Castle Lodge Independent Hospital

Quality Report

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

Ratings

Overall rating for this location	**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 Castle Lodge Independent Hospital as requires improvement because:

- The minimal levels of qualified nurses on shift were low for the mix of patient needs; the delayed recruitment of a clinical lead that had been of ongoing concern for over six months contributed to this.
- A lack of onsite cover from the responsible clinician, made it particularly difficult when a patient in the hospital needed detention.
- The range of mental health professions in the multidisciplinary team was too narrow to meet the psychological needs of patients in the hospital.
- The complex systems in place within medicine folders, involved a great deal of paperwork for each patient, increasing the risk of a medicines error.
- Care planning documents were not easy for staff to navigate, creating the possibility that important detail and patient choices could be missed.
- There was no clear model of care, care pathway and limited evidence-based practice.
- Patients were not always supported to maintain independent living skills.
- Key decisions about care made at ward rounds did not routinely involve patients, their relatives or an independent advocate.
- There was no clear criteria for admission to or discharge from this service.
- The hospital described an inappropriate discharge pathway: moving patients from detention under the Mental Health Act 1983 onto Deprivation of Liberty Safeguard under the Mental Capacity Act 2005, this highlighted a lack of understanding of the legislation.
- Capacity to consent and best interest decisions were not comprehensively completed or documented; the narrative as to how the assessment had been conducted was not evident from the documentation.
- Advanced decisions in place did not follow a transparent process, nor was recording completed with the detail required.
- Staff did not understand their individual responsibility in relation to the Mental Capacity Act 2005 to be able to apply this in practice.
- Barchester policies had not been updated or re-written to ensure compliance with the Mental Health Act Code of Practice.
- The hospital did not analyse reported risks to patients and staff effectively. There were no structures to ensure staff and managers learned lessons from incidents or complaints.
- Training record systems offered a lack of clarity for training figures; only 45% of staff had completed infection control training in the past year and no staff members were in date with equality and diversity training.

However,

- Staff knew patients well and responded to their needs, engaging with patients in a genuine, caring and respectful manner.
- Patients and carers became involved in the initial comprehensive admission assessment, which included physical health checks and care planning.
- Individual patient risk assessments including falls, linked to individual care planning for each patient.
- Patients received one to one time with staff, talking or engaging in activities.
- Staff understood their responsibilities to safeguard the patients in their care.
- The head chef worked closely with staff to meet specific dietary needs and patients had facilities to drinks and snacks 24 hours a day.
- Patients and relatives could become involved in community meetings about the service.
- The staff team on night duty spoke positively about their work and the support they received from each other.
- Detention paperwork was correctly completed, up to date and stored appropriately.

Summary of findings

- Staff records included documented evidence that all staff had received an annual appraisal and regular managerial supervision.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Requires improvement 	

Summary of findings

Contents

Requires improvement

We looked at:
two wards for older people with mental health problems and rehabilitation.

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 Castle Lodge Independent Hospital to inform our overall judgement of Barchester Healthcare Homes Limited.

Summary of this inspection

Background to Castle Lodge Independent Hospital

Castle Lodge 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 (MHA) 1983. It is registered for a maximum of 15 adults who have either been detained under MHA or who have been admitted informally.

The accommodation is purpose built and on one level. There are 15 single bedrooms all with en suite facilities. There are five bedrooms for female patients and ten for male patients with the facility to segregate these two areas. The hospital operates as one ward, split into two separate areas offering services for men with an organic diagnosis and women with a functional diagnosis.

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 the registered manager, who was also the controlled drugs accountable officer for the hospital, had been in post since 7th April 2015.

Castle Lodge Independent Hospital has been inspected five times by the CQC, most recently in August 2015 when an unannounced inspection focussed on the safe domain. This inspection found three breaches of the health and social care act 2008 regulation 12, safe care and treatment. The report was published on 18 January 2016 and at the time of our inspection the provider action plan had not been returned. We agreed with the registered manager to review these breaches whilst on site.

