the previous inspection, we found staff did not always receive regular and effective supervision and appraisals. During this inspection, staff reported having supervision every two months from either their manager or another designated supervisor. The percentage of staff that received regular supervision was 92%. This enabled the unit manager to provide staff with appropriate support and meet their development needs. The percentage of staff that had had an appraisal in the last 12 months was 95%.

Managers ensured that staff had access to regular team meetings. In addition to the monthly unit business meetings, a team effectiveness meeting ran once a week. Each unit took it in turns to attend the meeting and staff from other units provided cover so that all unit staff could attend. The psychologist and psychiatrist facilitated this meeting and most staff reported that this was a helpful meeting.

Following our previous inspection, the hospital director had focused on improving compliance with mandatory training. Managers were beginning to ensure that staff received the necessary specialist training for their roles. The hospital had developed a continuing professional development programme, which included staff across the hospital completing level one dementia training and Ullswater staff completing level two training.

We saw evidence that managers addressed staff performance promptly and effectively. Managers worked with staff to develop action plans to address poor performance and escalated issues as necessary through the disciplinary procedure.

Multi-disciplinary and inter-agency team work

Staff shared information about patients at handover meetings. The unit had handover meetings from one shift to the next. We observed a handover meeting. The nurse in charge of the previous shift led the meeting; all staff coming onto the next shift attended. The meeting detailed each patient's activities in the previous shift, any incidents, physical health, diet and fluids and discharge planning. We found that the qualified nurse communicated necessary information.

The hospital had a morning meeting four days a week that included the hospital director, unit managers, housekeeping, maintenance, and administration. Each person had an opportunity to provide feedback within the meeting. Staff followed an agenda and reviewed staffing levels across the hospital. Staff also reviewed all incidents in the hospital, considering whether duty of candour was appropriate.

Good

Wards for older people with mental health problems

When we inspected the hospital, staff held multidisciplinary team meetings once a week. The multidisciplinary team meetings reviewed any incidents that had happened during the week. Patients had regular opportunities to attend multidisciplinary team meetings to review their progress.

We observed a multidisciplinary team meeting for two patients with the doctor and nurses, including the unit manager. Staff clearly knew the patients and their history well. Staff invited patients to attend and if a patient refused then the doctor would meet with them after the meeting. The multidisciplinary team made patients feel welcome and listened to their views. However, ongoing treatment plans were agreed after the patient had left the meeting. Nursing and psychiatry dominated individual patient reviews and the meeting lacked the perspective of other qualified disciplines. There was no feedback form for patients to complete making staff aware of their views and wishes if they did not want to attend. Although patients knew what day their multidisciplinary team meeting was on, they did not know when they could join the meeting.

The unit had effective working relationships with teams outside the organisation for example with the district nurses, the local general practice and with care coordinators.

Adherence to the MHA and the MHA Code of Practice

Staff were trained in and had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles. 91% of staff had had training in the Mental Health Act.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. The Mental Health Act administrator was based in an office on Coniston Unit and was easily accessible to staff. Staff had easy access to local Mental Health Act policies and procedures that reflected the most recent guidance and to the Code of Practice. These were available within the unit offices and on the intranet.

Patients had easy access to information about independent mental health advocacy. The service displayed information notices about the independent mental health advocacy service in the communal areas. All detained patients received a referral to the advocacy service and were able to opt out of the referral if they did not wish to see an advocate. The advocate made frequent visits to the hospital and attended care programme approach meetings by request.

Staff explained to patients their rights under the Mental Health Act in a way that they could understand, repeated it as required and recorded that they had done it. An easy read booklet was available explaining rights under the Mental Health Act for patients and relatives. This was available on the unit and displayed in the reception area of the hospital. Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff ensured detained patients were able to take section 17 leave. We saw notices displayed by the exit to tell informal patients that they could leave the unit freely. There was an additional notice by exit from the activities area to the main hospital reception explaining that informal patients could leave freely.

Staff stored copies of patients' detention papers and forms correctly so they were available to all staff that needed access to them. The Mental Health Act administrator scrutinised Mental Health Act detention paperwork. They did monthly audits to ensure that staff applied the Mental Health Act correctly and ensured any actions were completed immediately. The Mental Health Act administrator used the providers' administration system to send out timely reminders to alert medical and unit staff when managers' hearings, tribunals, authorisation of medications, detention renewals, requesting a second opinion appointed doctor visits and report deadlines were due.

