Windermere House Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

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

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

Summary of findings

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

Overall summary

We rated Windermere House Independent Hospital as requires improvement because:

- managers had no key performance indicators to enable them to oversee the hospital's performance
- the hospital did not analyse reported risks to patients and staff effectively to enable them to learn lessons from incidents of harm or risk of harm
- Barchester policies had not been updated or re-written to ensure compliance with the Mental Health Act Code of Practice
- visits by the external pharmacist were not frequent enough to identify and correct any concerns about medication practice
- the provider did not undertake their own medicines management audits, nor investigation of discrepancies
- the hospital did not have effective systems to measure, control and improve the quality of services based on an overall vision for the service
- the hospital premises were not fit for the purpose of long-term recovery and rehabilitation
- the hospital had no clear arrangements for discharge planning so patients stayed longer than necessary
- the different staff disciplines did not work together effectively, and relationships and communication between them was poor
- staff did not review patients' care plans effectively or involve patients in the process appropriately
- staff had worked regular extra hours for over a year and uncertainty about the future of the hospital was causing anxiety

However,

- staff were genuine and caring, engaging with patients in a respectful manner
- feedback from carers about the treatment of patients and support for themselves was entirely positive
- the hospital had adopted a positive approach to risk management for its current patient population
- staff supported patients to make decisions, when they lacked capacity to do so decisions were made in their best interests
- the head chef worked closely with the patients, ward staff and dietician to ensure that specific
- there was a positive commitment to the training and development of staff in the hospital
- personnel files were uniform with staff records including documented evidence of supervision, appraisal and training.

Summary of findings

Contents

Requires improvement

Windermere House Independent Hospital

Services we looked at
three wards for rehabilitation and older people with mental health problems.

This report describes our judgement of the quality of care provided within this service. Where relevant we provide detail of each area of service visited.

We base our judgement on a combination of what we found when we inspected, information from our intelligent monitoring system and information given to us by people using the services, the public and other organisations.

We have reported on one core service provided at Windermere House Independent Hospital bringing together the three wards to inform our overall judgement of Barchester Healthcare Limited.

Summary of this inspection

Background to Windermere House Independent Hospital

Windermere House is a specialist independent mental health service based in Kingston-Upon-Hull. It is part of the complex care sector of Barchester Healthcare Limited, which provides assessment and medical treatment for people detained or restricted under the Mental Health Act. It offers services for men with functional or organic diagnoses on an informal and a detained basis. Although registered for 45 patients, the hospital now takes a maximum of 41 patients.

The three units are split into groups for working age and older adults:

- Coniston – an 11-bed rehabilitation ward for men
- Kendal – a 15-bed rehabilitation ward for men with long-term enduring mental health difficulties and assessment for older men with mental health problems
- Ullswater – a 15-bed rehabilitation ward for older men with enduring mental health difficulties including dementia

The hospital is registered with the CQC to carry out two regulated activities:

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

At the time of our inspection, there was no current registered manager or controlled drugs accountable officer; however, we had been notified of cover arrangements that had operated since 3 September 2015.

Windermere House Independent Hospital has been inspected four times by the CQC, most recently in 2013. The last inspection found no breaches of regulation. This is the first inspection of Windermere House Independent Hospital using the CQC's new methodology. Although under internal review at the time of our inspection, the hospital defined all its wards for the rehabilitation of men. We have reported on this main core service, commenting on specific needs of older people where appropriate to inform our overall judgement of Windermere House Independent Hospital.

Our inspection team

Team leader: Christine Barker, Care Quality Commission

The team that inspected the service comprised of three inspectors, one assistant inspector, a mental health act reviewer, a nurse specialist, an occupational therapist and an expert by experience (someone who has developed expertise in relation to health services by using them or through contact with those using them).

Why we carried out this inspection

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

How we carried out this inspection

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

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

Summary of this inspection

Before the inspection visit, we reviewed information that we held about the location, asked a range of other organisations for information and sought feedback from carers at a focus group.

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with nine patients who were using the service
- spoke with five carers of patients who were using the service
- collected feedback from six carers at a focus group, two patients and four carers through comment cards
- captured the experiences of patients who may have cognitive or communication impairments using the short observational framework tool for inspection (SOFI) on Ullswater and Kendal wards
- spoke with two ward managers, the deputy hospital manager, acting hospital director and divisional director
- spoke with 28 other staff members, including two administrators, two maintenance workers, two mental health administrators, one activities co-ordinator, the housekeeper, the head chef, seven qualified nurses, the occupational therapist, one clinical psychologist, the consultant psychiatrist, and nine care assistants
- reviewed 26 patients care and treatment records, including physical health checks
- carried out a specific check of the medication management on three wards including prescription charts
- reviewed the Mental Health Act paperwork for nine detained patients.

We also:

- received feedback about the service from Hull clinical commissioning group and Hull safeguarding adults team
- attended and observed three hand-over meetings, a multi-disciplinary meeting and a care programme approach meeting
- attended and observed one morning heads of department meeting and one clinical governance meeting
- reviewed five staff personnel files
- looked at a range of policies, procedures and other documents relating to the running of the service
- reviewed audits undertaken in the previous six months
- re-visited the service with a pharmacist post inspection.

What people who use the service say

Patients all said staff cared and treated them with respect. They could speak to staff to raise any concerns they had.

Feedback from carers was entirely positive, with one carer talking about staff always going the extra mile.

Patients and their relatives could attend care programme meetings. Access to multidisciplinary team meetings was possible, but less consistent, as the arrangements for these meetings were sporadic.

Carers valued the monthly carers' 'family and friends' group, facilitated by hospital staff, as a safe place to meet other carers, share stories and experience peer support.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- the hospital had no risk register in place, a risk register is a working document used to list, monitor and rate any identified risks across the hospital
- the spindles used on the stairs were identified as a 'high' ligature risk by the providers own assessment in October 2015, at the time of the inspection work to encase the spindles had not been carried out
- personal alarms for staff were available on Ullswater ward, there was a protocol in place that was not being followed by all staff, nor was this monitored
- following a serious incident in August 2015 a decision made to extend the personal alarm system to staff on Coniston and Kendal had not taken place
- the annual medicines management audit completed by the external pharmacy contractor was designed to support care homes not hospitals
- medicine pots were being re-used after washing in the clinic room with the potential of cross infection occurring
- duty rotas for all the wards showed staff had worked regular extra hours, which had been the case on some wards for over a year raising concerns over fatigue, stress and performance
- the hospital had no system or process for recording any incidents involving the use of Non-Abusive Psychological and Physical Interventions. This is the method of restraint used to support the management of challenging behaviour
- staff had to open patients doors for night time observations, potentially disturbing patients sleep
- staff had awareness that items within the hospital needed repair, yet had no confidence this would happen. The management team had asked that all equipment in need of repair or replacement to be re-reported.

However:

- the hospital adopted a positive approach to risk management for its current patient population and we saw individualised risk management in place
- where one-to-one observations were required, staffing levels were increased on all wards to accommodate this
- the clinic rooms were all clean, tidy and well arranged

Summary of this inspection

- compliance with cleaning schedules was high and 85% of staff were in date with infection control training
- staff knew how to report and record incidents of harm or risk of harm through ward systems and their awareness of how to safeguard adults from abuse was high. Staff training figures for safeguarding and duty of candour were 92%, which was above the providers target for mandatory training.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- neither policies nor training had been updated or re-written to ensure compliance with the Mental Health Act Code of Practice that came into force in April 2015
- visits by a pharmacist were not frequent enough to identify and correct any concerns about medication practice
- we found that there was a lack of cohesion between disciplines in care planning
- care plans were lengthy and not written in ways that were easily understood patients and carers
- care plan reviews took place for all patients monthly however, some were brief, not reflective and had little evidence of patient input
- not all patients had had access to input from psychology
- we saw no evidence of how poor performance within teams was monitored or would be addressed.

However:

- comprehensive admission assessments took place that included physical health checks
- assessments and initial care plans showed evidence of patient and/or carer involvement
- there was as a positive commitment to training in the hospital, overall mandatory training for all staff was 87%
- staff supported patients to make decisions. When they lacked capacity to do so decisions were made in their best interests and this was recorded
- easy read information about the rights of detained patients was available, and information about their rights was given on a regular basis.

Are services caring?

Good

We rated caring as good because:

- staff knew patients well, and responded to their needs
- we observed some genuine caring interactions between staff and patients

Summary of this inspection

- there was evidence of involvement from patients and carers in assessment and care planning
- patients and their relatives could attend care programme meetings
- relatives spoke highly about the care their relatives received, felt involved in care and supported by staff
- a monthly carer's 'family and friends' group offered a safe place to meet other carers and share experiences
- patients had access to advocacy services.

