Park Lodge Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	Inadequate
Are services safe?	Requires improvement
Are services effective?	Inadequate
Are services caring?	Inadequate
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.

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

Summary of findings

Overall summary

We rated Park Lodge Independent Hospital as Inadequate because:

- staff did not ensure that the ward environments were safe and clean. Some emergency equipment had passed its expiry date. A number of fridge and freezer temperatures were outside the recommended range and staff had not acted on this. Staff had not completed clinic room audits in line with hospital policy or acted on the outcomes of infection control audits. Some areas of the hospital were dirty
- staff did not assess or monitor the physical health of patients well. There was no evidence in the care records that staff had undertaken a physical health examination when patients were admitted. Staff had not developed care plans to monitor side effects for patients prescribed clozapine nor did they know whether patients prescribed antipsychotic medication above the British National Formulary guidance limit had monitoring plans. Staff did not provide therapeutic activities to promote recovery and rehabilitation
- the service stored patient records in paper and electronic format and records were not complete and contemporaneous. Staff did not routinely seek and share information related to patient care with commissioners
- staff did not understand the Mental Capacity Act. Staff did not consider patients' capacity to make decisions about their care in planning and delivering care
- some staff had minimal meaningful interactions with patients and were dismissive of patients. Some staff did not respond to patients' requests in a timely manner. Patients told us that some staff were not good listeners. Relatives told us that some staff were insensitive and abrupt. Some staff coerced patients to carry out tasks
- eight out of nine patients did not have discharge plans in place
- monitoring systems did not identify when audits had not been completed correctly and were not effective in ensuring outcomes of audits were acted upon. The service's risk register was an assessment of potential risks and did not include actual risks.

However:

- there was an up-to-date risk assessment of ligature points (places where someone intent on self-harm could tie something to strangle themselves). Staff conducted risk assessments of patients that were detailed and thorough. Staff knew how to report incidents of harm or risk of harm and learning from incidents was shared
- there was an action plan in place to ensure all staff received an appraisal. New starters and agency staff went through an induction process and staff received regular managerial and clinical supervision
- patients were involved in the care they received and told us their needs were being met. Regular community meetings took place where patients were encouraged to give feedback
- food was of a good quality and patients could have hot drinks and snacks at any time. Patients could make telephone calls in private. Bedrooms were personalised with patients' belongings
- action plans were in place to implement a governance structure as part of the transition process. Staff felt supported and were offered opportunities for professional development. Staff told us improvements had been made since the transition to Partnerships in Care.

Summary of findings

Contents

Summary of this inspection

Page

Background to Park Lodge Independent Hospital 5

Our inspection team 5

Why we carried out this inspection 5

How we carried out this inspection 5

What people who use the service say 6

The five questions we ask about services and what we found 7

Detailed findings from this inspection

Mental Health Act responsibilities 10

Mental Capacity Act and Deprivation of Liberty Safeguards 10

Outstanding practice 23

Areas for improvement 23

Action we have told the provider to take 24

Inadequate

Park Lodge

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Park Lodge Independent Hospital

- Park Lodge Independent Hospital is a 10-bed hospital offering care and treatment to adults over 18 who have a primary diagnosis of mental illness. Patients may be detained under the Mental Health Act 1983. The main focus of the service is providing rehabilitation and recovery. The hospital is in a large Victorian house close to Romiley village in Stockport.
- The regulated activities at Park Lodge Independent Hospital include assessment or medical treatment for persons detained under the Mental Health Act 1983, diagnostic and screening procedures, and treatment of disease, disorder or injury.
- The hospital manager was the registered manager and the controlled drugs accountable officer.

At the time of our inspection, the hospital had recently changed provider from Care UK to Partnerships in Care. As a result, the hospital was undertaking a transition to Partnerships in Care organisational processes and procedures.

Our inspection team

Team leader: Zena Rostron, CQC inspector

The team comprised of two CQC inspectors and a nurse with experience of providing care in rehabilitation services.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service and the information provided by the organisation as requested as part of the inspection process.

During the inspection visit, the inspection team:

- visited Park Lodge and looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with four relatives of patients who were using the service
- observed the staff interaction and care provided to patients
- spoke with 11 staff members; including managers, a doctor, an occupational therapist, nurses, support workers, a maintenance worker and administrative staff
- received feedback about the service from two commissioners and one safeguarding lead
- attended and observed two handover meetings and one multi-disciplinary team meeting

Summary of this inspection

- reviewed five care records of patients
- reviewed all patient prescription charts
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke to three patients individually. They said they had been given information about their care. Patients said there were a wide range of activities to engage in and they felt safe. Patients said they knew how to complain.

However, patients said some staff were always busy and they did not always respond to patient needs in a timely manner. Patients said some staff were not good listeners. They said the bathrooms were not always clean.

We spoke to four relatives of patients. Two relatives said they were happy with the service provided. One relative said staff were available when needed. One relative said the hospital was safe and felt homely.

However, two relatives said they did not feel involved in their loved one's care. They said some staff were insensitive and abrupt. One relative said there could be more variety of activities to suit their family member's interests.

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:

- staff did not complete clinic room audits in line with hospital policy
- emergency equipment was out of date
- some areas of the hospital were dirty
- a number of fridge and freezer temperatures were outside the recommended range and staff did not act on this
- staff did not act on outcomes of infection control audits.

However:

- there was an up-to-date risk assessment of ligature points (places where someone intent on self-harm could tie something to strangle themselves)
- the hospital did not comply with same-sex accommodation guidelines, however commenced work to segregate male and female bedroom areas and provided a female-only lounge during the period of our inspection
- staff conducted risk assessments that were detailed and thorough
- staff knew how to report incidents of harm or risk of harm and learning from incidents was shared.

