Glenhurst Lodge

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Are services effective?

Overall summary

We undertook this unannounced, focused inspection to find out whether the provider had made improvements to their long stay/rehabilitation mental health wards for working age adults since our last unannounced, follow up inspection on 21 and 29 September 2016. Following the inspection on 21 and 29 September 2016, we took enforcement action and issued the service provider with a warning notice due to breaches in regulation regarding patients' care or treatment.

At this inspection, we found the service had made some significant improvements to the quality of care and treatment given to patients. However, further improvements were required.

We found the following issues that the provider needs to improve:

- Care plans were still not rehabilitation or recovery focused. Care plans did not clearly reflect patients' goals, and the steps needed to achieve these. Staff did not record in care plans how they intended to support patients in their rehabilitation or recovery. They did not specifically detail patients' strengths and what level of support individual patients needed and how best to motivate and encourage them.
- Staff did not assess patients' nutritional or hydration needs. High-risk patients who were receiving care or treatment for dietary or nutritional issues were not effectively being assessed and monitored to ensure ongoing good health. Care plans did not contain any detail about a patient's nutritional intake or the level of support needed.
- For patients who were self-medicating, staff did not record the incremental steps needed to help them progress or what would happen should a patient not be able to adhere to the programme.

However, we also, we found the following areas of good practice:

Summary of findings

- Staff undertook a range of assessments with patients. These included a comprehensive physical health assessment, occupational-functional assessment, transport and kitchen assessment. However, this was not always recorded in the patients care plans.
- Staff sought patients' views and preferences and recorded these in the patients' care plans.
- Staff completed activity interest checklists with patients to ensure that care or treatment was designed to meet patients' individual needs and preferences. When patients had shown an interest in certain activities, they were supported to achieve these goals. Staff reviewed and discussed these goals and activities regularly to ensure they were still relevant to the patient. Each patient had an individual activity timetable.
- Staff had identified patients' physical healthcare needs and incorporated details of these into patients' care plans. On most occasions, staff recorded physical healthcare checks clearly and consistently so that they could quickly identify any changes or concerns and take the required action. Staff used a standardised approach called Modified Early Warning System. There was evidence of high scores being followed up. Staff were trained to use the Modified Early Warning System tool to observe changes in patient's presentation. One of the nurses at the service took a lead on this and was available to all staff to provide support and advice when needed. However, we did find two records where staff had not dated a review or documented recordings correctly.
- Staff used the Glasgow Antipsychotic Side-effect Scale (GASS). Where concerns were raised these were followed up. They were reviewed by the multidisciplinary team fortnightly and discussed with the patient during their individual ward rounds, or sooner if required. However, the outcome of the GASS assessment was not always documented in the patient's daily nursing notes.
- Each patient had a health action plan folder. Information relating to healthcare appointments, including copies of letters, were filed in the patient's paper records and follow up appointments were well documented.
- Staff in the service worked actively in partnership with external healthcare professionals. The service worked collaboratively with several local GPs in the area to ensure that patients' healthcare needs were met. We found that communication between the service and GPs had improved greatly since our initial inspection. Staff followed up information about clinical decisions and outcomes and recorded their actions clearly in the patients' notes.
- The service provided a wider and improved range of therapeutic activities on the ward and outside the hospital. The service had established links with the local colleges and in the local community to help facilitate voluntary work and reintegrate any patient, who wished to, back into the community.

Summary of findings

Contents

Summary of this inspection

Our inspection team

The team comprised a head of hospital Inspection from the Care Quality Commission (CQC), one inspection manager from the CQC, two inspectors from the CQC, a nurse and an occupational therapist both with expertise in long stay rehabilitation. The team leader was Hannah Cohen-Whittle (inspector CQC).

Why we carried out this inspection

We undertook this unannounced focused inspection to find out whether the provider had made improvements to their long stay/rehabilitation mental health wards for working age adults since our last unannounced follow up inspection on 21 and 29 September 2016.

Following the inspection on 21 and 29 September 2016, we took enforcement action and issued the service provider with a warning notice due to breaches in regulation regarding patients' care or treatment which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person-centred care.
- Regulation 12 Safe care and treatment.
- Regulation 14 Meeting nutritional and hydration needs.

The warning notice was issued to the service provider on the 21 November 2016. The warning notice served notified the service provider that the Care Quality Commission had judged the quality of care being provided as requiring significant improvement. We told the service provider that they must comply with the requirements of the regulations by 10 February 2017.