Good practice in applying the MCA

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Mental Capacity Act requires that, as far as possible, people make their own decisions and received helped to do so when needed. When they lacked mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. The hospital had a Mental Capacity Act policy that staff could access on the intranet.

Good

Wards for older people with mental health problems

Staff compliance with the Mental Capacity Act training was 93% across the hospital. Staff we spoke to had a good understanding of the Mental Capacity Act and the five key principles. They were able to give examples of how they assessed capacity in their day-to-day work.

For patients who might have impaired capacity, staff assessed and recorded their capacity to consent. They did this on a decision-specific basis concerning significant decisions. The hospital undertook capacity assessments in five key areas for all patients to assess their capacity to: consent to treatment, manage their finances, take psychiatric medication, take physical health medication, and whether they could consent to the use of restrictive interventions (such as observations). These capacity assessments followed the key principles of the Mental Capacity Act. Staff gave patients every possible assistance to make a specific decision for themselves before they assumed the patient lacked the mental capacity to make it. Staff reviewed capacity assessments within care programme approach meetings every six months.

When patients lacked capacity, staff made decisions in the patient's best interests, recognising the importance of the person's wishes, feelings, culture and history. Best interest meetings involved relevant people and relatives attended either in person or by phone. When advocacy and relatives had not been involved in the best interests meeting, staff invited them to attend the next care programme approach meeting to participate in the review of the decisions.

People can only be deprived of their liberty so they can receive care and treatment when this is in their best interests and legally authorised. Staff made deprivation of liberty safeguards applications and monitored the progress of applications with the supervisory bodies. Between 1 August 2017 and 31 January 2018, staff made one application for deprivation of liberty safeguards on Ullswater Unit. Three patients had deprivation of liberty safeguards in place.

Are wards for older people with mental health problems caring?

Good

During our inspection, we observed positive interactions between staff, patients and their carers. Staff engaged with patients in a respectful manner, offered reassurance and support to patients who were showing signs of distress. They recognised the importance of the patient's privacy and dignity. For example, staff made sure patients had adequate supplies of continence equipment with them when they took leave.

Staff were often unable to involve patients in their care in a meaningful way due to their cognitive impairment. However, each patient had a named nurse who worked with them and their relative to write care plans that met their individual needs. Staff had a good understanding of each patient's needs, preferences and dietary requirements and reflected this in the care and treatment they provided. We observed positive engagement with patients at mealtimes and during individual patient activities.

Carers we spoke with reported staff treated them well and were kind, helpful and supportive. They provided patients and carers with help, support and advice as it was required. We were unable to speak with any patients on this unit.

Staff were aware of the need to maintain confidentiality of information about patients. The design of the staff office on the unit meant that it was not possible for others to see any confidential information as all windows had privacy screening.

The involvement of people in the care they receive

The hospital involved carers and patients in decisions about their care and treatment were possible. Records showed patients were involved in their care plans as far as possible and that staff offered patients a copy of their care plan. There was evidence to support carers were involved in care planning. Staff invited patients to attend and be involved in their reviews. If a patient decided not to attend his review, the consultant met with them afterwards. Advocacy services attended the hospital at least weekly and supported patients as needed.

Records showed patients were involved in their care plans as far as possible and that staff offered them copies. There was evidence to support carers were involved in care planning. Staff invited patients to attend and be involved in their reviews. If a patient decided not to attend his review, the consultant met with them afterwards. Advocacy services attended the hospital at least weekly and supported patients as needed.

Good

Wards for older people with mental health problems

Patients attended monthly patient meetings; the minutes for these meetings were displayed in the patient communal area. Patients had the opportunity to give feedback on the care that they received at these meetings and through surveys and feedback forms.

Carers and family members of patients were involved appropriately in the care and treatment provided by the hospital. The hospital had open visiting hours for carers, although they ensured protected mealtimes. Where possible, each unit ensured patients were able to take escorted leave to visit their families.

Carers informed us that the hospital invited them to all relevant meetings and kept them informed if they were unable to attend. The hospital arranged quarterly carers meetings. They had recently sent carers a questionnaire to try and improve attendance at the meetings and for carers to give feedback on the hospital. The hospital director sent carers a monthly newsletter to keep them updated with service developments.

Patients invited their carers and relatives to attend events held at the hospital. For example, patients held a Macmillan coffee morning recently, baking cakes for the event and raising money in the process.

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

(for example, to feedback?)