Are services effective?

Inadequate

We rated effective as inadequate because:

- there was no evidence in the care records of physical health examination on admission
- care plans were not in place to monitor side effects for patients prescribed Clozapine
- staff did not know if monitoring plans were in place for patients prescribed antipsychotic medication above the BNF limit
- staff did not provide therapeutic activities to promote recovery and rehabilitation
- patient records were stored in paper and electronic format. Records were not complete and contemporaneous
- staff were not routinely seeking and sharing information with commissioners that related to patient care
- staff did not understand the Mental Capacity Act
- staff did not consider capacity issues in planning and delivering care.

However:

Summary of this inspection

- new starters and agency staff went through an induction process and staff received regular managerial and clinical supervision.
- there was an action plan in place to ensure all staff received an appraisal.
- staff read patients' rights under the Mental Health Act to them regularly. These are the rights of patients detained for treatment under the Act.

Are services caring?

Inadequate

We rated caring as inadequate because:

- on some occasions there were minimal meaningful interactions taking place between staff and patients
- some staff were dismissive of patients
- some staff did not respond to patients' requests in a timely manner
- patients told us that some staff were not good listeners
- relatives told us that some staff were insensitive and abrupt
- some staff coerced patients to carry out certain tasks.

However:

- patients told us their needs were being met
- patients were involved in the care they received
- regular community meetings took place where patients were encouraged to give feedback.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- eight out of nine patients did not have discharge plans in place

However:

- food was of a good quality and patients could have hot drinks and snacks at any time
- patients could make telephone calls in private
- bedrooms were personalised with patients' belongings.

Are services well-led?

Requires improvement

We rated well-led as requires improvement because:

- the risk register was an assessment of potential risks and did not include actual risks within the service
- monitoring systems in place did not identify when audits had not been completed correctly
- monitoring systems in place were not effective in ensuring outcomes of audits were acted upon.

Summary of this inspection

However:

- action plans were in place to implement a governance structure as part of the transition process
- staff knew how to use the whistleblowing process
- staff felt supported and were offered opportunities for professional development
- staff told us improvements had been made since the transition to Partnerships in Care.

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.

A Mental Health Act reviewer visit took place in January 2015, this was under the previous provider. A visit to review Mental Health Act documentation is yet to be carried out under the new provider.

During our inspection, all nine patients were detained under the Mental Health Act. Staff had an understanding of the Act and their role in relation to it. However, staff were unable to describe changes to the Code of Practice. Copies of forms showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts. Three out of eight authorisation forms did not include an assessment of the patient's capacity to make decisions about their treatment. Staff read patients' rights under section 132 of the Mental Health Act monthly. Independent Mental Health Advocacy services were provided by a local organisation, with information on how to access displayed on the noticeboard.

Mental Capacity Act and Deprivation of Liberty Safeguards

Overall we found some concerns with the requirements of the Mental Capacity Act (MCA and DoLS. Staff were not able to recall the statutory principles of the MCA. The hospital had a policy for MCA and DoLS, however staff appeared unsure that this policy was in place. Staff were unable to describe how they considered patients' capacity to make decisions in planning and delivering care.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Safe	Requires improvement
Effective	Inadequate
Caring	Inadequate
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

The hospital layout did not allow for clear lines of sight to be maintained at all times. Staff managed this using the hospital observation policy. Each patient was on a level of observation that meant staff were required to know patient's whereabouts at certain intervals. Staff told us the level of observation was increased dependant on the level of risk to the patient or to others. During the night shift a member of staff would locate themselves on each floor to ensure staff presence close to bedroom areas.

Staff checked the hospital for ligature points, which are places where patients intent on harming themselves, could tie something to hang or strangle themselves. The hospital had a ligature risk assessment in place and an action plan to mitigate the risks. Staff completed this audit monthly. Staff managed the identified risks associated with the building by undertaking observations on each of the floors. Staff knew where the ligature cutters were located.

The hospital did not comply with same-sex accommodation guidelines. Bedrooms were located on both the ground and first floor. The bedrooms did not have en-suite facilities and access to male and female bathrooms was available on both floors. The layout of the hospital meant female patients had to pass male patients' bedrooms to access the bathroom. There was no access to a female-only day room. The Mental Health Act Code of Practice states, "All sleeping and bathroom areas should be segregated, and patients should not have to walk through an area occupied by another sex to reach toilets or bathrooms. Separate male and female toilets and bathrooms should be provided, as should women-only day rooms." During the inspection visit the provider committed to completing work in line with the same-sex accommodation guidelines. At an unannounced visit to the hospital work had commenced to segregate the male and female bedroom areas and the provider had converted a bedroom into a female only lounge.

Resuscitation equipment was easily accessible in the clinic room. However, the emergency medication bag and equipment was out of date. We found airways and masks with expiry dates of 2014 in the bag. A new bag had been received from Partnerships in Care however, this was not in operation due to it holding emergency medication without a policy to support administration. During our inspection the regional manager advised staff to use the new bag with immediate effect.

Staff were not trained in immediate life support (ILS). Resuscitation Council (UK) quality standards for mental health inpatient care state "Immediate Life Support is recommended as a minimum standard for staff who deliver or are involved in rapid tranquilisation, physical restraint and seclusion. This guidance recommends that clinical staff in each mental health inpatient facility should receive regular update training in physical health skills in addition to ILS in response to an assessment of need undertaken by each organisation."

Staff did not complete the clinic room checklist daily in line with hospital policy and the checking of expiry dates was not detailed on the checklist. The sharps box was not labelled with a date, however this had been included

regularly in the checklist as having a date label. There was a list of emergency drugs detailed on the checklist that were not present in the clinic room. Staff told us the checklist was not suitable for the rehabilitation environment and the checklist required review.