However:

- the care delivered did not always support risks highlighted in the care plans
- patient involvement in care plan reviews was not clear
- carers were not regularly invited to attend multidisciplinary team meetings.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- the hospital had no clear arrangements for discharge planning so patients stayed longer than necessary
- there was wide recognition that the building was not fit for the purpose of long term recovery and rehabilitation
- on all three wards there was limited access to bathrooms
- all seating was generic and did not take into account individual needs
- on the older peoples ward dementia-friendly contrasting crockery and adaptive cutlery had been removed and replaced with white crockery on white table cloths.

However:

- the head chef worked closely with the dietician to ensure that specific dietary needs were being met, but also that patient's likes and dislikes were catered for
- patients were able to personalise their rooms and once risk assessed some had their own keys
- some patients had individually assessed equipment, for example wheelchairs.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- the hospital was unable to provide a local risk register and it was unclear how risk was monitored

Summary of this inspection

- senior managers were open in describing the issues regarding data collation but there were no actions plans in place to improve these issues
- staff could not describe the vision and values of the provider and senior managers had made no attempt to frame the work of the hospital around these
- with no internal monitoring of key performance indicators, we were unable to find evidence of how managers could have oversight of the hospital's performance
- following 17 'baseline' hospital audits completed in November 2015, no action plan contained actions for every issue identified
- staffing levels relied heavily on overtime and the use of bank and agency staff
- the hospital had introduced its own procedure for dealing with staff sickness, although well-established we found no documentation to describe it, nor was it in accordance with Barchester policy
- throughout the hospital we saw poor communication between the management and the staff.

However:

- staff morale on the wards within their teams was positive
- there had been support for all grades of staff to learn and develop
- staff records included documented evidence of supervision, appraisal and training
- where disciplinary action had been undertaken the Barchester Healthcare Limited policy for disciplinary was used.

Detailed findings from this inspection

Mental Health Act responsibilities

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

The Mental Health Act (MHA) manager had reviewed and rewritten the audit processes for MHA documents across the provider to improve the quality of information fed back to the Barchester complex care sector on the use of the Mental Health Act. The providers hospital administration system was used to alert staff when renewals were due. Timely reminders about detention renewals, managers' hearings and tribunals, report deadlines, authorisation of medications and requesting a second opinion appointed doctor (SOAD) visit were received. Detention documents were scrutinised by the mental health administrator and ward staff, however, the ward staff designated to receive documents had not received training in this task.

Mental Health Act up date training was mandatory for qualified nurses annually compliance was 16 out of 17 (94%) however, staff had received no training on the new Code of Practice that came into force in April 2015. Copies of the new Code of Practice were available on all wards. Barchester policies had not been updated or re-written to ensure compliance with the Code. The Department of Health deadline for providers to complete this work was October 2015.

Detained patients were given information about their rights on a regular basis in line with section 132 requirements. Easy read information about the rights of detained patients was available. The Mental Health Act manager was working to improve information given to patients' nearest relatives who might not fully understand some of the issues involved. Staff referred all detained patients to the independent mental health advocate (IMHA).

Mental Capacity Act and Deprivation of Liberty Safeguards

Patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. People who might have impaired capacity had their capacity to consent assessed on a decision-specific basis. Staff had an understanding of the five principles of the mental capacity act (MCA) and could refer to the policy. Staff supported patients to make decisions where appropriate. When they lacked capacity to do so decisions were made in their best interests. Staff knowledge of patients allowed them to do this in line with their wishes, feelings, culture and history. Best interests meetings included a wide range of people to support individual patients however, capacity assessments were being completed in multiples.

In the first six months of 2015 the service had made four Deprivation of Liberty Safeguards (DoLS) applications, two of these DoLS applications were not authorised. They both related to patients who were out of area. Hospital staff had put in the application but felt unable to make any progress. During our inspection, a safeguarding adult's referral was raised in relation to this situation.

The hospital had identified three levels of safeguarding training that included training in the principles of the MCA, Deprivation of Liberty Safeguards and Duty of Candour. 94 out of 102 (92%) staff had completed level one training, 84 out of 102 (82%) had completed level two training, and 40 out of 102 (39%) had completed level three training.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

There was wide recognition from all staff including management and the hospital provider that the environment needed updating as it was not fit for the purpose of long term recovery and rehabilitation. Historically there had been a refurbishment plan in place. The provider had withdrawn this whilst a full re-assessment of required environmental changes was undertaken. We were assured there was a two-year plan for major investment on the site but the design for this modernisation had not yet been agreed.

At the time of our December inspection we found similar issues to those outlined in the provider's own quality first visit of October 2015. These included worn furniture in need of replacement, some bedroom furniture in need of repair, and some bathrooms with damp. There was a significant lack of quiet space on wards. All rooms had en suite facilities however, there was limited access to bathrooms: on Coniston and Kendal wards there was with one bath and one shower for 11 and 15 men respectively and on Ullswater one shower and one assisted bathroom for 15 men, several of whom had continence issues. Staff told us there had been plans to provide patients individual showers in en suite rooms but we found no evidence these would be implemented.

The three wards Coniston, Kendal and Ullswater were all for male patients. Every patient had his own bedroom, with an adjoining toilet and washbasin. The doors on patients' rooms had no viewing panels so it was necessary for staff to open the door and enter the room if a patient required observation at night, potentially disturbing patients sleep. Unless patients were on higher levels of observation, scheduled checks at night took place at 2am and 4am. On Coniston ward staff left bathroom doors open during the night to block the light coming in from the corridor during observations, however this meant that staff had to fully enter patient's bedrooms in order to adequately complete night time observations.

The bedrooms are off a U shaped corridor with no mirrors to alleviate blind spots. Patients did have unsupervised access to corridors and rooms that had ligature points: hand basin taps; rigid metal window restrictors; grab rails; door handles, openers and inside locks.

Outside, each ward had an external garden area for patient use: fencing panels, guttering, branches, a pergola and brackets from the air conditioning were all potential ligature points. Whilst patients from Ullswater and Kendal were accompanied in their gardens following individual risk assessments, some patients from Coniston had access to the garden with no supervision from staff.

Staff told us that for the patient group within the hospital were at low risk of self-harm and that staff awareness of individuals, and risk assessments which included positive risk taking, were in place to mitigate risk. Over a six-month period of 280 incidents, seven were self-harm. All related to patients hitting themselves against walls or floor.

An annual environmental ligature risk audit was completed in September 2015. Whilst some physical work to reduce

risk was complete: non-weight bearing curtain tracks put in; pull cords removed throughout and the replacement of some hand basin taps. There remained recommendations identified in this audit with no timescales attached. The spindles used for the stairs between floors were identified as a 'high' ligature risk by the providers own assessment. However, at the time of the inspection work to encase the spindles outlined in the central Barchester action plan had not been carried out. This meant patients had unsupervised access to high-risk areas without adequate mitigation. Ligature cutters were available and accessible on each ward.

The clinic rooms were all clean, tidy and well arranged. They all had blood pressure monitoring equipment and scales, none had an examination couch. Resuscitation equipment was available recalibrated and well maintained. On Coniston this was checked weekly, on Kendal and Ullswater daily. Drugs cupboards and fridges were in good order with fridge and room temperatures checked daily. Emergency drugs were present, checked and in date.

There were no seclusion facilities at Windermere House and we found no evidence of seclusion or long-term segregation taking place.

The hospital environment as a whole presented some challenges for staff and patients, particularly in terms of maintaining cleanliness. Originally built as a care home the layout of the wards and the need for refurbishment were high on the agenda for all staff who had some positive suggestions about improvements that could be made. We were told changes to the environment would follow clarity around patient population.

The décor on Ullswater ward was tired with paint coming off bedroom doors and furniture in need of replacement. There were rust marks on the flooring from chairs. Plans for a complete refurbishment of this ward, with substantial funding were awaiting Board approval at the time of our inspection. Staff who knew the patients there were pleased, however, were concerned they had had little input into these plans. We were told that there would be a consultation period when both the provider's estates team and a dementia specialist would meet with staff to discuss the proposed refurbishment.

On Ullswater ward, we found out of date staff food in the fridge in the ward kitchen. The housekeeping staff felt they were unable to throw this out as it belonged to staff. We found that the majority of the ward was clean; with the exception of one bed that had been made up over dried faeces. Following discussion with staff we learned that cleaning bodily fluids was the responsibility of care staff. The domestic team believed that at times there was reluctance from care teams to do this in a timely manner. We raised both issues with the nurse in charge for immediate resolution and we were assured arrangements would be made to ensure neither practice continued.

On Coniston ward we found a metal panel hanging off the tumble dryer that had previously been held in place using sellotape. Patients or staff could have hurt themselves on this loose panel; or it could have been used as a weapon.