Good

Access and discharge

The hospital admitted patients to Ullswater following an initial pre assessment and agreement from the multi-disciplinary team. The unit had a clear admission criterion. This ensured the unit only admitted patients that were suited to the environment and care and treatment provided. In the six-month period ending 31 January 2018, the service assessed four patients who found alternative placements or were not suitable for the unit.

The hospital provided information for average length of stay for the period 1 January 2017 to 17 April 2018. Ullswater reported an average length of stay of 1,313 days. The hospital was committed to moving patients on to more suitable environments to meet their needs. Staff discussed patients discharge plans at their monthly unit round meeting. They had successfully discharged five patients during this period, including a patient who had been at the hospital five years. Occupancy levels were below expected occupancy levels, the unit currently had only five patients. The average bed occupancy for the six-month period ending 31 January 2018 was 55%.

At the time of the inspection, all of the patients were out of area placements. Beds were available when needed to people living in the catchment area. Staff did not admit patients into leave beds, which meant that when patients left the unit on leave their bed was always available for them when they returned.

The service did not move patients between units during an admission episode unless it was justified on clinical grounds and was in the interests of the patient. Staff and patients discussed discharge arrangements at the unit review meetings and care programme approach meetings. In the last 12 months, there were no delayed discharges. Staff arranged discharge times at a time that was convenient to patients, and their families.

The facilities promote recovery, comfort, dignity and confidentiality

The facilities promoted comfort, dignity and privacy for the people using them. During the previous inspection, we did not find the environment to be dementia friendly. At this inspection, we saw that the hospital had:

- improved signage to support patient orientation
- improved levels of activity for patients

All patients had their own bedrooms. There were pictures on the door and a memory box mounted on the wall with items specific to the person and their history. Staff risk assessed and offered patients a key to their bedrooms, currently one patient had a key. Some patients chose to personalise their bedrooms and all bedrooms provided a lockable safe for patients to keep their possessions safe. All patients had access to their rooms during the day. Bedrooms were ensuite and the doors that led to toilets were painted blue to support patients to find their way.

The hospital had an ongoing plan to update areas of the hospital. Following the discharge of a patient from Ullswater, the provider redecorated and refurbished the room in an appropriate style for patients with dementia.

Good

Wards for older people with mental health problems

The corridors were themed to support patients to know where they were. These themes were based on the background of the patients, for example the beach and farming. Doors that led to areas that were not patient accessible, for example the sluice room, were painted to blend with the corridor and had their handles removed. This meant that patients would not become frustrated by trying to repeatedly open a door they could not get access to.

Staff and patients had access to a range of rooms and equipment to support patients' treatment and needs. This included small clinic room, a relaxation room, kitchen area, and communal areas. An occupational therapy assistant provided patients with a range of meaningful daytime activities and opportunities to socialise. These included visits to the seaside for fish and chips, bread making, competing in and winning the provider wide bake off competitions at Christmas and Easter. Notice boards clearly displayed the activity timetable for each day of the week. The garden area had been adapted to reflect the history of the patients on the unit, for example, there were pictures of chickens within the garden.

There were quiet areas on and off the unit where patients could meet visitors. Patients had access to the garden allocated to their unit at all times. The garden area, which included a designated smoking area, was well maintained. Throughout the inspection, we saw patients freely access these facilities.

Patients could make a phone call in private. Patients had access to a portable unit phone that they could use in their own private room.

At the time of the inspection, there was an interim head chef. Carers we spoke with said the food was of a good quality. Catering staff offered patients a daily choice of meals. The menu choice rotated every four weeks. We observed lunch on the unit. The staff serving the food understood patient's dietary requirements, likes and dislikes. Support workers were friendly and made sure the patients they supported had what they wanted. Patients had access to hot drinks and snacks 24 hours a day. Pictorial prompts for food and drink were displayed in the communal area.

Cold drinks were available and we saw signs to prompt patients to drink and have snacks. These included picture prompts. Dementia friendly plates of different colours and specialist drinking equipment were available in the kitchen. Although there was a dining area, patients could eat in other areas of the unit if they found it difficult to cope at mealtimes.

Meeting the needs of all people who use the service

The hospital could accommodate patients and visitors with mobility issues. Ullswater was located on the ground floor. Patients who had mobility issues used wheelchairs when appropriate. Where patients had a need, the hospital provided profile beds and movement sensors to detect falls. Patients had access to an assisted bathroom. Individual patients' ensuites had aids and equipment to assist with the management of continence and all patients' rooms had privacy screens on the windows.