There was no seclusion facility at the hospital as the hospital was a rehabilitation unit supporting patients for discharge into the community.

During our inspection we observed staff cleaning all areas of the hospital and saw a comprehensive cleaning schedule that was signed each day. However, we observed a number of areas that were not clean. On both days of our inspection the male bath had debris in the bottom of the bath and appeared not to have been cleaned. Patients told us sometimes the bathrooms were dirty. The stairs had a number of drink stains on the steps. In the dining room, used cutlery had been left on the table and the table was sticky to the touch. The inspection team commented that their feet were sticking to the floor in the dining room. Furnishings were generally in good condition, however one of the sofas in the lounge was worn.

Records showed that staff checked fridge and freezer temperatures daily. However, a number of records indicated that the temperature of fridges and freezers were outside the recommended range documented on the checklist. Staff told us they would not routinely act on this as at the next check the temperature may have returned to the recommended range. Staff were unsure of the procedure for escalating concerns relating to fridge and freezer temperatures.

The building was tired and in need of refurbishment, there were plans in place for a refurbishment and an extension. The hospital had a maintenance worker who was responsible for the upkeep of the building and dealing with maintenance issues. We found evidence of work being carried out when required to ensure the hospital was well-maintained.

There were handwashing technique posters displayed near sinks. Records confirmed a hand hygiene audit had been completed dated August 2015. This audit was a five page document listing outcomes to be achieved. The document was a Care UK document and provided percentages for compliance. Full compliance was 85% or above, partial compliance was 76% to 84% and minimal compliance was 75% or below. The hand hygiene audit scored 63% overall.

An infection control environment audit had also been completed, dated July 2015, with a score of 74%. A sharps handling and disposal audit had been completed, dated September 2015, with a score of 71%. A waste management audit had been completed, dated July 2015, with a score of 63%. All audits scored in the minimal compliance range, however there was no evidence of any action plans to support driving quality and improvements.

Hand sanitiser was available around the hospital. The hospital infection prevention and control policy stated that staff should roll up long sleeves for handwashing and clinical intervention. We did not observe staff rolling up their sleeves during our inspection.

The hospital maintenance worker was new in post and at the time of our inspection was in the process of testing all equipment. This was documented in the environmental risk assessment and an action plan was in place to complete the remaining equipment tests.

Staff completed an environmental risk assessment every month. A number of items had an up to date inspection certificate, including kitchen gas appliance, fire extinguishers, gas safety and alarms. There was a fire risk assessment, a fire systems service report certificate and a planned preventative maintenance certificate which were all in date. We found an emergency evacuation plan, dated November 2013. We were advised some documents required updating to Partnerships in Care policies.

There was a nurse call system and staff had access to radios. There was an emergency button and an assistance button on the nurse call pad and there was a pad located in each room. Staff told us the alarm would be used when required however this did not happen frequently. Staff told us the radios were mainly used at night when staff were located on different floors to enable communication as there was only two staff on duty.

Safe staffing

- Total establishment levels qualified nurses 6
- Total establishment levels support workers 6.5
- Number of vacancies qualified nurses 0.5
- Number of vacancies support workers 0.5
- Number of shifts filled by bank or agency staff to cover sickness, absence or vacancies 168
- There were no shifts that had not been filled by bank or agency staff where there is sickness, absence or vacancies

Long stay/rehabilitation mental health wards for working age adults

Inadequate

- Data provided as of September 2015 showed the number of substantive staff as 20
- Number of substantive staff leavers in the last 12 months 12
- Total turnover of all substantive staff leavers in the last 12 months 60 percent
- Total permanent staff sickness overall 4 percent

Staff leavers in the last 12 months was high. The hospital manager had recruited new staff into vacant posts, with two part-time vacancies remaining overall.

Staffing levels per shift was either two qualified nurses and two support workers or one qualified nurse and three support workers, dependent on need, during the day. At night there was one qualified nurse and one support worker for the full shift and one support worker for a twilight shift 8pm to midnight. Rotas reviewed from September 2015 to October 2015 confirmed that these staffing levels were maintained.

We found evidence that agency and bank nurses were familiar with the ward and patients. Some staff were given contracted hours from the agency to ensure continuity of care for patients.

The ward manager was able to make adjustments to staffing levels to ensure safe staffing in the event of staff sickness, increased levels of observations and annual leave. Staff told us managing the night shift could be difficult as after midnight there was one staff member located on the ground floor and one staff member located on the first floor.

We observed a member of qualified staff in communal areas during our inspection. Relatives told us staff were available when needed.

Staff told us patients were having regular named nurse sessions, however this was not formally documented. Named nurse sessions were not planned in advance. Records for one patient showed the last documented named nurse session as October 2014. Patients told us they did not have regular one to one time with their named nurse.

Patients told us that leave was facilitated by staff and regular activities took place. Staff told us occasionally leave would be cancelled, however this was due to patients becoming unwell rather than being short staffed. We saw no evidence that leave was cancelled on a regular basis.

The consultant psychiatrist visited the ward once a week to review patients. On call cover was provided throughout the day and night. Staff told us the response time was around 30 minutes, however in an emergency the emergency services would be used.

Mandatory training was highlighted as a priority for the hospital, to be completed by 30 November 2015; there was an action plan in place to support compliance by the target date. Mandatory training included safeguarding adults, basic life support, food hygiene, fire safety, health and safety, infection control and ideas, suggestions and complaints. The hospital manager told us training was being reviewed weekly to meet compliance in a timely manner. Mandatory training records showed three out of 20 staff had completed basic life support training which included the hospital manager, hospital administrator and occupational therapist. There was a plan in place to ensure all staff received training in basic life support. All staff had not received food hygiene training. Staff were responsible for supporting patients preparing and cooking meals.