How we carried out this inspection

This was an unannounced, focused inspection. We assessed the key question - 'is this service effective'.

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

During the inspection visit, the inspection team:

- spoke with the hospital director
- spoke with six staff, including nurses, support workers, occupational therapists and doctor
- spoke with four patients
- looked at eight patient care records, including care plans, risk assessments, physical health monitoring forms, nutrition and hydration recording forms
- attended and observed a daily planning meeting on Davenport and Sandown ward, and;looked at a range of policies, procedures and other documents relating to the running of the service.

Information about Glenhurst Lodge

Glenhurst Lodge is registered to provide the regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; accommodation for persons who require nursing or personal care; treatment of disease, disorder or injury; and diagnostic and screening procedures.

Glenhurst Lodge has two locked rehabilitation wards for working age adults. Davenport ward has 11 beds for men and Sandown ward has 11 beds for women. During the inspection, the service was providing care or treatment to 11 men and 8 women.

We have inspected Glenhurst Lodge seven times since registration with the Care Quality Commission (CQC) in

Summary of this inspection

2011. When we last inspected the service on 2 and 3 September 2015, as part of our comprehensive inspection programme, we rated long stay/rehabilitation mental health wards for working age adults as **good**.

Following the inspection in September 2015, we rated the service as good for safe, responsive, caring and well-led and as requires improvement for effective. We issued the provider with two requirement notices which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 12 Safe care and treatment.
- Regulation 18 Staffing.

Following the inspection on 21 and 29 September 2016, we issued the provider with a warning notice due to breaches in regulation regarding patients' care and treatment which related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person-centred care.
- Regulation 12 Safe care and treatment.
- Regulation 14 Meeting nutritional and hydration needs.

We told the provider that it must take the following actions to improve long stay/rehabilitation mental health wards for working age adults:

- The provider must ensure patient care plans are rehabilitation or recovery focused. Care plans must reflect individual needs and goals and how these are to be achieved.
- The provider must ensure care plans are kept up to date.
- The provider must ensure care plans include all physical health care needs and nutritional and hydration needs and what support is needed.
- The provider must ensure physical healthcare checks are recorded clearly and consistently.
- The provider must ensure effective processes are put in place to support partnership working and communication with other healthcare professionals.
- The provider must ensure patients have their nutritional and hydration needs assessed and reviewed.
- The provider must ensure patients have assessments to establish their skill level in budgeting and cooking to ensure appropriate support can be given.
- The provider must ensure all patients have an activity interest checklist completed and these should be regularly reviewed to ensure they meet the patients preferences and needs.
- The provider must increase the level of activity outside of the hospital.

We also told the provider that it should take the following actions to improve long stay/rehabilitation mental health wards for working age adults:

- The provider should record and monitor referrals to the IMHA service.
- The provider should ensure that there are clear protocols in place for using clinical assessments such as GASS.
- The provider should ensure that patients health action plan folders are kept up to date.

What people who use the service say

We spoke with four patients during the inspection. All told us that staff were caring and were available to speak with them when needed. Patients on both wards told us there had been an improvement in their access to section 17 leave and staff communicated reasons for delays or changes to leave arrangements. Patients told us that activities both on and off the ward had increased and they were happy with the varied choices available to them. Patients liked the food because they got to choose what they wanted to eat and cook. They were receiving more support from staff to choose healthier meal options and now had a choice of supermarkets they could shop at. Patients felt better supported by staff and felt their skills in activities such as cooking and budgeting were improving. Patients told us they felt safe on the wards and confident when in the community.

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 effective?

We found the following issues that the service provider needs to improve:

- Care plans were not rehabilitation or recovery focused. Care plans were not always based on individual need and did not detail the level of support patients needed. Care plans did not clearly reflect goals and how these would be achieved.
- Staff did not assess patients' nutritional or hydration needs. Care plans did not contain any detail about a patient's nutritional intake or the level of support needed.
- For patients who were self-medicating, staff did not record the incremental steps needed to help their progress or what would happen should a patient not be able to adhere to the programme.

However, we also found the following areas of good practice:

- Staff undertook a range of assessments with patients. Staff completed activity interest checklists with patients . However, this was not always recorded in care plans.
- Patient views and preferences were sought by staff and they recorded them in their care plans.
- There were systems in place to assess, monitor and review patients' physical healthcare needs. Physical healthcare checks were mostly recorded clearly and consistently.
- Physical healthcare needs were incorporated into patient care plans and were detailed.
- There was improved active partnership working with external healthcare professionals. The service worked collaboratively with several local GPs in the area to ensure patient needs were met.
- Therapeutic activities on the ward and outside the hospital had increased and improved.