We reviewed three specific breaches from the report that related to Regulation 12 of the Health and Social Care Act (HSCA) 2014 safe care and treatment to check compliance. We found the provider had taken actions to address all these points.

Staff did not have the required mandatory training in all areas, specific concerns related to the Mental Capacity Act (MCA) 2005, Mental Health Act (MHA) 1983 and cardiopulmonary resuscitation (CPR) which were 60% or lower.

This was a breach of regulation 12 (2)(c)

When reviewed the statistics for legislative and mandatory training these met the Barchester requirement.

Staff did not have regard for the proper and safe management of medicines we had found the drugs fridge was unlocked with the key was in the lock.

This was a breach of regulation 12 (2)(g).

When reviewed we found the drugs fridge locked, ensuring the safety of the medication and it's key with the medicine keys held by the nurse in charge of the shift.

Staff did not assess the risk of and prevent infection control the clinic room floor was dirty and single use medicine pots were washed in the sink.

This was a breach of regulation 12 (2)(h)

When reviewed the clinic room was clean and single use medicine pots were no longer in use.

This is the first comprehensive inspection of Castle Lodge Independent Hospital using the CQC's new methodology. We have reported as a main core service, commenting on the specific needs of the women with a functional illness and men with an organic illness where appropriate to inform our overall judgement.

Our inspection team

Team leader: Christine Barker, Care Quality Commission

Summary of this inspection

The team that inspected the service consisted of one CQC inspector, one inspection assistant, a mental health act reviewer, a nurse specialist, an occupational therapist and a consultant psychiatrist.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

- visited both areas of the ward at the hospital, looked at the quality of the environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- captured the experiences of patients who may have cognitive or communication impairments using the short observational framework tool for inspection (SOFI)
- spoke with five carers of patients who were using the service
- spoke with the hospital director and divisional director
- spoke with 17 other staff members, including one activities co-ordinator, two housekeepers, the head chef, the mental health administrator and mental health lead, four qualified nurses, a nurse practitioner, the occupational therapist, the consultant psychiatrist, the training administrator and four support workers
- reviewed seven patient's care and treatment records, including physical health checks
- carried out a specific check of the medication management including prescription charts
- reviewed the Mental Health Act paperwork for four detained patients
- held focus groups ahead of inspection for carers, support workers and qualified nurses
- received feedback about the service from Hull clinical commissioning group and Hull safeguarding adults team
- attended and observed a hand-over meeting and a multi-disciplinary meeting
- reviewed three staff personnel files
- looked at a range of policies, procedures and other documents relating to the running of the service
- collected one comments card from the three boxes left on site ahead of the inspection.

What people who use the service say

The patients we were able to talk with spoke positively about the environment being both clean and safe, with support staff present and available. Patients felt their physical health needs were being met and their privacy maintained. Drinks were always available and the food was good. Some patients had concerns there was nowhere peaceful to be and relax, especially in the colder weather when the garden areas were used less. For patients far from home the absence of visitors was upsetting.

Summary of this inspection

The carers we spoke to all said they would approach staff with any concerns. The response they received from staff seemed variable depending who was on shift. Should carers wish to escalate a concern, carers said they would go to the hospital director who they knew. We heard comments about support staff who knew their loved one well and were caring towards them. Concerns were raised about the lack of therapeutic activities taking place. Lack of communication following changes made to which meant not seeing their loved one in the lounge had been difficult for some carers. Others missed the carers support group.