Assessing and managing risk to patients and staff

All staff told us that restraint was not used at the hospital. Initial data provided by the hospital showed zero incidents of restraint in the last 12 months. Staff were unclear about the definition of restraint. A review of incident forms showed evidence that restraint had been used in the form of 'low level holds'. Staff were not aware that this was classed as restraint. Staff could not locate the managing violence and aggression policy at the time of our inspection. This policy was provided following our inspection and was dated December 2014. This pre-dated the acquisition of Park Lodge. A review of the policy defined restraint as 'passive restraint using friendly come alongs level 1 and level 2. Level 1 and level 2 holds may be described as two people simply holding a patient's arms to walk them from A to B'. We highlighted this with the hospital manager during our inspection. From the feedback provided the hospital manager arranged for the restraint lead to attend the hospital to discuss this further.

We reviewed five care records. All patients had an up to date risk assessment in place. Risk assessments were completed using The Salford Tool for Assessment of Risk which was detailed and thorough. Risk assessments were reviewed every three months unless there was a need to

Long stay/rehabilitation mental health wards for working age adults

Inadequate

review sooner. There was also a risk assessment completed by the occupational therapist using the Model of Human Occupational Screening Tool, however not all patients had this completed.

Staff told us there were no blanket restrictions in place at the hospital and staff did not search patients. Staff would ask patients if they had any items that may pose a risk at the hospital, such as lighters. There had been a problem with patients smoking in their bedrooms. Staff told us if patients' bags and pockets required searching this would be discussed and agreed by the multi-disciplinary team and documented in the patients' care plan.

Staff had received safeguarding training from the local authority and staff knew how to raise a safeguarding alert. We found evidence of safeguarding alerts being raised.

Medicines were ordered through the GP. We found a system in place to ensure medication was ordered regularly. Hospital prescriptions were completed by the consultant psychiatrist and supplied by the local pharmacy. An external pharmacist visited the hospital every three weeks to review medication administration records. Examples of issues highlighted by the pharmacist included refusal of depot medication however remained documented on T3 form (a certificate of second opinion) and queries about why particular medications were given. We found no evidence that staff took action from issues raised from the visits. The information was not fed back to staff through supervision or team meetings.

Medicines were stored securely in locked cabinets in the clinic room. Staff reported a problem with medicines stock not being rotated as all medicines were stored in individual patient boxes. Staff highlighted the potential for medication errors to occur and told us this had been escalated to the hospital manager.

There was no procedure in place for children visiting the hospital. The hospital environment lacked the facilities to ensure safe child visiting. Staff told us children would not be allowed to visit the hospital, however support would be provided in the community.

Track record on safety

There were five serious incidents recorded between December 2014 and September 2015. During our inspection we reviewed the records and found the incidents to be related to safeguarding. On reviewing the safeguarding information we saw evidence that appropriate policies and procedures had been followed when managing the concerns raised.

The managing incidents and untoward occurrences policy dated August 2014 identified what a serious incident was, how to report it and a procedure in place for learning lessons from incidents.

Learning from other services within the Partnerships in Care group was provided to staff. Regular meetings took place with the regional manager and hospital managers to share lessons learned from serious incidents.

Reporting incidents and learning from when things go wrong

All staff knew how to report an incident. Records showed that incidents were regularly reported and reviewed by the hospital manager. There was a separate file to store incident forms. The forms completed were handwritten as the hospital had not moved over to the Partnerships in Care electronic system. We found that incidents were not routinely documented in patients care records or on the handover sheet.

Staff received feedback from the investigation of incidents via the morning meeting and team meetings. Staff told us changes had been made following feedback of incidents, however could not provide any evidence of these changes. Staff told us that debriefs occur following incidents but there were no minutes to evidence the recording of the meeting and context.

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

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We reviewed five care records. There was no evidence in the clinical records of physical examinations on admission. Physical examinations, blood tests and electrocardiograms (ECGs) were undertaken by the General Practitioner (GP) or practice nurse but there was no record of them kept in the

patient notes at the hospital. These notes were stored in the GP surgery records. Each patient had a Rethink My Physical Health Assessment, this was a tool being used to undertake annual physical health checks.

One patient was prescribed antipsychotic medication above the British National Formulary (BNF) maximum guidance limit. There was no high dose antipsychotic monitoring plans in place. Staff were unaware whether the GP had a monitoring plan in place.

All five of the care records reviewed, five were holistic and person centred. Four of the care plans were recovery focused. One care plan did not include patient strengths and goals, however goals were included in a separate document.

Care records were in a mixed format of paper and electronic versions. Care plans and daily records were documented on an electronic system. All other records relating to patient care were stored in paper format. A ring binder file was used for each patient and included risk assessments, annual physical health checks, consultant psychiatrist reports, side effects monitoring and other information relating to patient care. There was a patient self-assessment completed for some patients, which included patient likes, dislikes and goals for the future. Copies of care plans and daily records were not included in the file. Records were kept in the nursing office in a secure filing cabinet to which all clinical staff had access. Agency staff did not have access to the electronic system, which meant they could not access patient care plans. There were copies of Mental Health Act (MHA) paperwork in each file, originals were kept in a separate file located in the clinic room. Staff told us they were in the process of inputting information recorded in paper format onto the electronic system. We found two files containing information about a number of patients in a separate filing cabinet, this information was not included in the paper records or on the electronic system. This meant that patients were put at risk due to information not being available to all staff at all times.