We saw large print, easy read information for the explaining of rights to detained patients. We did not see any leaflets translated into different languages. The hospital gave assurances they would provide leaflets in a different language where there was a need. The service had access to interpreters and an online translation service if required.

Each unit had notice boards that displayed a range of information about treatments, local services, the Mental Health Act, and how to complain. Information leaflets in different languages could be requested if there was a need. Many of the information leaflets were in easy-read format.

Patients had a choice of food available to meet their specific dietary requirements such as diabetes or soft/ pureed food. We saw evidence that staff supported patients with specific dietary requirements. These patients had an individualised care plan.

The hospital accommodated cultural and spiritual needs. During the inspection, those patients who wished to attended a church service on site. Staff supported patients to attend a mosque or church using their section 17 leave if this was the patient's wish.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with all staff. This core service received two complaints between January 2017 and December 2017. Following investigation, the hospital upheld one of

Good

Wards for older people with mental health problems

the complaints and partially upheld the other complaint. The service had not referred any complaints to the ombudsman. We saw evidence of learning fed back to staff following an investigation into the complaints.

The hospital displayed its complaints process on notice boards in the community area. The complaints process was typed in small print and patients possibly struggled to read and understand it,

Carers told us they knew how to complain. Staff said patients tended to raise concerns verbally. Informal discussions took place to resolve concerns, with verbal feedback given to patients. Staff knew how to support patients to make a formal complaint and ensured patients received feedback. The hospital had a 'you said, we did' board presenting comments made by patients and what actions had been taken.

Following the successful discharge of a patient from Ullswater, carers sent the service a compliments card in each case.

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

Good

Vision and values

The provider had a vision for what it wanted to achieve and workable plans to turn it into action.

The provider communicated their values through newsletters and posters on communal area notice boards. In addition, staff discussed the values at the beginning of every meeting. Consequently, staff we spoke with had a good understanding of the new values and were able to describe how they applied to the care and treatment they provided.

Staff knew who the most senior managers in the organisation were. All staff knew the service's divisional director, who visited the hospital on a regular basis. Staff were less familiar with the chief executive officer and chief operating officer, and some staff were unaware they had recently visited the service.

Good governance

There was a framework of meetings at unit, hospital and directorate level to enable managers to share and discuss essential information.

At hospital level, the hospital director had systems in place that gave a good oversight of the performance of their units. This included supervision, appraisals and staffing levels.

Staff undertook and participated in clinical audits such as medicines management and care plans at unit level. The audits were sufficient to provide assurance and staff acted on the results when required.

Management of risk, issues and performance

At our previous inspection, we found that although the hospital had a risk register, there was no robust process to effectively assess and manage the risks identified. Staff discussed service risks at team level and could escalate concerns through line management if needed. Hospital managers discussed risks during clinical governance meetings, where they were able consider for inclusion on to the hospital risk register. The hospital risk register clearly identified occupancy levels as an extreme risk. Staff concerns matched those on the risk register.

During this inspection, we found that hospital managers reviewed the existing risks during their clinical governance meeting and updated the risk register to reflect any actions taken or change to the level of risk.

Information management

The unit manager had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care. For example, bed occupancy rates, mandatory training, supervision and appraisal completion. They could easily produce and review specific performance reports, which they discussed their team's performance at the monthly clinical governance meetings with senior management.

Staff had access to the electronic equipment and paper documents they needed to do their work. The electronic systems supported staff to document and update risk. There was sufficient equipment and information technology for staff to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care.

The service made notifications to external bodies as required.

Leadership, morale and staff engagement

The hospital director was fully committed to improving the quality of care and treatment on Ullswater and ensuring it met the needs of the patients. There had been number of staff changes, which included the hospital director and unit manager since the last inspection. The unit manager had access to leadership training and other management specific training courses. They supported staff with their training needs through the appraisal and supervision process. The unit manager for Ullswater was also the clinical lead for the service.

The hospital director had a good understanding of the systems and processes that gave oversight to the performance and the quality of the service. They planned staffing rotas at least four weeks in advance, which allowed the manager to plan for any identified gaps in staffing. The hospital director was aware of the importance of using resources effectively and had oversight of the unit budget. They regularly discussed issues about occupancy levels with senior managers and the provider's financial department. They shared this information with all staff working on the unit, particularly any information relating to the future viability of Ullswater unit.