Staff had awareness that items needed repair, yet had no confidence this would happen. The divisional director had asked for equipment in need of repair or replacement to be re-reported so this could be actioned.

Most of the equipment we checked was clean and well maintained. Throughout the hospital, electrical items had evidence of portable appliance testing, although on Kendal ward the weighing scales and an appliance in one of the patient's bedrooms did not.

We found evidence that cleaning schedules were in use and completed by the housekeeping staff, although in a ten-month period only six had been signed off by the ward managers. Trolleys to avoid putting dirty laundry on floor, identified as an infection risk, had been purchased. However, the laundry facilities remained small with limited space between dirty and clean laundry.

Staff compliance with infection control training was 85%. Staff demonstrated an awareness of effective handwashing; the facilities required were available throughout the hospital. However, infection control principles were not followed in all areas. For example, there were no disposable cups to dispense medication. The cups available were re-used after being washed in the sink. This was an issue because pots should be washed in hot water between use to avoid cross infection and to ensure all medication is thoroughly cleaned from the pot before being re-used.

A regional director assessed the hospital environment bi-monthly as part of the provider's quality first visits. Windermere House had a report, which was made

available to us, from October 2015. Outstanding actions identified in a previous report were reviewed with new any new actions identified were included on a central action plan for the service.

All wards had an alarm system linked to the nurse's station however, there were insufficient alarm points on the walls. A decision had been made following a serious incident in August 2015 to extend the personal alarm system to staff on Coniston and Kendal. However, this had not been introduced by the time of the inspection.

On Ullswater ward personal alarms for staff were available, and there was a protocol in place for staff to collect a personal alarm at the start of their shift and acknowledge this by signing a specific sheet. We observed a number of staff not carrying personal alarms. We reviewed signing sheets for personal alarms for October and November 2015 and found that none of the four sheets was fully completed and that some had only three staff names recorded. The system in place, to sign out and return individual alarms at handover meetings was not being followed by all staff, nor was this being monitored.

Safe staffing

Establishment Levels August to October 2015 inclusive

Ullswater (15 patients)

Ward manager (vacancy)

Qualified Nurses Whole Time equivalent (WTE): 5

Number of vacancies qualified nurses: 2

Nursing Assistants (WTE): 30

Number of vacancies nursing assistants: 3

Shifts covered by bank or agency: 341

Shifts not filled: 80

Staff numbers daytime - a minimum of 1qualified nurse (usually 2 RMNs 9-5) and 6 support workers

Staff numbers night time - a minimum of 1qualified nurse and 3 support workers

Kendal (15 patients)

Ward Manager 1

Qualified Nurses (WTE): 5

Number of vacancies qualified nurses: 1

Nursing Assistants (WTE): 21

Number of vacancies nursing assistants: 1

Shifts covered by bank or agency: 30

Shifts not filled: 2

Staff numbers daytime- a minimum of 1qualified nurse (usually 2 RMNs 9-5) and 4 support workers

Staff numbers night time - a minimum of 1qualified nurse and 1 support worker

Coniston (11 patients)

Ward Manager 1

Qualified Nurses (WTE): 5

Number of vacancies qualified nurses: 1

Nursing Assistants (WTE): 14

Number of vacancies nursing assistants: 2

Shifts covered by bank or agency: 10

Shifts not filled: 2

Staff numbers daytime - a minimum of 1qualified nurse (usually 2 RMNs 9-5) and 4 support workers

Staff numbers night time - a minimum of 1qualified nurse and 2 support workers

Staff turnover in the period December 2014 to November 2015 was 30%. Staff recruitment and retention was of ongoing concern. Over three months to November 2015 there were six whole time equivalent vacancies for support workers, four for qualified nurses and one for a ward manager. Whilst positions had been advertised, we saw little effort to be more innovative with staff recruitment. This left the hospital with a constant shortage of staff.

Ullswater had been short staffed for over a year. One of the vacancies was the ward manager position, which had been vacant since August 2015. Efforts to fill this position had not been successful. A manager from Kendal ward was covering two wards to try to fill this gap.

Nursing staff were working extra hours to cover the shortfall. We asked how this was monitored by the hospital and we were told that staff were not allowed to work more than seven shifts in a row without a day off. This could mean staff working up to 84 hours some weeks, raising

concerns over fatigue, stress and performance. Shifts not covered were due to short notice in the case of staff sickness. The hospital reported a low staff sickness rate of 3%.

The ward managers used regular allocated staff to produce duty rotas for their own ward. These rotas identified staff working regular extra hours. The admin team collated the rotas and time sheets from every ward, inputting the details on a central database. The administrator was responsible for flagging situations where staff had worked more than seven consecutive days to the deputy manager who in turn ensured a day off was taken.

Staff told us that if a patient required one to one observation additional staffing was made available. There were four patients on one to one observations at the time of our inspection. This meant there were up to 10 staff members working on Ullswater ward with 15 patients. Communal areas were busy with many people in one area. Staff did not wear uniforms so there was no way for patients to distinguish between staff and patients in such a crowded environment.

Due to the small number of qualified nurses per ward, the ward manager was often required to work in the shift to cover shortages. There was no built in supplement within the nursing establishment to cover for planned absence for training or annual leave. This meant the managers were not always available to undertake managerial duties. Previously low appraisal and supervision rates had been addressed in the three months prior to inspection. No audits had been undertaken for over six months prior to those completed in November 2015. These were described as having been done quickly to create a baseline and had no action plans or timescales attached.

For qualified key nurses, one to one time with patients could be difficult to ensure. Whilst the ward team supported individual patients, we were told time spent reviewing care and progress could be difficult to find alongside running the ward. Escorted leave and ward activities were rarely cancelled because of too few staff.

The consultant psychiatrist, the responsible clinician for all patients, would respond to crisis or urgent matters for patients throughout the week and was kept informed about patients through calls from the hospital. There was no junior doctor or nurse prescriber. Physical health care emergencies were dealt with through the patient's general practitioner.

There were nine mandatory training modules for all staff with two additional modules for nurses only. On 1 December 2015, overall mandatory training overall compliance was 87%. The lowest compliance with mandatory training was 59% of qualified nurses completing cardiopulmonary resuscitation (CPR) training.

Following low compliance rates staff supervision had been a focus in the three months prior to our inspection. At the time of inspection, 87% of all staff met the company target for bi-monthly individual supervision. These figures included supervision of eight regular bank staff on Ullswater ward. Other bank and agency staff were understood to receive individual supervision elsewhere however, there was no system in place to check this. In addition to individual supervision, ward teams received group supervision. This happened regularly with a team from each ward attending every three weeks.

Assessing and managing risk to patients and staff

There were no seclusion facilities at Windermere House. We found no evidence of seclusion or long-term segregation taking place.

There were no reported incidents involving the use of restraint between May and November 2015. Restraint interventions were only recorded in patient's records. During discussion with managers, it was explained that the hospital had no system or process for recording any incidents of the use of Non-Abusive Psychological and Psychical Interventions (NAPPI). This meant there was no way of measuring the use of restraint, any issues or any lessons learned from incidents involving restraint. Staff did report that patients could become aggressive at times, but staff who knew the patients well, could identify their triggers and intervene effectively at an early stage. The staff we spoke to were clear that if they were to need to use any physical intervention under the NAPPI training they would not use prone restraint.

We were told rapid tranquillisation was not used on Coniston or Ullswater wards, but occasionally used on

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Kendal ward. There we saw it was care planned, prescribed and reviewed. However, there was no system in place to record the frequency of rapid tranquilisation, so the provider was unable to give us specific numbers.

The hospital had adopted a positive approach to risk management for its current patient population. This takes into account the individual risk assessments of patients using the Galatean risk and safety tool (GRIST) and detailed risk management plans which draw on staff knowledge of individuals alongside their vigilance. We reviewed 26 patients care and treatment records, all had up to date individual risk assessments using GRIST. However some of the risk assessments we saw were very long, for example, one on Ullswater was 50 pages, which was unlikely to be accessible to agency staff covering shifts. Strong robust risk plans were in place and we saw individualised risk management plans in patients notes.

The hospital submitted Barchester Healthcare's 'Managed Disturbed Behaviour' and 'Therapeutic Management of Violence and Aggression' policies as evidence for how they managed risk to patients and staff. However, both policies were four months overdue for review at the time of the inspection and neither included details of the updated 2015 Mental Health Act code of practice.