Best practice in treatment and care

National Institute for Health and Clinical Excellence (NICE) guidance CG178 "psychosis and schizophrenia in adults: treatment and management" states that when patients are prescribed clozapine, staff should "monitor and record the following regularly and systematically throughout treatment, but especially during titration: …side effects of treatment, taking into account overlap between certain side effects and clinical features of schizophrenia (for example, the overlap between akathisia and agitation or anxiety) and impact on functioning." There was no information detailed in care plans regarding side effect monitoring or issues relating to clozapine other than blood monitoring. Care plans stated that the patient would inform staff of any side effects they were experiencing. However, the Liverpool University neuroleptic side effect rating scale was completed monthly.

The hospital had access to two psychologists who provided patient assessments and staff support sessions. There was no evidence in patient records of psychological therapies being provided. Staff told us psychologists were currently providing autism assessments and intelligence quotient (IQ) testing to some patients.

Patients' physical healthcare was managed by the local GP. Out of area patients were temporarily registered at the local GP surgery to ensure access to assessment and treatment. One patient was supported to manage diabetes and we found evidence of ongoing physical healthcare, including regular podiatry appointments. Two patients with a secondary diagnosis of learning disability had health passports in place.

A nutritional profile and malnutrition universal screening tool had been completed for each patient. There was evidence in care plans of patients who required support in making healthy food choices.

Staff told us the hospital used the Recovery Star Tool to monitor patient outcomes. We saw evidence of these outcomes in patients' care records. However, staff were unclear about outcome monitoring. This made it difficult to assess whether staff took necessary actions to improve patient's outcomes.

Clinical staff were not currently participating in clinical audit, however there was a Partnerships in Care programme for a 12 month audit plan.

Skilled staff to deliver care

There was a sufficient range of staff delivering care at the hospital. However, there was a lack of therapeutic activities to promote patient independence, recovery and rehabilitation. Records showed that most care plans were

tailored to meet the rehabilitation needs of patients. However, there was no evidence that staff were delivering the interventions required to promote rehabilitation and recovery.

There was an occupational therapist and an occupational therapist assistant who provided group activities including arts and crafts. The occupational therapist carried out group activity risk assessments for all patients.

The consultant psychiatrist visited the hospital one day a week to review patients.

There was access to two psychologists, however there was no evidence therapy was being provided to patients following assessment.

Pharmacy support was provided by a local chemist. An external pharmacist visited the ward to undertake regular reviews of medication administration records.

We reviewed four new starter induction records. There was an induction and mentorship workbook that all new starters completed. Review dates were scheduled for day one, week one, week four, week eight and week 12. Areas covered as part of the induction process included key capabilities, ethical practices, knowledge, the process of care, interventions and specific skills to local site.

There was an agency induction checklist in place which was clear and comprehensive. The checklist was signed by the agency nurse and the member of staff carrying out the induction.

We found a supervision tree in place to show staff responsibilities for supervision. This was displayed in the manager's office. Partnerships in Care had a supervision database that was to be implemented and reviewed monthly. Staff told us they receive supervision on a monthly basis and can also ask for supervision in between. Regular team meetings took place where patient and organisation issues were discussed.

Initial data provided showed 18 out of 20 staff had not received an appraisal in the last 12 months, an action plan was in place to address this as a priority. This had reduced at the time of our inspection to 15 out of 20. We found a timetable scheduling all appraisals for staff commencing September 2015 to December 2015. Three members of staff were not allocated a date for appraisal, however one member of staff was on maternity leave and two members of staff were due to commence in post in November 2015.

Appraisal documentation included a section where employees could provide information on any further support required including training, skills development and achievements. Staff told us they were supported to undertake further training relevant to their role.

Records showed that poor staff performance was addressed promptly and effectively. Performance meetings had taken place and notes of the meetings were signed by the manager, the staff member and a witness.

Multidisciplinary and inter-agency team work

Multidisciplinary team meetings were held weekly when the psychiatrist visited to review patients. We observed a multidisciplinary team meeting during our visit. The meeting was held in the dining room where patients accessed hot drinks. This meant that the meeting was paused when patients wanted to use the facilities. Staff told us they used a flexible approach to the meetings due to the lack of space. Staff spoke about respecting the fact that the hospital was where the patients lived. The patient, psychiatrist and two nurses attended the meeting. Staff told us relatives were invited to meetings in advance however, there were no family members present. The meeting included a conversation with the patient about progress in the past week. Medication and activities were also discussed. Staff asked for patient views in relation to the care they were receiving.

Handovers took place at 8am for the day shift with the nurse in charge and support workers on shift. There was also a planning meeting that took place at 9am for staff starting work at that time and to plan the activities for the day. We observed a handover at 8am, information provided to staff included patient symptoms, symptom management, medication, risk, engagement. Staff spoke positively about patient progress. We saw evidence of historical handover sheets however, staff did not use a handover sheet at the meeting we observed. Staff told us the handover sheet was being reviewed. We also observed a planning meeting at 9am. At this meeting risks and mental health symptoms and management were not discussed. This meant that staff starting work at 9am did not receive a full update regarding any changes to patient care including risk. Staff told us they would seek out information relating to patient care and risk when this was not handed over by staff.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Initial feedback showed there was a lack of meaningful engagement between staff at the hospital and people involved in planning patient care. Staff were not routinely sharing information relating to patient care with commissioners. This made it difficult for commissioners to adequately monitor the placement. We were provided with a care and treatment review for one patient prior to our inspection. Staff had not made attempts to contact the appropriate teams to ensure they were provided with a copy of the review. This meant that staff could not act on findings and recommendations relating to patient care.

Adherence to the MHA and the MHA Code of Practice

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

All nine patients were detained under the Mental Health Act.

Information provided by the hospital showed 12 out of 20 staff had received training in the Act.