Long stay/rehabilitation mental health wards for working age adults

Effective

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- During this inspection, we found improvement in the range of assessments staff undertook with patients, both on admission to the ward and throughout their care and treatment. These included a comprehensive physical health assessment and occupational functional assessment, including activities of daily living. The service had recently implemented the use of World Health Organization Disability Assessment Schedule. This tool measures health and disability and looks at an individual's level of functioning in major life domains such as mobility, self-care, participation and life activities.
- The service had implemented a multidisciplinary care plan that was based on "My Shared Pathway" which was a patient focused recovery model of care. A care pathway is a structured approach to care delivery that clearly describes the journey a person is likely to take when moving through the care system. This ensures that individuals receive the most appropriate care and treatment, with clearly agreed timescales and in the least restrictive environment.
- During the inspection in September 2016, we found that care plans did not always reflect the patients' individual needs and goals or how these were to be achieved. We were concerned that patients were not receiving care or treatment that was based on an assessment of their individual needs and preferences and found limited evidence of rehabilitation or recovery care plans being used. During this inspection , we reviewed eight care records of patients across both wards. We found some improvement had been made in this area but further work was still required. For example, staff better sought the patient's views and recorded them well in their care plans. However, staff still did not specifically detail what the patient's strengths were, what level of support that individual patient needed and how best to motivate and encourage them. Outcome measures were mostly generic across all care plans and target dates were not set.
- Care plans still did not reflect what steps patients needed to take to achieve their goals. For example, we could see that patients had access to leave from the ward but it was not clear what a patient needed to do to move from escorted section 17 leave to unescorted section 17 leave. There was no staged plan to support patients and no process in place to measure the patient's progress. However, we did see that the occupational therapist had carried out transport and risk assessments with the patient in the community to support them to acquire new skills as part of their recovery and rehabilitation.
- During the inspection in September 2016, we found staff did not regularly complete activity interest checklists with patients to ensure that care or treatment was designed to meet their individual needs and preferences. There was an activity timetable displayed on the wards and results from a patient activity satisfaction survey carried out by the service in September 2016 identified that activities could be improved. During this inspection, we found significant improvement in this area. We reviewed eight care records and found all patients had activity interest checklists, completed by staff with patients. We found staff regularly reviewed and discussed these during multidisciplinary team meetings and care programme approach reviews to ensure they were still relevant to the patient. As well as an activity timetable for the ward, each patient also had an individual activity timetable. The service had implemented a vocational workshop, which was co-facilitated by staff and a patient. The workshop was designed to help and support patients in applying for bus passes, advice on safe use of the internet and writing curriculum vitae.
- During the inspection in September 2016, we found the service had no links with any of the local colleges or adult education centres and had not established links with the local community to help facilitate voluntary work and reintegrate any patient who wished to back into the community. During this inspection, we found significant improvement in this area. Where patients

had shown an interest in college courses or voluntary work they were now being supported to achieve these goals. For example, one patient had started voluntary work and another patient was enrolled in a college course. One of the patients regularly attended a yoga group in the community and another patient was supported by staff to attend a diabetes course to increase self-awareness and support the management of their condition.