There was a list of banned contraband items on reception for visitors to the hospital. It was also used as a starting point when risk assessing individual patients. There was no policy on mobile phones, patients who were able to and wished to could have a mobile phone if it was safe, following an individual risk assessment. Patients had locked drawers on Coniston and Kendal wards within their own rooms where phones could be stored. Other patients had access to the ward phone. We saw one patient using this to take a private call in his own room. Staff were aware there was a searching policy in place, which was rarely used. Knowledge of patients and the quality of relationships with staff meant items for example; lighters were voluntarily handed to staff when patients returned to the ward. Informal patients could leave the hospital at will, door codes were known by individual patients, or given to them by staff when asked.

Staff awareness of their responsibilities to report adult safeguarding was high and 92% had received safeguarding training. Staff knew how to raise a safeguarding alert with the local authority. In a six-month period, 39 safeguarding incidents had been recorded. The severity of any adult safeguarding concern was measured against a matrix given to providers by the local authority safeguarding team. Ahead of inspection there had been a concern that reports of incidents from Windermere House to the local authority had been nil for a year. During inspection, we saw evidence that incidents were reported through to the local authority. However, if they scored low on the matrix these had not been recorded on the local authority system. Following discussion with both agencies, a meeting was to take place to further clarify the adult safeguarding processes.

On Kendal ward there was a large amount of expired medication in an open uncovered container on the floor of the clinic room. We raised concerns that this medication was not locked away within the clinic room with the acting hospital director as requiring urgent action. We were assured when we left the building on the Tuesday night all medication was locked away. On Wednesday morning this was checked and the open container was in the clinic room. We requested that this was dealt with immediately and the lid was placed on the container in front of us, effectively sealing it.

We discussed the need for the hospital to introduce appropriate systems for the safe disposable of drugs. This was something identified by Barchester in October during their internal Quality First visit. By the time we re-visited the hospital with a pharmacist this disposal issue had been resolved. We re-checked the storage arrangements for medicines on all three wards. Medicines were stored securely in locked treatment rooms and the keys held by the nurse in charge. All expired or unwanted medicines were in appropriate pharmaceutical waste bins, and disposed of according to current legislation.

The controlled drugs accountable officer was the previous registered manager. Controlled drugs (CDs) were stored in a CD cupboard on one ward, access to them was restricted and the keys held securely. If CDs were required by the other wards, staff had to leave their ward to go and sign them out of the register. This meant that CDs were being transported unsecured around the hospital. Staff did not routinely check the balances of CDs held in the cupboard; under Barchester's policy, this check was required weekly. These issues had been identified in a review of medication systems conducted in November 2015 by a nurse employed by the provider but had not been rectified.

Prescription charts were clearly written by the psychiatrist with a clear indication of what PRN medication could be

used for however, the PRN policy form for Barchester was not being completed. There was no junior doctor or nurse prescriber. There was a separate card for mental health medicines. Changes to medicines made by the psychiatrist were faxed to the patients GP who produced a prescription. This was supplied to the hospital through an external pharmacy contractor, although if urgent, medicines were collected by staff. This meant each patient had his own-labelled supply of medicines to last for a month. Staff told us they had recently introduced a stock management system to ensure that medicines were ordered in good time and we saw an example of this in use on each of the wards.

On Ullswater ward medicines administration records (MAR) were in use. We checked three of these and saw that they were completed appropriately. We also saw one example of covert administration where a mental capacity assessment and best interests meeting had taken place documented in the patients care plan. We saw one patient who was self-medicating on Coniston ward. This process safely followed a bespoke policy written within the hospital three years ago. A comprehensive risk assessment and documentation were in place and reviewed regularly. The provider's medicine management policy stated that each hospital would have a local procedure agreed with the GP and consultant psychiatrist; however, we were told there was no written protocol in place.

The external pharmacy contractor completed an annual medicines management audit in January 2015, but this was designed to support care homes, not hospitals. We found that visits by a pharmacist to look at medication issues were not frequent enough to identify and correct any concerns about medication practice at Windermere House. The provider did not undertake their own medicines management audits, nor investigation of discrepancies. There were no audits of T2 and T3 compliance but were told that 'when required' an audit was done centrally by the provider and recorded electronically. We did not see when the last audit took place. Over a six-month period, two medication errors had been reported.

All patients were on Ullswater ward had a falls risk assessment. Incidents of falls, including triggers were recorded and reviewed by staff. We were able to case track a patient admitted to the local general hospital following a fall. At Windermere House, a falls assessment was completed on admission and repeated monthly informed the patient's comprehensive care plan. Interventions were in place to support the patient and monitor any deterioration. Their risk of falling was discussed in their care programme approach meeting that had representation from the family, consultant psychiatrist, ward manager, psychology, social worker and the independent mental health advocate. A best interests meeting followed to further discuss and agree additional supportive interventions to mitigate risk of falling, for example a movement sensor in the bedroom.

Child visiting procedures were in place and these visits took place off the ward. Other visitors were able to visit patients on the ward provided there were no incidents occurring at the time. On Ullswater, ward carers sometimes stayed with their loved ones through mealtimes.

Track record on safety

There had been one serious incident requiring investigation reported in the six months prior to inspection. This occurred in August 2015 and involved a patient assault on two staff members. A debrief took place for staff individually and within team supervision sessions. The ward teams supported the two members of staff involved; however, we saw no formalised process for supporting staff following incidents. The hospital had followed procedures and reported this incident to the local authority.

Reporting incidents and learning from when things go wrong

Over a six-month period from April to November 215 there were 280 incidents/accidents reported across all wards. Kendal Ward had the highest number of incidents at 159. Incidents were recorded as physical aggression towards other people and the environment, falls witnessed and patients unwitnessed, safeguarding, choking, medication errors, self-harm, verbal aggression a patient absconding and a road traffic accident. None of these incidents/ accidents resulted in staff injury.

All but the one serious incident were identified as no injury/ near miss, this was the lowest severity rating available. Whilst we saw evidence of discussion of incidents during clinical governance meetings there were no action plans following these discussions. In addition, we found no evidence of any root cause analysis into incidents and accidents, or any analysis of trends.

Staff knew how to report and record all other incidents. Ward managers reviewed recordings of all incidents on

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

their ward, with some incidents being taken to clinical governance for wider discussion. Whilst we could find individual examples of good practice in terms of debrief and actions taken to support staff, we found little evidence of a system in place to ensure that changes made following lessons learned was consistent. When used to manage behaviour, restraint interventions were recorded in patient's records.

There was a policy in place to support duty of candour and 92% of staff had received training. Staff told us they were aware of their responsibilities and the current management team spoke of developing a culture of transparency within the service.

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

All patients had comprehensive admission assessments. Of the 26 care records we reviewed, all but one on Kendal ward, had physical health checks as part of their assessment with evidence of ongoing physical care.

Care records were to a uniform standard however, we found some records lacked detail in terms of describing the delivery of individualised care. Care plans had nine separate sections for each patient.

Of the 26 care records reviewed, one of patients on Kendal and one of the patients on Coniston had been given their own copy. On Ullswater we were told all ten patients had copies of their care plans. We saw no easy read care plans to share with patients or carers and were concerned that if the patients on Ullswater ward did have copies they would not be able to read or understand these.

Initial care plans showed evidence of patient and/or carer involvement. On Ullswater ward, although there had been individual assessments of likes and dislikes, these were not all being followed by ward staff at mealtimes. On Kendal ward care plans referred to statements made by the patients about shared and agreed goals, with nursing interventions to support these. On Coniston ward we saw a commitment within care plans for staff to support patients to follow their individual interests.

Reviews of care plans were taking place for all patients monthly however; some were brief and not reflective with little evidence of patient input. Care plan reviews did not link to outcomes from multidisciplinary team meetings, nor were care plans updated or referenced at handovers. Actions identified in care planning were not always documented as having been followed.

We questioned the accuracy of several of the care plan reviews in patients care records. Some reviews seemed to have been copied and pasted from an earlier review. One care plan on Ullswater referenced support required for a patient at a hospital appointment that had already happened. We saw evidence on Ullswater ward of auditing of care plans by night staff however, this had not picked up the mismatches we identified from the records seen.

The hospital used a paper-based system, with patient notes kept securely in locked cabinets in the ward offices. Staff knew where patients' notes were and how to access them.

Best practice in treatment and care

On becoming a hospital in 2005, Windermere House introduced a model of care developed jointly by nurses and people who had used mental health services, which became its ethos. Its focus is on patients leading their own recovery. The psychiatrist expressed concerns that there had been a loss of this recovery focus in the hospital in recent months.

The occupational therapist used specific tools to assess patients' abilities in order to support and measure the effectiveness of care. For rehabilitation patients the model of human occupation screening tool (MOHOST) provided a baseline assessment and documented progress towards occupational therapy intervention goals. For patients with dementia the focus was on quality of life (QoL) which included emotional, social, and physical aspects of the individual's life. This was an assessment of a patient's well-being, and had a role in supporting staff to provide choices appropriate to individual needs. The pool activity level (PAL) tool, a checklist to aid the selection of activities that would be both appropriate and personally meaningful for the patient, supported this.