Staff had an understanding of the Act and their role in relation to it. Staff were unable to describe changes to the Code of Practice.

Copies of forms showing that patients had consented to their treatment (T2) or that it had been properly authorised (T3) were completed and attached to medicine charts. Three out of eight authorisation forms did not include an assessment of the patient's capacity to make decisions about their treatment.

We saw evidence in care records that patients' rights under section 132 of the Mental Health Act were read to them monthly. A timetable of rights due to be read was displayed in the nursing office and signed when completed.

A mental health act administrator provided administrative support and advice on the implementation of the Act. Support was also available from the regional mental health act manager.

Staff stored documents for patients relating to the Act in a file kept in the clinic room. Copies of detention papers were filed in patients' care records.

The mental health act administrator completed audits, under the previous provider, to ensure that the Act was being applied correctly and learning was taking place. However, staff told us that they were unsure about audits taking place under Partnerships in Care.

Independent Mental Health Advocacy services were provided by a local organisation, with information on how to access displayed on the noticeboard.

Good practice in applying the MCA

Deprivation of Liberty Safeguards (DoLS) are rules on how someone's freedom may be restricted in their best interests to enable essential care or treatment to be provided to them. The safeguards ensure that the least restrictive option that can be identified to meet a specific need is applied.

None of the patients were subject to restrictions and no applications for restrictions had been made in the last six months.

Information provided by the hospital showed that 10 out of 20 staff had received training in the Mental Capacity Act 2005 (MCA) and DoLS. All training was completed in 2014. One member of staff said they required refresher training.

Staff said they had received training in the use of the Act and DoLS. However, on further investigation, it became clear that staff were not able to recall the statutory principles. Staff appeared unsure about whether the hospital had a policy and where to get advice about the MCA. One member of staff told us mistakenly that the MCA did not apply to Park Lodge as all patients were detained under the Mental Health Act.

Although the hospital had an MCA and DoLS policy, staff had difficulty accessing it so it was difficult to know whether they had read the policy and referred to it when needed. Staff were unable to describe how they considered patients' capacity to make decisions in planning and delivering care.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

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

Inadequate

Kindness, dignity, respect and support

On some occasions we observed limited meaningful interactions between staff and patients. During activities and time spent in the lounge there was minimal conversation taking place. We observed two members of staff being dismissive of patients on both days of our inspection. One member of staff was observed to be dismissive of one patient's requests by turning their back and shaking their head. Staff appeared busy with other tasks and did not make the time to address patient's requests in a timely manner.

Three patients spoke about their experience at Park Lodge. Patients told us staff were always busy and were not good listeners. Patients told us they did feel respected but this could be improved. Two relatives told us staff were insensitive and abrupt and they did not feel listened to.

It was unclear whether staff understood the individual needs of patients due to limited interactions taking place. One patient with higher communication needs was sat alone on a number of occasions without any attempts made by staff to communicate or interact.

We found 'house rules' displayed around the hospital. Some of the rules were worded in a negative way and included 'no shouting', 'no pestering others for money' and 'no butting in during other people's conversations'. We found staff talking about patients 'complying' with treatment. We found documented evidence of staff persuading patients to go to their room or take medication or negative situations would occur, such as no escorted leave and staff intervening. On one incident form staff had reported telling a patient that their behaviours would not be tolerated.

However, this did not apply to all staff. One member of staff spent time listening to a patient and saying goodbye at the end of their shift, showing positive engagement. Three members of staff were actively listening to a patient's views during ward round. During handover, we observed staff talking about patients in a respectful manner. Staff appeared pleased at progress made by patients. Staff assisted patients with their meals and drinks. Patients were encouraged to participate in food preparation, setting the table, cleaning and tidying at meal times. We found a rota displayed in the kitchen for patients to complete certain tasks at meal times.

The involvement of people in the care they receive

The hospital did not have a welcome pack for patients on admission. There was no defined documented policy or criteria for admission. Staff told us patients could visit the hospital prior to admission. One patient told us they were well orientated to the hospital and had received information on admission.

Staff told us patients were involved in the care they receive. Staff were working on an 'all about me file' detailing individual information about the patient. Records showed that patient's views were included in care plans. Four out of five care records showed patients had a copy of their care plan. One patient told us they had received a copy.

Advocacy was available for patients to access. Contact details of the advocacy service was displayed on the notice board. The advocacy service visited the hospital at least once a month and more frequently if required. One patient told us that they see advocacy once a month.

Staff told us relatives and carers were invited to attend meetings to discuss patient care. Invites were planned in advance to give relatives the opportunity to attend. We spoke to four patients' relatives. Two relatives told us they did not feel involved in patient care despite being involved in meetings. One relative told us they were unable to visit the hospital and were not kept informed by staff. One relative told us they were not regularly invited to meetings however, had attended one meeting six months ago.

Community meetings were held regularly, facilitated by staff. Patients were encouraged to attend to give feedback and suggestions regarding the service. There was evidence in the community meeting minutes of staff thanking patients for their involvement and patients proposing ideas for the refurbishment of the hospital. Patients suggested ideas for new activities including a trip to Alton Towers and visits to the library. We found evidence that patient suggestions had been actioned in the minutes of the meetings. There was a 'you said, we did' poster displayed

Long stay/rehabilitation mental health wards for working age adults

Inadequate

on the notice board detailing the suggestions from patients and the actions taken by the hospital. Staff told us patients would be involved in the recruitment of staff under the Partnerships in Care policy.

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

Patients were placed from four different boroughs. Three patients were from Manchester, three were from Bolton and there was one patient each from Salford and Cheshire and Wirral.

We requested information about the average length of stay for patients prior to our inspection. This information was not provided to us and staff were unable to tell us the average length of stay for patients. The care records we reviewed during our visit showed that the length of stay was over two years. One patient had been receiving treatment at the hospital for four years.