- During the inspection in September 2016, we found three patients were self-administering medications as part of their rehabilitation. We were concerned that none of the three patients had any clinical assessments, care plans in place to support them as per the provider's policy and staff did not review, or monitor patients progress with the programme. During this inspection, we found improvement in this area. Staff recorded that patients understood their medications, had consented and what support they needed. Staff actively monitored patients' success and recorded this clearly. The progress of patients was reviewed by the multidisciplinary team fortnightly and discussed with the patient during their individual ward rounds. However, staff did not record the incremental steps needed to help them progress with the programme or what would happen should a patient not be able to adhere to the programme. For example, during the inspection we were informed the service had requested a second opinion appointed doctor (SOAD) to come and review one of the patients due to concerns with their capacity to consent to medications. Despite these concerns, the patient was continuing to self-medicate. The role of the SOAD is to safeguard the rights of patients who are detained under the Mental Health Act who either refuse the treatment prescribed to them or are not capable of consenting. The SOAD decides whether the treatment recommended is clinically appropriate for the patient
- During the inspection in September 2016, we found that physical healthcare checks were not always recorded clearly or consistently so that changes or concerns could be quickly identified and responded to. The records we looked at during this inspection showed significant improvement had been made. There were systems in place to assess, monitor and review the physical healthcare needs of patients. Staff conducted an initial physical health check of patients on admission to the ward and annually thereafter. All eight care records that we reviewed contained evidence that a comprehensive annual physical health check had been undertaken. The service had a physical health monitoring policy.
- When we inspected the service in September 2016, we were concerned that physical healthcare needs were not always incorporated into patients' care plans or were limited in detail.During this most recent inspection, we found improvement had been made in this area. For example, there was clear guidance about diabetes, renal failure and respiratory disease in care plans, how to manage these conditions safely and what to do in case of an emergency.
- The service used a standardised system called Modified Early Warning System (MEWS) to monitor and record the physical health of patients. This system worked by staff allocating a score to a series of physical health measures such as blood pressure and oxygen saturation levels. When a patient's score reached a given level this triggered what action was required from staff.
- During the inspection in September 2016, we found that MEWS were inconsistently completed by staff and contained errors. For example, recordings were incorrectly documented in the score box. The adding up of scores was incorrect and there was no evidence of high scores being followed up. During this inspection, we found improvement in this area. There was evidence of high scores being followed up. The purpose of the score is to help clinical staff decide whether to call a doctor or emergency service in the event that a patient's health suddenly deteriorated. This meant that staff were taking the required action to ensure patients received safe care or treatment. Any abnormal results recorded on MEWS were clearly recorded in the patients' daily nursing notes. However, two MEWS charts were not dated. and contained minor errors in the adding up of scores.
- The service used the Glasgow Antipsychotic Side-effect Scale (GASS). This is a self-reporting questionnaire used to help identify the side effects of antipsychotic medication. It consists of 22 questions with points assigned based on the answers given by the patient. During the inspection in September 2016, we found not all patients on antipsychotic medication had been supported by staff to complete the self-questionnaire, outcomes were not documented and any reported concerns were not followed up. During this inspection, we found significant improvement in this area. Out of

the eight care records reviewed, we found all had a completed GASS assessment. Where concerns were raised these were followed up. They were reviewed by the multidisciplinary team fortnightly and discussed with the patient during their individual ward rounds, or sooner if required. However, the outcome of the GASS assessment was not always documented in the patients daily nursing notes.

Best practice in treatment and care

- Each patient had a health action plan (HAP) folder. A HAP is a personal plan about what the patient needs to do to stay healthy, including a record of past and future medical appointments. Staff referred patients to external healthcare services for treatment when needed such as opticians and dentistry. This was then recorded in the patient's HAP. During the inspection in September 2016, we found staff did not always record in the patient's HAP the last date the patient had visited a healthcare practitioner. During this inspection, we found significant improvement in this area. Information relating to healthcare appointments, including copies of letters, were filed in the patient's paper records and follow up appointments were well documented.
- During the inspection in September 2016, we had several concerns regarding nutrition and hydration. Our concerns included, patients' food intake not being monitored to ensure they were eating a balanced diet, staff had not assessed patients' nutritional or hydration needs to support ongoing good health and nutritional intake was not consistently recorded, monitored or reviewed to prevent unnecessary weight loss or weight gain. We reviewed the provider's food and nutrition policy. The policy stated that all patients would be screened for malnutrition using the Malnutrition Universal Screening Tool (MUST). Once completed patients would then be categorised as low risk, medium risk or high risk. Clear guidelines were documented as to what action staff would need to take. However, we found no record of MUST being used in any of the care records we reviewed.
- During this inspection in February 2017, we found the service provider had reviewed their food and nutrition policy. The newly implemented policy stated that no hospital patient would be screened for malnutrition using MUST and no other screening tool was referred to. We remained concerned that high-risk patients who were receiving care or treatment for dietary or nutritional issues were not effectively being assessed and monitored to ensure ongoing good health. For example, one patient was receiving nutritional shakes with no clinical risk history or rationale recorded.
- We reviewed eight care plans. We still had concerns that information about nutrition was inconsistently documented in the section 'Staying healthy' or 'My life skills'. Care plans did not contain any detail about a patient's nutritional intake or the level of support needed. As staff did not carry out screening assessments, patients who would otherwise be identified 'at risk' were not offered appropriate support. For example, for one patient it was recorded in their notes that they should not have caffeine. However, the reason for this was not documented in their notes or referenced in their care plan. We reviewed their food monitoring charts and could see they were having caffeinated drinks.
- People with severe and prolonged mental illness are at risk of dying 15 to 20 years earlier than other people. The majority of these deaths are due to preventable physical medical conditions such as diabetes, hypertension and weight as a result of poor nutrition.
- Of the eight care records we reviewed, we found staff had undertaken a kitchen assessment with all of the patients. However, care plans were still not individual and contained generic information as to what support patients needed with planning, budgeting, or producing well-balanced meals. For example, care plans stated for staff to support the patient with planning healthy weekly meal plans and support with budgeting. Patients had varying levels of skill and interest in this area. This was not reflected in their care plans to ensure staff could provided the appropriate support . However, we spoke with four patients who all told us they felt better supported in budgeting and planning their meals.
- The occupational therapist used a range of assessment tools including, 'The Model of Human Occupational Screening tool' (MOHOST). This is an occupation-focused assessment that determines the extent to which individual and environmental factors facilitate or restrict an individual's participation in daily life. We reviewed eight care records and found that all had a MOHOST. However, not all were fully completed, as they did not have the analysis and summary.