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Requires improvement

Not all patients had had access to psychology. An assessment of psychological functioning had been developed for patients on Kendal and Coniston wards however, it was not yet widely used. Some patients had a brief history, aims of treatment, and a formulation recorded by the psychologist in their notes.

The psychology team could offer a range of evidence-based practice tailored to each patient. These included: Raven's matrices designed to measure reasoning ability; Addenbrooke's cognitive examination III to assess cognition; the Wechsler test of adult reading to measure the degree of intellectual function prior to the onset of illness; Bach's House-Tree- Person test designed to measure aspects of a person's general mental functioning and F-A-S verbal fluency test. However, records of psychology assessments that had been undertaken were not evident in patients care files; we were told they may have been stored separately in the psychology office.

The focus of care on Coniston ward was for patients to lead their own recovery. Individual patients had protected days from the activity timetable to ensure they could do things outside the hospital. There was support for individuals to access chosen activities away from the hospital in the local community. The basic premise of the staff was to risk assess positively, only care planning restrictions if there was evidence that the patient needed a specific intervention to achieve their goal safely.

On Kendal ward staff used the mental health recovery star, designed to support adults to manage their own mental health. Staff responded positively to the spiritual needs of patients. There was a complex mix of patients on Kendal ward. Some older patients who following assessment had not been able to access a clear care had needs that did not meet the criteria for a rehabilitation ward. A number of staff on Kendal ward requested dementia training to support them to better meet the needs of the current patient group.

On Ullswater ward, there was limited evidence of NICE guidance being followed for patients with dementia. Key workers worked closely with families to understand more about patients likes and dislikes. Picture cards were available to support menu choices at mealtimes. Following assessment of physical needs, which included nutrition, hydration and falls, each patient had a specific care plan that reflected their individual needs.

The clinical outcome measure Health of the Nation Outcome Scales (HONOS) monitors change for service users with severe mental illness. Clinical staff rated and documented this for individual patients at assessment on all wards. This was repeated, after a course of treatment or some other intervention.

None of the clinical staff we spoke to were participating in any clinical audit.

Skilled staff to deliver care

There was one occupational therapist (OT) working eight half-day sessions a week to cover all three wards at Windermere House. The OT had been working within this service for four years and knew the patients well. Occupational therapy focus was primarily on meeting the mental health needs of the patients. The OT supervised and supported two activities co-ordinators who were supernumerary. Activities were considered and offered, within the unit, within the OT department and where possible in the community. The OT was not a specialist in assessing the complex physical health needs seen primarily on Ullswater ward.

The OT was employed through a service level agreement with the local NHS trust and received supervision and some bespoke training through them. The OT was seen as an important part of the team at Windermere and received informal managerial supervision and support. There was a small OT budget of £25 per week allocated to support activities however, this was administered centrally which at times lead to frustration around ease of access.

Psychology services were provided under a service level agreement with a local psychology and psychotherapy consultancy service. Eight half-day sessions of qualified psychology and 12 sessions of psychology assistant were in place each week. In addition to work with patients, the psychologist had supported development by becoming involved with some of the internal staff training.

The consultant psychiatrist, the responsible clinician for all patients, was employed on a part time basis for 1.5 days a week. Employed by the provider for ten years the consultant was a specialist in the treatment of resistive mental disorder. There was no junior doctor or nurse prescriber. The psychiatrist also worked full time with a local Trust and had good links with the neurologist. This meant access to specific assessments for patients were actioned with ease.

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Requires improvement

Visits by the external pharmacist to look at medication issues were not frequent enough to identify and correct any concerns about medication practice at Windermere House.

There was a positive commitment to training in the hospital with systems in place to monitor compliance, alerting staff when training is due or writing to them individually if any mandatory training has expired. There were nine mandatory training modules for all staff, with two additional modules of mandatory training identified for nurses only. Management were aware of the low compliance with one of these, CRP training. They told us letters had been sent to staff stating it was a priority that all qualified staff attend this training. On 1 December 2015, overall mandatory training compliance was 87%.

Non-abusive psychological and psychical interventions (NAPPI) was the system in place to manage challenging behaviour of patients, 84% of staff were compliant with this training. Staff were clear that when NAPPI was used the interventions were primarily de-escalation, with physical interventions rare. Following the serious incident in August 2015, due to limitations of the NAPPI system, there had been a plan to change this to the management of actual or potential aggression (MAPA), this had not yet happened.

Staff training in some form took place weekly. In addition to mandatory training; a range of internal skills based courses to support clinical staff had been developed. Sessions included the management of clinical risk; safe and therapeutic observations; signs and symptoms of mental disorders; talking with psychotic patients; medication side effects; resilience in work; communication and the Tidal recovery model. There was also an aspiration that in addition to qualified staff, support workers would receive cardiopulmonary resuscitation (CPR) training. All ward staff we spoke with had accessed both mandatory, and skills based sessions.

Support was available for staff to train externally with four support workers completing their first year of study as assistant practitioners, a ward manager undertaking a master of arts degree in business management at university and a junior member of the administration team completing a work-related NVQ qualification.

There was an induction portfolio for new starters incorporating the care certificate for support workers. Paper versions of key topics for example: safeguarding, Mental Capacity Act and communication were given to bank staff and new starters to provide a basic induction. These had questions and quizzes that were marked to form the basis of feedback given to these staff. Both staff and patients could access training resources available in the hospital.

The company standard for supervision of all staff employed by Barchester was two monthly. The monitoring system in place highlighted if any staff were not meeting this target. Of the 89 staff on the system, four were off work long term; excluding these, there was an adherence of 87% to the standard, this included eight regular bank workers on Ullswater who received supervision from the ward team. We were told other bank and agency workers received supervision externally from their main employers; however, there was no system to check this.

Staff records included documented evidence of supervision, appraisal and training. Figures on 1 December 2015 showed appraisal and revalidation for all staff was 100%.

We attended handover on each ward from night to day shift, not all staff coming on duty were present on any ward. We asked if the late arrival of staff happened on a regular basis and we were told that it did. We saw no challenge by the nurse in charge. We were subsequently told that the process in place to address poor performance of staff was within individual supervision and at annual appraisal.

Multi-disciplinary and inter-agency team work

There were links with two local General Practitioners surgeries where patients were registered. Where possible staff supported patients to access community services and attend appointments at the local general hospital. Referrals could be made to speech and language therapists, district nurses and physiotherapy through a patient's GP. A dietician, optician, chiropodist and dentist would visit patients at the hospital if required.

We found some examples of positive individual work by members of the ward teams supporting individual patients to fulfil their potential. However, there was a lack of cohesion between disciplines in care planning. There were examples of several good assessments from psychiatry, psychology, occupational therapy and nurses but no examples of multi-disciplinary assessments that drew together the recommendations of the whole team. Several members of the team reported poor communication and

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Requires improvement

relationships within the multi-disciplinary team (MDT). Senior managers had recognised that the MDT was fragmented and expressed commitment to work towards improvement.

Weekly MDT meetings reviewed observation levels for each patient. Incidents were also discussed however, these discussions were not recorded. There was a new system in place for patients to be reviewed at MDT a minimum of every three weeks. Previously this had been more ad hoc with some patients not being discussed on a regular basis. It was hoped a more regular pattern of reviews would allow relatives to attend.

We attended a MDT meeting where three patients were discussed. The charge nurse, psychiatrist, occupational therapist and psychologist were present. No family had been invited to these MDT reviews and the planned list of patients seen had been changed to meet more urgent clinical need. The patients' diagnosis, progress, needs met and unmet, were discussed. Psychology offered no advice around behavioural strategies.

Care Programme Approach (CPA) meetings were well attended by care co-ordinators for patients from the locality. However, we were told could be difficult to ensure a patient's care co-ordinator from out of area would attend. This role is important in keeping a link for the patient with their local area and any family there.

With the permission of the patient, we attended a CPA during inspection. The patient was treated respectfully and was able to contribute to the meeting throughout. The independent mental health advocate (IMHA) and care co-ordinator had been invited but both were unavailable. The patient had chosen not to invite family but had agreed they be informed of any outcomes after the meeting. The patient had paper copies of the reports prepared for the meeting. It was not clear how far ahead of the CPA these had been given to the patient. Staff present were aware of the patient's needs and discussed these openly with him encouraging his contribution throughout. Notes taken about decisions made were, these were to be shared with the patient once typed up.