Beds were not used when patients went on leave as the hospital did not accept emergency or unplanned admissions. However, the hospital guide to the referral process stated that emergency referrals could be made and assessed within hours.

Patients remained at the hospital during their admission unless there was a clinical need to move patients to a different hospital. Patients were admitted to the emergency admissions in-patient ward at Stepping Hill Hospital when more intensive support was required.

Initial data provided by the hospital showed that there was one delayed discharge at the hospital between April 2015 and September 2015. The delay was due to Mental Health Act procedures and funding. At the time of our inspection there was a patient whose discharge was delayed. Staff told us there were problems identifying suitable onward placement for the patient to be discharged to. It was unclear whether the figures provided for delayed discharges were accurate. This was because staff were unable to tell us the average length of stay for patients and staff told us that they experienced difficulties facilitating discharge due to a lack of appropriate onward placements for patients and funding issues.

Eight out of nine patients did not have a discharge plan.

The facilities promote recovery, comfort, dignity and confidentiality

The facilities at Park Lodge included a mixed lounge area, a dining room, a laundry room, a kitchen and a clinic room. The clinic room did not have a bed to allow physical examination of patients; this was carried out in patients' bedrooms when needed. The dining room was used for a number of tasks including ward round, group activities, meal times, hospital manager's hearings and mental health act review tribunals. Patient's accessed the dining room during meetings to make hot drinks. This meant that patient confidentiality could not be maintained when meetings took place to discuss patient care.

The laundry room was also used to store the maintenance worker's tools in locked cabinets. Staff told us more space was needed and planning permission was in place to extend the building.

There was access to an enclosed courtyard at the side of the building, where there was wheelchair access into the nursing office. The courtyard had a seating area and a separate sheltered seating area.

Patients requiring quiet time would often spend time in their rooms.

Food was of a good quality and patients were supported in planning and preparing meals. Feedback was received at patient meetings and any suggestions were included in meal plans. There was access to hot drinks and snacks at any time.

Patients could make telephone calls from the public telephone located in the corridor. Patients had access to their own mobile phones and the office cordless phone which could be used to make a call in private.

Bedrooms were personalised with patient's belongings. Patients could have keys to their rooms. Personal possessions could also be stored in locked cupboards, however staff had to access them for patients.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Information displayed on the hospital notice board included advocacy, CQC, Partnerships in Care 'talk to us' telephone numbers, how to complain, activity planner and the Mental Health Act Code of Practice 1983 in easy read format.

Resources in the communal lounge for patients to use included a television, radio, computer with internet access, DVDs, CDs and books.

Meeting the needs of all people who use the service

There was wheelchair access into the nursing office from outside the building. The lift was de-commissioned, however there were bedrooms located on the ground floor.

Information leaflets were provided in English, which was appropriate to the patient group at the time of our inspection. Access to an interpreter was available if needed.

Staff supported patients with the choice of food they wanted to meet their dietary requirements and to meet their religious and ethnic needs when required. We found evidence of two patients being supported to make healthier food choices.

There was access to spiritual support within the local community. We saw evidence that patients were supported to access spiritual support.

There was a wide range of group activities available including arts and crafts, yoga, current affairs, pub visit, local library and free time. The hospital regularly scheduled days out. The last trip was a visit to Alton Towers and the next scheduled trip was to Blackpool illuminations. Patients were encouraged to make suggestions about all activities including any individual interests they had.

There was information on how to complain displayed around the hospital. Minutes from community meetings were displayed on the notice board and included actions that staff were taking. There was a suggestion box located in the dining room for patients who did not wish to attend the community meetings.

Patients were not provided with any written information at the time of admission to assist with orientation to the hospital.

Listening to and learning from concerns and complaints

Initial data showed there were two formal complaints, both made during May 2015. We reviewed the complaints and saw evidence that they were managed appropriately in line with the policies and procedures. There were no complaints referred to the ombudsman.

Information was available to patients on how to complain. The hospital had a complaints book that was blank at the start of our inspection. We found evidence in community meeting minutes that patients had complained about meal selections and noise levels at the hospital. These complaints were not documented in the complaints book. During our visit patient complaints were logged in the complaints book and were being handled appropriately.

Staff told us learning from complaints was shared. Minutes of staff meetings showed evidence of patient and staff complaints being discussed.

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

Requires improvement

Vision and values

Staff were not aware of the organisation's visions and values. We found values listed in appraisal records and policies. The values were valuing people, caring safely, working together, quality and integrity. Staff told us there was an action plan in place to embed Partnerships in Care visions and values at Park Lodge. Team objectives were to be further developed with the regional manager.

The hospital displayed information which outlined how the service intended to meet the Care Quality Commission inspection domains of safe, effective, caring, responsive and well-led.

Staff told us senior managers had been visible during the transition to Partnerships in Care and were approachable.

Good governance

At the time of our inspection the hospital was in the process of transitioning to a new provider. As a result of the transition, systems and processes were being developed and implemented at the hospital.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

Partnerships in Care had a governance structure which was being implemented at the hospital as part of the transition process. There was a good ward to board reporting model and an action plan in place to ensure regional and local meetings were being held regularly by December 2015. A monthly quality account report which was submitted to the board included red, amber and green ratings with actions taken, expected results and timescales. Examples of quality areas reported included community meetings, complaints, incidents, safeguarding and mandatory training.

We found no evidence that staff took action from issues raised from pharmacist visits. The information was not fed back to staff through supervision or team meetings.

Staff were not up to date with mandatory training, however there was an action plan in place and staff told us this was a priority for the hospital.