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.
- Shifts with only one qualified nurse on duty were frequent; this was a change from our last inspection for the same mix of patient needs.
- Recruitment of a clinical lead had been of ongoing concern for over six months, which had left a gap in clinical support and direction for the nursing team.
- There was a lack of onsite cover from the responsible clinician which had been difficult when a patient in the hospital needed to be detained.
- Qualified staff had raised concerns about the system pharmacy system introduced in October 2015, and still had no reference guidance.
- The medicine folder contained a great deal of paperwork for each patient increasing the risk of a medicines error.
- When the door to the female side of the ward was shut, support workers were concerned that at times they were lone working and therefore potentially vulnerable. We did not see a lone working policy.
- Only 45% of staff had completed infection control training in the past year.
- No members of staff were in date with equality and diversity training, the last staff members to complete this training did so in June 2014.

However:

- Individual patient risk assessments were in place.
- All patients had a falls assessment and specific falls risks were linked to individual care planning for each patient.
- Staff understood their responsibilities to safeguard the patients in their care.
- Resuscitation equipment was available and accessible, the qualified nurses had good knowledge and understanding of how to use and maintain this equipment.
- Annual fire training figures were 97% compliant, staff knew what the procedures were and 90% had completed fire drills training.

Summary of this inspection

Are services effective?

Requires improvement

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

- There was no clear model of care and limited evidence-based practice, this meant it was difficult to measure the effectiveness of treatment.
- Care planning documents were not easy for staff to navigate, this increased the potential that important details and patient choices could be missed.
- It was not usual for patients to be part of the ward round, nor were their relatives routinely invited to participate in this meeting where significant care decisions were made.
- The range of mental health professions in the multidisciplinary team was narrow. Patients had no access to psychology, and very limited access to occupational therapy to meet their psychological and rehabilitation needs.
- The responsible clinician did not get involved in the patients physical health care, this separation between physical and mental health needs meant the patients with dual needs were not receiving holistic health care.
- Staff did not show a good understanding of the application of the Mental Capacity Act 2005.
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  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 hospitals discharge pathway was described as moving patients from a section under the Mental Health Act 1983 onto deprivation of liberty safeguard, which was an inappropriate understanding of the two legal regimes and not an appropriate care pathway.

However:

- Comprehensive admission assessments took place that included physical health checks.
- There was a positive commitment to training in the hospital, and the training administrator aspired to support staff to reach high targets of compliance.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- Staff spoke of routinely involving patients in their care and wherever possible gained verbal permission for interventions in the moment.
- The staff team on night duty spoke positively about their work and the support they received from each other and the staff nurse in charge.

Summary of this inspection

All staff had received an annual appraisal of their work performance and received regular managerial supervision.

Are services caring?

Good

We rated caring as **good** because:

- We observed some genuine caring interactions between staff and patients.
- The staff knew patients well and responded to their needs.
- We saw evidence of involvement from patients and carers in initial assessments.
- Patients received dedicated one to one time with support staff, talking or engaging in activities.
- Relatives spoke highly about the care their loved ones received.
- Patients and relatives could become involved in community meetings about the service.
- The hospital had an arrangement to access local advocacy services.
- Patients detained under the Mental Health Act had access to an independent mental health advocate when required.

However:

- Ongoing care planning did not routinely involve patients or their relatives.
- It was unusual for patients, their relatives or an advocate to be present at ward rounds where key decisions were made.
- Patients who required access to an independent mental capacity advocate when capacity or best interest decisions were made did not always have this.

The process to agree advanced decisions was not transparent, neither was the detail required completed within the recording of an advanced decision.

Are services responsive?

Requires improvement

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

- There was no clear criteria for admission to or discharge from this service.
- There was a lack of an effective care pathway for patients at Castle Lodge.
- Patients were well cared for, but not always supported to maintain independent living skills.
- Not all doorways were easily accessible for wheelchairs.
- Four patients were experiencing a delayed discharge whilst awaiting suitable alternative placements.
- Following a complaint there was no recording of the outcome of any investigation, feedback to staff or lessons learned.