We attended the handovers on each ward from night to day shift. Handovers lasted 15 minutes, all patients were discussed and information shared included key details from the previous handover, patients' mood, risk, and levels of observation. The short length of time meant staff could not easily reference individual care plans. The immediate focus was to allocate duties to the arriving shift. Several staff arrived late into handover or after the handover had finished. There was no clear process to ensure staff arriving late were fully up to date with the information shared at handover. This meant all staff working in the shift did not have necessary information to ensure safe care and treatment of the patients on the ward without the shift leader repeating the information given to them individually.

Each weekday morning there was a 'stand up meeting' that included ward managers, housekeeping, administration, psychology and occupational therapy leads and the deputy hospital director. Its purpose was to update and review any urgent issues and improve communication across the hospital. Activities planned that day and in the near future were discussed. We observed each representative given time for his or her update at this meeting.

Adherence to the Mental Health Act 1983 and the Mental Health Act Code of Practice

Mental Health Act up date training was mandatory for qualified nurses annually. Training figures reported 1 December 2015 achieved a compliance of 16 out of 17 (94%) however, we found that staff had received no training on the new Code of Practice that came into force in April 2015. Copies of the new Code of Practice were available on all wards. However, Barchester policies had not been updated or re-written to ensure compliance with the Code. The Department of Health deadline for providers to complete this work was October 2015.

We found evidence that detained patients were given information about their rights on a regular basis in line with section 132 requirements. Easy read information about the rights of detained patients was available. The mental health act administrator was working to improve information given to patients' nearest relatives who might not fully understand some of the issues involved. The carers who spoke to us told us that ward staff kept them fully involved and informed of any issues relating to the care of their family member.

Barchester intranet's hospital administration system provided a range of prompts to ensure paperwork relating to consent to treatment was correct. The mental health act (MHA) administrator used this system to alert the medical and ward staff when renewals were due. A new MHA

administrator was receiving training and support in the role from a MHA manager from another hospital within the Barchester group. The support consisted of regular visits to Windermere House, telephone and email advice with plans for external training in future.

The mental health act (MHA) manger scrutinised all new detention documents. However, we found that ward staff designated to receive these documents had not received training in the receipt and scrutiny of documents. Neither process had picked up a simple spelling mistake on a detention application form. We suggested that the MHA manager discussed this particular error with their legal advisors.

We found that ward and medical staff received timely reminders about detention renewals, managers' hearings and tribunals, report deadlines, authorisation of medications and requesting a second opinion appointed doctor (SOAD) visit. The responsible clinician (RC) documented their discussions with patients to establish their capacity, or lack of capacity, to consent to medication.

Section 17 leave forms were signed by patients who had the capacity to do so. Patients were offered copies of the forms. Leave conditions were specified and a record was made of how leave had gone.

The mental health act (MHA) manager had reviewed and rewritten the audit processes for MHA documents across the provider to improve the quality of information fed back to the Barchester complex care sector on the use of the Mental Health Act.

Staff automatically referred all detained patients to the independent mental health advocate (IMHA). This contract was with an independent company, whose service supported detained patients to understand their rights, including any restrictions or conditions on them. The IMHA also assisted in preparation and attendance at hospital mangers meetings and mental health review tribunals. There had previously been a weekly surgery at Windermere House for patients to access the IMHA this changed to a referral service during 2015. Patients who did not have capacity could be referred to an independent mental health capacity advocate (IMCA).

Good practice in applying the Mental Capacity Act

The hospital had identified three levels of safeguarding training that included training in the principles of the mental capacity act (MCA), deprivation of liberty safeguards (DoLS) and duty of candour. 94 out of 102 (92%) staff had completed level one training, 84 out of 102 (82%) had completed level two training, and 40 out of 102 (39%) had completed level three training.

In the first six months of 2015 the service had made four deprivation of liberty safeguards (DoLS) applications, two on Ullswater ward and two on Kendal ward. Two of these DoLS applications were not yet authorised. They both related to patients who were out of area. During our inspection, a safeguarding adult's referral was raised with the local authority in relation to this situation.

Staff had an understanding of the five principles of the mental capacity act (MCA) and could refer to the policy. Not all staff had fully embedded the application of the MCA in their practice. There was a reliance on the consultant psychiatrist, who was only available part time, routinely taking the lead in the MCA. Following consultation, the psychiatrist completed all capacity assessments, if staff routinely did this it would build on their competence and application of the MCA.

Patients were given assistance to make specific decisions for themselves before they were assumed to lack the mental capacity to make it. People who might have impaired capacity had their capacity to consent assessed on a decision-specific basis. Staff supported patients to make decisions where appropriate. When they lacked capacity to do so decisions were made in their best interests. Staff knowledge of patients allowed them to do this in line with their wishes, feelings, culture and history.

Best interests meetings included a wide range of people to support individual patients. However, capacity assessments were being completed in multiples. We found the recording of a meeting where eight separate decisions had been made, all of which had the consultant psychiatrist as the relevant person's representative.

Staff knew where to get advice regarding mental capacity act (MCA), including deprivation of liberty safeguards (DoLS). Staff understood and where appropriate worked within the MCA definition of restraint.

Patients who did not have capacity could be referred to an independent mental health capacity advocate (IMCA) however, the company offering independent support to

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Requires improvement

patients who lacked capacity had failed to respond to calls made by staff on six consecutive working days. Due to this lack of response, staff contacted the company contracted for detained patients who did respond.

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

Good

Kindness, dignity, respect and support

We observed genuine caring interactions between staff and patients. Staff engaged with patients in a respectful manner, offering reassurance and support to patients who were showing signs of distress. We saw that patients received dedicated one to one time with staff, either talking or engaging in an activity with staff.

We spoke with nine patients, all said staff cared and they were treated with respect. Patients could access their rooms when they wanted to and some patients had both a key to their room and the 'key code' to access the ward freely. Two patients we spoke to said staff did not always knock on their bedroom door before entering at night.

We undertook a short observational framework for inspection (SOFI) over lunchtime on Kendal ward. There was background music on during the meal. This was choir music, quite loud and distracting. The hospital had recently changed the meal time policy to improve the patient experience. Meals were prepared outside of the dining area and served to patients who were offered choice where they were able to make a choice. Staff used patient's names and showed respect throughout the meal. The chef attended the dining room to view the patient experience and observe eating habits of patients with a view to being able to modify meals.

We observed patients during the meal. Two of the patients were very able, they were given a choice of lunch and drink, and they spoke with staff with ease whilst eating a good meal.

Two patients were less able. One was able to accept support cutting up his meal; staff were very respectful about how this was done. This patient did disengage at times throughout the meal and he also shouted out at times, but staff continued to offer support and prompts.

One patient was much less able. His meal was put in front of him and he was offered some verbal prompts but he did not initiate any movements towards eating his lunch. He picked up a chip on three occasions looked at it and put it back down. After 30 minutes a staff member sat at the table to eat lunch and offered more support to assist with eating. The patient appeared unable to verbally communicate but he was smiling and seemed content. He politely refused to eat by not accepting any food but smiled. His main meal was removed, and the staff member attempted to support with dessert. This was also refused. Staff made comment that the patient had been up late and had a big breakfast with two cups of tea. He did not eat any lunch and did not accept a drink.

We undertook a short observational framework for inspection (SOFI) in the afternoon on Ullswater ward. Four patients were observed in the lounge area. Two patients were on one to one observations with support workers. During the 30 minutes observation there were only three staff interactions. Activity levels were low and there was very little effort to engage in any meaningful way with patients.

One patient sat across a chair with his legs crossed. He appeared to be a low weight and trying to get himself into a comfortable position. We viewed the care plan for this patient. Assessments had been completed showing him to have a high risk around nutrition, choking and pressure areas. Whilst this had been copied through into care plans, we did not see any evidence that the care delivered supported any of the highlighted risks.

We collected feedback from six carers at a focus group and spoke to five carers during the inspection. Feedback from carers was entirely positive, one carer said 'you can't fault the staff, they go the extra mile'.

Of the six feedback cards received, five of them were positive, with one comment from a patient asking for 'more time out of the ward'.

We spoke to seven qualified nurses and nine care assistants across the three wards; all of whom could describe patients care needs and their background in detail.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The involvement of people in the care they receive

Care plans showed evidence of involvement where possible in initial care planning, risk assessment and activity planning of patients and their carers. The level of involvement varied for individual patients. Care plans were reviewed monthly however, patient involvement in reviews was not clear. Some of the updates we saw lacked quality, with some reviews having been cut and pasted from previous reviews.

Coniston ward held a community meeting, where patients could raise issues and complaints. For example, we were told that the hours when patients could access the garden had been extended following discussion at a community meeting.