Not all staff had received an appraisal, however there was a timetable in place scheduling appraisals for staff. This was to be completed by December 2015.

There were two systems in place for storing care records. Care plans and daily records were documented on an electronic system. All other records relating to patient care were stored in paper format. Copies of care plans and daily records were not included in the paper file. Records were kept in the nursing office in a secure filing cabinet to which all clinical staff had access. Agency staff did not have access to the electronic system, which meant they could not access patient care plans. We found two files containing information about a number of patients in a separate filing cabinet, this information was not included in the paper records or on the electronic system.

We asked staff about a number of policies. Staff appeared unsure what policies were in place and where these were located. Staff had difficulties accessing policies during our visit.

There was support in place for the integration and transition to Partnerships in Care. An integration support co-ordinator had been appointed to support staff in the clinical setting during operational transition.

There were action plans in place for information technology and communication systems, human resources, staff training, staff supervision, staff appraisal, health and safety, carer involvement, patient care and involvement, clinical effectiveness, refurbishment and policies.

There was a quality and assurance benchmarking timetable which detailed plans for data collection for a number of areas, including patient satisfaction survey, hand washing audit, mattress audit and Patient Led Assessment of the Care Environment.

The hospital manager told us they had enough time and autonomy to manage the hospital. They also felt they could raise concerns and reported being positive about the transition to Partnerships in Care.

Staff were completing audits, however were not acting on the outcomes of the audits. Monitoring systems in place did not identify when audits had not been completed and did not ensure that outcomes of audits were acted upon. The clinic room audit had not been completed in line with hospital policy and emergency equipment was out of date. Staff did not act on fridge and freezer temperatures that were outside of the recommended range.

Initial data provided by Park Lodge detailed 16 items on the risk register. The risk register provided was not a reflection of actual risks within the service. It included an assessment of the potential risk, likelihood, impact and risk rating.

Leadership, morale and staff engagement

There were no grievances being pursued and there were no allegations of bullying or harassment.

The hospital provided information on staff sickness prior to our inspection. The sickness rate was 4% in the past 12 months as of September 2015. Records showed that sickness absence was being managed appropriately and included offering additional support to staff through signposting or occupational health.

Staff knew how to use the whistleblowing process and felt able to raise concerns.

Staff told us the team they worked in was supportive and they were supported by their line manager.

Staff were offered opportunities for clinical and professional development courses. One member of staff was being supported to undertake leadership training.

Long stay/rehabilitation mental health wards for working age adults

Inadequate

The hospital manager felt supported by the regional manager and other local hospital managers within Partnerships in Care.

Staff told us morale had improved since the transition to Partnerships in Care. Staff spoke about liking their roles and working well as a team.

Records showed that staff were offered opportunities to give feedback on services and input into service development. Minutes of staff meetings detailed staff contributions to refurbishment and addressing patient concerns.

Commitment to quality improvement and innovation

The hospital was not participating in any national quality improvement programmes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- the provider must ensure that there is evidence of a physical health examination completed on admission in the care records
- the provider must ensure that all staff receive the necessary mandatory training and appraisals
- the provider must ensure that the hospital is clean
- the provider must ensure that emergency equipment is in date and safe to use
- the provider must ensure that staff use care plans to monitor side effects for patients prescribed Clozapine
- the provider must ensure that staff follow monitoring plans for patients prescribed antipsychotic medication above the British National Formulary limit
- the provider must ensure that staff keep complete and contemporaneous records for each patient
- the provider must ensure that staff seek information related to patients' care from partner agencies and share information with them
- the provider must ensure that staff take patients' capacity to make decisions about their care into consideration in planning and delivering care
- the provider must ensure that staff treat patients with dignity and respect
- the provider must ensure that staff respond to patients' requests in a timely manner
- the provider must ensure that therapeutic activities are provided to promote recovery and rehabilitation
- the provider must ensure that all patients have a discharge plan in place
- the provider must ensure that staff identify risks relating to providing the service, keep a register of them and take action to mitigate the risks
- the provider must ensure that monitoring systems are in place to identify audits being carried out effectively
- the provider must ensure that monitoring systems are in place to act on outcomes of audits.

Action the provider SHOULD take to improve

- the provider should ensure that staff are aware of and have access to policies
- the provider should ensure that staff spend regular one-to-one time with patients
- the provider should ensure that staff record and report restraint in line with hospital policy.

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 Staff did not provide therapeutic activities to promote recovery and rehabilitation. Staff did not routinely plan discharges with patients. Staff did not consider patients' capacity to make decisions about their care in planning and delivering care. This was a breach of regulation 9 (1) (b) and 9 (3) (d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect We saw examples where patients were not treated with dignity and respect. Staff were dismissive of patients. Staff did not respond to patients' requests in a timely manner. Staff coerced patients to carry out tasks. This was a breach of regulation 10 (1)

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Staff did not know if care plans were in place for patients with medication prescribed above the BNF limit. Care plans were not used for anti-psychotic medication that required additional monitoring. Emergency equipment was out of date This was a breach of regulation 12 (2) (b) (e)

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 When we visited areas of the hospital were dirty. Baths were not clean and patients also told us this. This was a breach of regulation 15 (1) (a)

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 The risk register did not include actual risks in the service. The monitoring systems did not identify when staff had not completed audits. The monitoring systems were not effective in ensuring outcomes of audits were acted upon.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Not all staff were up to date with training in basic life support. Staff did not understand the Mental Capacity Act which meant they were not able to support people in understanding and care and treatment choices. 15 out of 20 staff had not had an appraisal. This was a breach of regulation 18 (2) (a)
	Systems were not ensuring a complete and contemporaneous care record was being maintained. This was a breach of regulation (17)(2)(a)(b)(c)