However:

Summary of this inspection

- Pre-admission assessments took place to check Castle Lodge could meet specific patient needs.
- The head chef worked closely with staff to meet specific dietary needs.
- Patients had facilities access drinks and snacks 24 hours a day.
- Patients were able to personalise their rooms.
- Some patients had individually assessed equipment, for example an electronically adjustable bed.

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.
- There were no structures to ensure staff and managers learned lessons from incidents or complaints.
- Clinical staff felt unheard about the skill mix required to nurse this complex patient group effectively.
- Clinical audits to enable staff to learn from the results and make improvements to the service did not take place.
- Some of the systems in place to collate reported information critical to the running of the hospital needed attention.
- 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.

However:

- Staff records included documented evidence of supervision, appraisal and training.
- We saw clear governance structures in place.
- Staff understood their responsibility in relation to duty of candour and described being open with patients and their carers when things go wrong.

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 1983 Code of Practice (MHA Code) states that it is important that persons (approved clinicians, managers and staff of providers) have training on the Code and ensure that they are familiar with its requirements. Castle Lodge reported 100% compliance in annual mandatory training for qualified nurses in legislative Mental Health Act 1983. However, this training had not included the MHA Code that came into force in April 2015. The qualified nurses we spoke to were aware they did not have a good working knowledge of the MHA Code and had requested additional training.

Barchester Healthcare policies had not been updated or re-written to ensure compliance with the MHA Code. The Department of Health deadline for providers to complete this work was October 2015. The hospital did not have a scheme of delegation in line with the Mental Health Act Code of Practice 37.9. The mental health lead planned to raise this with senior managers within the company.

Detention paperwork was filled in correctly, up to date and stored appropriately. The approved mental health professional's reports were on file. We saw evidence of assessments of capacity to consent to treatment and copies of consent to treatment forms attached to medicine charts.

There was evidence of attempts to explain rights to patients recorded in the patients care notes.

Detained patients had access to an independent mental health advocate. This contract was through an independent advocacy company, whose service supported detained patients to understand their rights, including any restrictions or conditions on them.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act (MCA) training was included with deprivation of liberty safeguard (DoLS), safeguarding and duty of candour as mandatory each year. Four out of five (80%) nurses and 18 out of 23 (78%) care staff had completed this. Staff had an understanding of the five principles of the MCA and could refer to policies. Not all staff had fully embedded the application of the MCA in their practice.

Staff were able to say what the abbreviation DoLS stood for but unable to differentiate or articulate what least restrictive approaches were. Staff believed there was a culture of applying best interests in patient care.

Patients appeared to be supported with decision-making and staff spoke of routinely involving patients in their care. Staff gained verbal permission for interventions in the moment where possible; however, we heard confusion about the differences between this and informed consent.

Capacity to consent was assessed and recorded. However, a tick box form was used to assess capacity without any narrative about how the assessment was undertaken or decisions reached. It was not clear from the records we saw what assistance was given to patients to help them make their own decisions.

We saw best interest assessments for significant decisions, but again the narrative as to how the assessment was conducted was not evident from the documentation seen. During the ward round the responsible clinician made and documented a best interest decision with no input from relatives or an advocate. No staff present challenged this.

There were five DoLS applications made between June and November 2015. We were told all DoLS applications required for patients at the hospital had been submitted in accordance with the legislation.

Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

Castle Lodge Independent Hospital was linked via an airlock corridor to Castle Park care home. The hospital had two ward areas, one for five female patients and one for ten male patients. Access between the two ward areas could be separated by closing a door within the corridor. The door was lockable with access using an adjacent key pad. The ward office was centrally based near the entrance to the hospital but this did not allow staff in the office to observe either of the communal ward areas.

On the male side, there was a large lounge area with a quiet room at the end of the corridor. The female side had a large open plan lounge containing a dining area. The central dining room was locked, except for at mealtimes. This was to isolate a hot water boiler in the room. Both sides of the ward had private garden areas.