Noticeboards displayed a range of information about how to complain; the Mental Health Act; the advocacy service; activities and menus. The hospital reported that they used both specialist Independent Mental Health Advocate (IMHA) and Independent Mental Health Capacity Advocate (IMCA) services. There had been some concerns about the responsiveness from the IMCA service that had led to a request from staff that the management review this contract.

Patients and their relatives could attend care programme approach (CPA) meetings. Access to multidisciplinary team (MDT) meetings was possible but less consistent as the arrangements for these meetings were sporadic. Ten carers indicated they felt involved in the care planning for their relative and confirmed they were part of discussions at or following a MDT about the care of their relative. Two carers commented that staff telephoned between visits to keep them informed and discuss any changes. Another carer whose relative was experiencing end of life care said 'staff support with all hospital appointments and always keep the family updated'.

There was a monthly carer's 'family and friends' group facilitated by hospital staff. This offered a safe place to meet other carers, share their stories and experience peer support. Staff attending listened, offered support and sometimes took notes to understand more about individual patients in their care.

At the time of our inspection, none of the patients at Windermere House were involved with local patient representative groups.

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

Requires improvement

Access and discharge

The bed occupancy at Windermere House figures over the period May 2015 to November 2015 were an average of 97% across the three wards. Ullswater had the highest bed occupancy rate at 100%. Beds at Windermere House were never used by others when a patient was on leave.

For patients admitted when Windermere House was a care home, discharge planning had not commenced on admission. The belief of both patients and staff at the time was that placement here was a home for life. Seven patients had been within this service over ten years, six patients over five years and 27 patients under five years. The longest stay was a patient who had been at Windermere House since January 1999. The most recent admission was one month before our inspection. The majority of patients were from Hull or the East Riding of Yorkshire, with eight patients from out of area.

Windermere House did not define itself as a long stay hospital, yet there was a lack of discharge planning evident in the patients' care records. There was a reluctance from both patients and staff for individuals to move on. The hospital acknowledged that the average length of stay for patients was too long and that time needed to be spent developing effective care pathways. A key difficulty in working towards discharge were concerns around the quality of future placements.

The hospital reported two delayed discharges between May 2015 and November 2015, one on Coniston Ward and one on Kendal Ward. A delayed discharge occurs when a patient who is judged clinically ready for transfer from a service continues to occupy a bed in the service. The service reported that these delayed discharges were due to the breakdown of a trial placement section 17 leave in the first case and due to the hospital being unable to find a suitable placement because of increased physical healthcare needs in the second case.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The facilities promote recovery, comfort, dignity and confidentiality

Patients on all wards were able to personalise their rooms and once risk assessed some had their own keys. Patients could go to their room or use the quiet room on each ward for privacy. They had access to the ward telephone free of charge to make calls.

Patients could make, or have drinks and snacks made throughout the day and night. Patients made daily choices about their own food. There was a monthly feedback system for all patients (or carers) to express and update dietary preferences. The verbal feedback we received from patients and their carers about food was positive.

Each ward had its own external garden for patient use. Patients from Ullswater and Kendal were accompanied in their gardens; some patients from Coniston could access the garden with no supervision from staff. The hospital had supported plans to improve one of the gardens with the introduction of a vegetable patch with raised beds for patient use.

An upgrade of Coniston ward took place over two years ago reducing the number of beds from 15 to 11. All patients were risk assessed to see if they could have their own bedroom key, at the time of inspection, all patients on Coniston ward did. Informal patients had the codes to external doors so were able to come and go with ease.

Whilst large, the lounge/dining area was also a passageway from the external door to the nursing office. A small separate lounge offered a quieter environment and privacy. Patients could use the telephone here or in their bedrooms. In the separate conservatory, the pool table was against the window as it was broken. Patients told us this had been the case for some time and they missed being able to play. To encourage independence patients had access to their own kitchen and small laundry room on the ward.

On Ullswater the noise levels were high in the large lounge/dining room. The television was on continually but we did not observe any patients watching the TV. There were not enough chairs in the lounge/dining room to allow all the patients to be together in one room without using the dining chairs. However, there was a quiet room and conservatory off the lounge where patients could spend time with visitors or staff away from this environment.

The bedrooms on Ullswater ward had personalised door signs, however, the doors were locked with a small notice explaining that that rooms could be opened for patients at any time. This was not easily seen and it was unlikely to be understood.

On Kendal ward the dining chairs were very heavy making them difficult for staff or patients to move. The quiet room was available and accessible with a range of activities for patient use. There was a newly installed bath with a spa and blue tooth for music. Bedrooms were all personalised.

We saw a Windermere House activity plan alongside ward and individual patient activity planners however; we were told they are not always adhered to. Activities coordinators primary role was to ensure leisure activities were available to patients. These included table-top activities for example arts and crafts, and community outings.

Art from Windermere House had been exhibited in a local gallery. An internal newsletter was published quarterly for patients. When possible ward staff support activities with patients. During inspection we observed a limited number of activities taking place with patients.

Meeting the needs of all people who use the service

Although limited in number three assisted baths and showers with pull down seats and handrails were available. Individual patient's washrooms had aids and equipment to assist with the management of continence and there were privacy screens on patient's windows.

Some patients had individually assessed equipment for example wheelchairs, raisers and bed sticks. However, all seating was generic and did not take into account individual needs, some patients sat and ate their meals in a wheelchair.

A patient whose care plan contained a choking risk assessment was observed to be lying down and eating in a horizontal position. No specialist chair or equipment had been provided. We made the provider aware of our concerns and this was addressed immediately. The occupational therapist was then asked to come to undertake a full assessment. We were assured that any additional equipment required would be brought in.

Some beds were of an old design, with un-used bed rails still in place. There were no electronically adjustable beds. Some mattresses were found with thick polyurethane

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

coverings that had not been removed since delivery. These were not mattress protectors and may have been uncomfortable to sleep on. We made staff aware and these were removed.

Handrails to support patients' mobility were in place throughout Ullswater however, these were identified on the environmental risk ligature audit as in need of replacement.

On Ullswater ward we learned that dementia-friendly crockery and adaptive cutlery had been removed and replaced with white crockery prior to inspection to improve the patient's dining experience. Staff were concerned this had meant some patients were less able to be independent at mealtimes. The divisional director assured us subsequently that the provision of adaptive crockery would be reintroduced following individual assessment of each patient on the ward. The occupational therapist was happy to support ward staff in this process.

The head chef worked closely with the dietician to ensure that not only were specific dietary needs met, but also that patient's likes and dislikes were fully catered for. There were themed nights introducing patients to foods from different countries and religious celebrations. On patient's birthdays, the catering staff would make personalised birthday cakes chosen by the patient and/or their carer.

Notice boards displayed information about mental health problems, detention in hospital and advocacy however, this was not in a format that would be easy to follow or understand by all patients.

Staff were confident they could access interpreters if required. Links to local chaplains and churches were available to individual patients. Staff told us they would support individuals to meet their spiritual needs if requested to do so.

Listening to and learning from concerns and complaints

Between December 2014 and November 2015 the hospital had received two complaints. One complaint was upheld. The response to the upheld complaint showed evidence of an apology and a series of actions to prevent the issue happening again. Whilst the actions were a comprehensive response, the hospital had not undertaken all of them.

The hospital reported that Barchester Healthcare Limited had an on-line complaints handling system, with standardised stages, letters and follow-up requests for managers investigating the complaint. The Director of Care Quality at a provider level oversaw the complaints system. We did not see this system in use.

There was written information on notice boards about how to complain, however this may not have been accessible to all. Patients and carers told us they would complain to staff if they had a concern. Staff were approachable and they felt their concerns would be heard and responded to. On Coniston, some patients used ward suggestion sheets or their community meeting as a way of complaining more formally.

Staff were very clear about how they would raise a safeguarding concern internally and externally. We saw posters about how to whistle blow in ward offices. Staff said they were confident they would do so if the need arose however, when concerned about low staff numbers in the autumn they had not done so.

Staff were not sure how feedback worked following a complaint. They described that sometimes lessons learned were shared at meetings or in supervision groups however, there did not seem to be a formal process nor a consistent approach to this.

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

Requires improvement

Vision and values

Barchester Healthcare Limited had both a mission statement and a set of vision and values at the time of inspection which was developed at provider level. We found that knowledge of these at Windermere House was limited. Staff were unable to describe the vision and values. We found no evidence of any attempt by the senior managers to frame the work of the hospital around the mission statement or the vision and values. A range of staff discussed uncertainty about the vision for this hospital in the future. There was acknowledgement that changes were

happening but anxiety about the direction they would take. Staff did not feel involved in the changes or that there was good communication with them about the future of the hospital.