The unit manager and the hospital director appropriately addressed staffing levels and absences. The hospital director was familiar with the learning and development needs of the staff and encouraged them to take lead roles on the unit according to their skills and areas of interest.

Staff reported the hospital director was visible on the unit. All staff knew the service's divisional director. However, some staff were unfamiliar with the senior managers at board level and told us they did not visit the unit.

Culture

Staff morale varied but overall staff reported working in a supportive team. Staff we spoke with mentioned the amount of change the service had been through in the last twelve months was challenging, with changes within the management team and staffing teams. However, staff worked well together and took action to make sure they had enough support when they needed it.

Staff felt confident to use the whistleblowing process and said they would raise concerns without fear of victimisation. They knew about the organisations whistleblowing policy and that they could contact external organisations to report concerns. There were no reported cases of bullying in the twelve months preceding, or during this inspection.

The hospital director dealt with any staff issues such as poor staff performance and long-term sickness. They worked jointly with the provider's human resources department to support staff to address such issues. The provider had arrangements in place for staff to access support for their own physical and emotional health needs through an occupational health service.

Staff appraisals included conversations about career development and the support available. The provider recognised staff success within the service, with an employee of the month award. Staff working within the hospital nominated an individual each month to receive this award. In addition, the provider held annual care awards across all its services. Previously the hospital had not nominated any staff for an award. However, this year several nominations had been made.

Engagement

The hospital provided regular information updates for staff, patients, and carers about the service, the work of the provider and the services they used, through emails, newsletters and a variety of meetings. Staff, patients, and carers could access initial information about the service through the provider's website, although this was not up to date. Staff felt that senior managers kept them sufficiently informed of the future of the service and the hospital as a whole.

The service worked closely with external stakeholders such as commissioners, both locally and out of area. Commissioners visited the service and had input into patients' care programme approach meetings. We engaged with commissioners involved with the service and received positive feedback about the service provision.

Everyone had opportunities to give feedback about the service. This could be through staff, patient and carer meetings, surveys or comment cards. We saw evidence that patients were involved in decisions about changes to their unit.

Commitment to quality improvement and innovation

Good

Wards for older people with mental health problems

Staff did not take part in any standardised work that supported quality improvement and innovation Nor did they participate in any peer accreditation programmes. However, the hospital directors and those heading the different units and services within the hospital met on a regular basis to explore service development and innovations.

The provider had developed a quarterly peer review system where senior staff visited locations to review the quality of service against a range of standards. . Following the most recent peer review visit, the hospital director had developed an action plan for those issues identified as requiring improvement. We noted most of these issues either had been resolved or were currently being dealt with.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are sufficient numbers of suitably skilled staff deployed on all the units and that all disciplines contribute their perspective during patients' multi-disciplinary reviews.
- The provider must ensure all nursing and support staff working on Kendall unit have a clear understanding of the difference between the Mental Health Act and the Mental Capacity Act and the implications for their practice.

Action the provider SHOULD take to improve

- The provider should ensure that mirrors are in place along corridors where there are blind areas limiting lines of sight.
- The provider should ensure that the duty consultant psychiatrist can access the hospital within 30 minutes.
- The provider should ensure staff understand and follow the process for the transcription of prescription charts.
- The provider should ensure that nursing staff working on the rehabilitation wards understand how best practice relates to the care and treatment they provide.
- The provider should ensure the hospital uses a recognised rating scale to assess and record severity and outcomes.
- The provider should ensure staff seek the views of patients prior to their multi-disciplinary review and include patients wanting to attend their review in the decisions making process.
- The provider should ensure that when staff undertake capacity assessments they are consistent and of good quality.
- The provider should ensure the rehabilitation wards discharge ethos is linked to recovery and set goals for the planned length of stay for patients from admission.

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 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: Qualified nurses and support staff we spoke with on Kendal unit told us they treat all patients the same, whether they were detained or informal and awaiting deprivation of liberty safeguards authorisation. This was a breach of regulation 11(1)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: There was no occupational therapist in post at the time of the inspection although one had been appointed. There was a part time psychologist in place providing 12 hours input a week, mainly to the rehabilitation service. This limited the range of disciplines involved in meeting patient's psychological and physical care needs. The medical and nursing staff views dominated patients' multi-disciplinary reviews. Staff made decisions about the patients care and treatment before they invited the patient into their review. Qualified nurses struggled to relate the care and treatment they provided to best practice.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 18(1)