Long stay/rehabilitation mental health wards for working age adults

Skilled staff to deliver care

- During the inspection in September 2016 we found staff did not always receive the necessary specialist training in diabetes and physical health monitoring. During this inspection, we found significant improvement in this area. We spoke with six staff who all confirmed they had received training in both diabetes and physical health monitoring. We reviewed the training matrix for the service and spoke with the hospital director. We could clearly see that most staff had completed both training courses and those who were due refresher training where scheduled to do so. Staff were trained to use the Modified Early Warning System tool to observe changes in patient presentation and one of the nurses at the service took a lead on this and was available to all staff to provide support and advice when needed.

Multidisciplinary and inter-agency team work

- Multidisciplinary team (MDT) meetings took place weekly at the hospital. Each patient was seen and/or reviewed by the MDT every other week. The MDT collaborated to make treatment recommendations that facilitate quality patient care. During the inspection in September 2016, we were concerned that information was not always consistently recorded and it was not clear if information across the MDT was being communicated and shared effectively to ensure patients received safe care and treatment. During this inspection, we found significant improvement in this area. We looked at the MDT meeting minutes for the eight care records reviewed and found that when a concern or change had been highlighted with a patient's physical health this was recorded, actions clearly documented and followed back up in the next MDT meeting.
- During the inspection in September 2016 we were concerned that there was limited active partnership working with external healthcare professionals. The processes in place to support this were not effective. There was no process in place to ensure that information was effectively and safely conveyed between the professionals sharing the patient's care. During this inspection, we found significant improvement in this area. The service had taken appropriate action to arrange for the patients to see a regular general practitioner (GP). They worked collaboratively with several local GPs in the area to ensure this need was met. We found that communication between the service and GPs had improved greatly. Information about clinical decisions and outcomes was followed up and clearly recorded in the patients notes. For example, we saw good evidence of the service liaising with the GP and other external health professionals. The GP had requested that medications for the management of the patient's mental health be reviewed due to concerns for an ongoing physical health need. The service undertook a review, contacted the pharmacist and the patient's specialist team at the general hospital to ensure the patient received the most effective level of physical and mental health care.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure patient care plans are rehabilitation or recovery focused. Care plans must reflect individual needs and goals, level of support needed and how these are to be achieved.
- The provider must ensure they identify an appropriate risk-screening tool for nutrition and hydration.
- The provider must ensure patients receiving care and treatment for dietary issues have their nutritional and hydration needs assessed and reviewed.
- The provider must ensure care plans include nutritional and hydration needs and what support is needed.

Action the provider SHOULD take to improve

- The provider should ensure all parts of 'The Model of Human Occupational Screening tool' are fully completed and documented when used to assess patients.
- The provider should ensure they have robust audit processes in place to check for errors on MEWS charts.
- The provider should ensure the outcome of the GASS assessment is documented in the patient's daily nursing notes.

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
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Care plans were not rehabilitation or recovery focused. Care plans were not always based on individual need and did not clearly reflect patient's goals and the steps needed to achieve these.** **Staff did not record in care plans how they intended to support patients in their rehabilitation or recovery.** This was in breach of regulation 9(1)(3)(a)(b)(c)(d)(e)(i)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs **Staff did not assess patients' nutritional or hydration needs. Care plans did not contain any detail about a patient's nutritional intake or the level of support needed.** This was in breach of regulation 14(1)(2)(4)(a)(b)(d)