The ward complied with the department of health requirement that all hospital accommodation should meet department of health mixed sex guidance. Male and female bedrooms and bathrooms were on different parts of the ward, separate lounges were available and each side of the ward also had an assisted bathroom.

The environmental audit report on ligature risk from May 2015 identified points on window restrictors, door handles, grab rails, taps and bed rails from which an item could be tied on in order to attempt hanging. An action plan following the environmental ligature risk audit identified physical changes to be made and an escalation of action should a patient's profile identify any increased risk of wanting to harm themselves. There were no timescales attached for removal or replacement of items on the audit however, there were plans to relocate this ward to another building on the same site in late spring 2016. Where it was not possible to recommend the removal of a ligature point, for example a grab rail required for mobility, we saw a risk assessment in patient records that would be reviewed according to a patient's profile.

There had been no reported incidents of self-harm at Castle Lodge. Patients had individual risk assessments and all were believed to be at low risk of suicide. Staff awareness of patient's risk level seemed high. We observed that staff within the ward areas supervised most of the patients most of the time. Ligature cutters were accessible to staff in the nursing office. In addition to the nurses, all support staff knew the code for this door.

The nurse in charge held the keys for all medicines and had responsibility for the clinic room. The medicine trolley was clean, well organised and secured to the wall. The fridge could be locked ensuring the safety of the medication within it. The clinic room was clean.

Cupboards were tidy and well arranged, some were lockable. It is good practice to secure all clinical equipment and medication in lockable cupboards. This was possible at Castle Lodge for some, but not all clinical equipment.

The clinical waste bin had no foot lever to open it so staff needed to lift this lid by hand. If there was a need to use this bin during a medication round, there was a high risk of

contaminating medication. A staff handbag was stored in the clinic room, this was not appropriate within a clinical environment as it increased the likelihood of cross infection.

The sharps bin was on the floor of the clinic room posing a higher risk of sharps injury as staff could easily knock it over in this location.

The system to dispose of pharmaceutical waste which involved collection by contract meant three full bins of waste medication remained uncollected within the locked clinic room. This medication was within a lidded box was not fully secure as it was outside the cupboard on the clinic floor. We raised this with the hospital director and were assured immediate collection would be arranged.

When we first saw recordings of the fridge and clinic room temperatures on 16th February there was a gap, with the most recent recording made on 6th February 2016. This was raised with the hospital manager. On the following day were shown a completed form with recordings for these dates which had not been shown to us previously.

Resuscitation equipment that included oxygen, a defibrillator and suction machine was available. A resuscitation bag was easily accessible to staff. Staff completed equipment checks and recorded these on a daily basis over the previous two months. Nurses had good knowledge and understanding of how to use this equipment. The provider reported 100% compliance for qualified nurses completing cardiopulmonary resuscitation training. In addition, 9 out of 23 support staff (39%) had completed this training.

Emergency drugs were stored in a separate cupboard and checked weekly.

The lounge furnishings were homely. Whilst on the female side the furnishings were well maintained, in the male lounge some of the seating had scratches and tears. Throughout the hospital, electrical items showed evidence of portable appliance testing (PAT), although, individual items belonging to patients were not all PAT tested.

The ward was tidy and free from odours. There were two ward domestic staff who had the resources and equipment required to do their job. A daily cleaning schedule was in place for all ward areas. Domestic staff reported any maintenance issues that they found. Cleaning resources were locked in a cupboard on the adjoining Castle Park care home. This meant the night staff with responsibility to clean the clinic room did not have easy access to this equipment.

Most of the areas accessed by all patients on the ward appeared clean, although we did see cobwebs and dirty windows in both communal and individual bathrooms. We saw the completed records, reviewed by the housekeeper, which demonstrated all areas of the ward environment had been regularly cleaned. The domestic staff monitored temperatures on the ward daily. The range of temperatures were appropriate. They were aware of and responded to individual patient preferences about the temperature of their bedroom.