Good governance

We found limited evidence of an effective governance framework to support the delivery of good quality care. The hospital was unable to provide a local risk register and it was unclear how risk was effective monitored. Clinical governance meetings did have risk management as a recurring item on the agenda. We reviewed meeting minutes and found that where risk was identified there were examples of no action, or no named individual responsible for action, to mitigate the risk. It was not always possible to ascertain from the following month's minutes if any action had been taken.

We were told by ward managers that there was recognition that the clinical governance meeting had expanded beyond its original terms of reference and become more of a senior management meeting. This was to be addressed.

The hospital had an annual schedule of audits however, we found on inspection that all 17 audits had been undertaken over a four day period in November 2015. Of the 17 audits, 15 had attached action plans that were either left blank, with no actions listed, with no named individual responsible or no dates for completion. No action plan contained actions for every issue identified in the audit. This meant highlighted issues identified were not being actioned, potentially leaving staff and patients at risk.

There were 280 reported incidents in the six months prior to inspection. Staff members described completing an incident form a copy of which was sent to admin to be recorded on a central system. However, we saw no centralised documentation recording the use of Non-Abusive Psychological and Psychical Interventions (NAPPI) restraints, although this was recorded in individual patient's notes. Ward managers were open in describing the issues regarding data collation; however, there were no actions plans in place to improve these issues.

Patients detained under the Mental Health Act (MHA) were given information about their rights on a regular basis. Paperwork was scrutinised by a members of administrative and ward staff. MHA training was mandatory for qualified nurses annually compliance was 16 out of 17 (94%).

However, staff had received no training on the new Code of Practice that came into force in April 2015. Barchester policies had not been updated or re-written to ensure compliance with the Code.

Patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. People who might have impaired capacity had their capacity to consent assessed on a decision-specific basis. Staff had an understanding of the five principles of the mental capacity act (MCA) and could refer to the policy.

Staff had a strong awareness of their role to safeguard the vulnerable adults in their care. The procedures followed involved the use of a local matrix system that assessed severity. None of the safeguarding concerns sent to the local authority since December 2014 were logged there. A meeting with the local adult safeguarding team was to be arranged to clarify the use of this system effectively.

The hospital had identified three levels of safeguarding training that included training in the principles of the MCA, Deprivation of Liberty Safeguards and Duty of Candour. 94 out of 102 (92%) staff had completed level one training, 84 out of 102 (82%) had completed level two training, and 40 out of 102 (39%) had completed level three training.

The personnel files were of a uniform and high standard. Staff records included documented evidence of supervision, appraisal and training. Figures re-submitted to us on 1 December 2015 showed appraisal and revalidation for all staff was 100%.

The company standard for supervision of all staff employed by Barchester was two monthly. The monitoring system in place highlighted if any staff were not meeting this target. Of the 89 staff on the system, four were off work long term; excluding these, there was an adherence of 87% to the standard set. This included eight regular bank workers on Ullswater who received supervision from the ward team. We were told other bank and agency workers received supervision externally from their main employers; however, there was no system to check this.

Training for all staff was recorded and monitored using a centralised system with a report run monthly identifying any mandatory training requiring update. On 1 December 2015, overall mandatory training compliance was 87%. Managers had supported all grades of staff to learn and develop.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Although the hospital was meeting its own safe staffing levels this relied heavily on overtime and the use of bank and agency staff. We saw how overtime was monitored by both the administration team and the deputy manager and we were told that the administration team would escalate any instance of a staff member working more than seven consecutive days. Staff reported that overtime was flexible although staff occasionally felt that they had to agree to overtime or leave the ward short staffed.

We were told that the hospital was struggling to recruit to fill vacancies and the minutes of clinical governance meetings provided evidence that the hospital had recognised that it was relying on staff goodwill to function. However, it was not clear if there was any long-term plan for maintaining staffing levels apart from a continued reliance on bank and agency staff.

The hospital operated with several local service level agreements (SLAs) with the local NHS Trust and other third parties to provide consultant cover, occupational therapy, psychology and pharmacy support. We were told by managers that the SLAs were due for review in the near future and may be changed. We found positive links and good working relationships with the local general practitioners where most patients were registered.

The hospital had been without a registered manager since September 2015. Although there were cover arrangements in place we found there was a lack of accountability for the hospital performance at a hospital director level. With no internal monitoring of key performance indicators (KPIs) we were unable to find evidence of how ward managers could have oversight of the hospital's performance.

We found evidence that service performance measures were reported but limited evidence they were monitored. Staff were clear that whilst audit results were compulsorily collated at provider level, they had never received feedback on their results or any actions to improve performance.

Leadership, morale and staff engagement

Staff reported that ward managers were approachable and that senior management visibility had improved with the cover arrangements since September 2015. However, we found examples of poor communication between the senior management and the staff throughout the hospital. The hospital had recently employed an interim hospital director who had left the service the week prior to the inspection and after only two weeks in post. Several staff members were unaware that the new director had left the service and still identified him as driving change in the hospital. This was an example of the poor communication between management and their staff team.

We found that staff morale was positive on wards although there was a general uncertainty on the future direction of the service. Some staff reported feeling better since the hospital had started to undergo a period of change whereas others expressed concerns that a new model was being introduced "top-down", with change happening to rather than with the staff.

The sickness figures for the past year for permanent staff were 3%. The hospital had introduced its own procedure for dealing with staff sickness. The sickness procedure was based on four welfare interviews with each interview involving progressively more senior management staff. Although we were told that the sickness procedure was a well-established practice we found no documentation that described it in staff handbooks or in the provider's sickness policy. It was unclear how staff members could be aware of the procedure in cases of long-term sickness.

We found no reported incidents of bullying within teams. Twelve staff told us they felt that they could raise concerns without fear of victimisation. Where disciplinary action had been undertaken the Barchester Healthcare Limited policy for disciplinary was used. We found that the policy was not prescriptive and left the decision making to the hospital directors. There was no guidance in the policy about the frequency of meetings and no direct guidance to decide individual outcomes.

We reviewed two incidents of disciplinary. In the most recent case the hospital had fully documented the disciplinary process with minutes and copies of all communications sent. The reasons for dismissal were documented and based on employment law obligations.

Commitment to quality improvement and innovation

The hospital reported that they have not participated in any national service accreditation schemes or peer-review schemes. We found no evidence of participation in national research/clinical audits.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure the development of a care pathway that incorporates discharge planning.
- The provider must encase the spindles on the stairs identified as a 'high' ligature risk in October 2015.
- The provider must ensure there is an effective system in place to capture risks.
- The provider must ensure regular documented checks of medicines management are embedded into routine practice on all wards.
- The provider must ensure personal alarms are available to staff and the protocol in place is followed.
- The provider must update both their policy and training to ensure compliance with the Mental Health Act Code of Practice that came into force in April 2015 and update both their policies Managed Disturbed Behaviour and Therapeutic Management of Violence and Aggression to ensure compliance with the Code.

Action the provider SHOULD take to improve

- The provider should increase visits and audits by a pharmacist to look at medication issues.
- The provider should ensure the any expired medication is in appropriate pharmaceutical waste bins, and disposed of according to current legislation.
- The provider should install controlled drugs cabinets on all wards and ensure that these medicines are managed in line with current legislation.
- The provider should ensure that care plans are reviewed in an appropriate and effective way.
- The provider should ensure that the CPR figures for mandatory training improve sufficiently to support staff to carry out their role safely and effectively.
- The provider should ensure the environment is suitable and safe for long-term recovery and rehabilitation.
- The provider should ensure there is a system in place to record and monitor any incidents in the use of Non-Abusive Psychological and Physical Interventions.
- The provider should ensure the multi-disciplinary team work together effectively and where possible include carers in meetings.
- The provider should ensure that regular audits contain actions and timescales for issues identified.
- The provider should improve communication between the management and the staff.

The provider should recruit more permanent staff, reducing the reliance on staff overtime.

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 9 HSCA (RA) Regulations 2014 Person-centred care **There was a lack of discharge planning and reluctance for individuals to move on.** **This was a breach of regulation 9 (3e)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The spindles used on the stairs were identified as a high ligature risk by the providers own assessment in October 2015, at the time of the inspection work to encase the spindles had not been carried out.** **This was a breach of regulation 12 (2a)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The hospital had no risk register in place, to list, monitor and rate any identified risks across the hospital.** **This was a breach of regulation 12 (2b)**

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regular documented checks of medicines management were not embedded into routine practice on all wards. This was a breach of regulation 12 (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Personal alarms for staff were available on one ward, there was a protocol in place that was not followed by all staff, nor was this monitored. This was a breach of regulation 15 (1,d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Neither policies nor training had been updated or re-written to ensure compliance with the Mental Health Act Code of Practice that came into force in April 2015. The Department of Health deadline for providers to complete this work was October 2015. This was a breach of regulation 17 (1)