The most recent food safety inspection carried out by the local authority in March 2015 gave the kitchens at Castle Care Village where the food is prepared a rating of 'good'. The head chef monitored standards, checked the recordings of food temperatures on the ward and all cleaning related to food hygiene in the kitchens. A change in the trolley system to manage waste and dirty crockery more effectively had been in place since October 2015 and was working well, avoiding cross contamination.

Staff spoke to us about the importance of infection control, including handwashing. We did not see any specific handwashing assessments. Best practice suggests all staff should receive infection control training annually. Only 15 of 33 (45%) staff were recorded as having completed this training in the past year. At meal times, sinks were available for handwashing in both dining areas with materials for washing and drying hands. Staff wore cloth aprons when supporting patients to eat, these were laundered following each use.

A health and safety audit report from June 2014 completed by the provider rated the service 'good', however it related to the hospital 20 months ago. The registered manager told us that since September 2015 health and safety within the hospital environment was assessed bi-monthly as part of the provider's quality first visits. We asked to see copies of these reports whilst on site as the information sent prior to the inspection was a description of the quality first process rather than the specific reports relating to Castle Lodge. The specific reports were not given to us. We did see minutes from a health and safety committee meeting, October 2015 that indicated on going oversight of health and safety issues.

Requires improvement

Wards for older people with mental health problems

Fire training figures were 97% compliant. Staff knew what the procedures were when asked, 90% of staff had completed fire drills training. Qualified nurses were the only identified fire marshals in the hospital. Three out of four had completed this update training in the last 12 months.

When an alarm was raised within the ward the qualified nurse on duty and those support workers not on one to one observations responded. Recently the volume of the alarm system was increased to ensure staff throughout the ward heard it, however, the alarm volume level day and night was the same, which had the potential to disturb to patients sleep. Room sensor alarms were also in use, whilst this was positive least restrictive practice, not all staff were sure how this system worked.

Safe staffing

Clinical Lead (vacancy for over six months)

Qualified Nurses (whole time equivalent): 5

Number of vacancies qualified nurses: 0

Support Workers (whole time equivalent): 18.3

Number of vacancies support workers: 0

Hours covered by bank or agency over 12 months: 4213 (10.4%)

Shifts not filled: 0

During the day, we saw minimum staff numbers of one qualified nurse and four support workers. On a Monday and Tuesday an additional qualified nurse worked 9am to 5pm to support additional workloads on these days. A twilight shift for a support worker shift had been introduced form 10am to 10pm to cover times staff had identified they needed additional support. Staff reported this was working well. On the night shift we saw a minimum of one qualified nurse and three support workers.

To avoid high levels of agency staff covering shifts, when possible nurses and support workers worked overtime. The duty rota did not clearly show how many staff were on duty every day by numbers or hours so it was difficult to check the efficacy of the matrix system, or how much individual overtime was being worked. However, neither qualified nor support staff felt under pressure to do overtime if they did not wish to.

Until the recent recruitment of a fifth qualified nurse, agency nurses had covered vacant shifts. When possible the agency sent the same nurses to offer consistency to patients, however at times this had been difficult to achieve. Staff turnover in the six-month period June to November 2015 was 16%, with a sickness rate of 4%.

The hospital director had sufficient authority to increase staffing levels whenever this was required. She used Barchester's dependency indicator care equation (DICE) tool, which monitored the dependency of patients to calculate staff ratios. Where patients had additional needs or were on higher level of observations additional support staff regularly covered this.

Concerns had been raised by both the nursing and support workers that the hospital was short staffed, the hospital director believed the hospital was never short staffed. The staffing rota showed a consistency of numbers. We saw the care hours required based upon the acuity of patient need. However, support workers filled any additional hours required and shifts with only one qualified nurse on duty were frequent. This was low for a hospital environment with a mix of patient needs.

Qualified staff numbers increased on days when meetings took place however, this was not always the case when the diary was busy. The hospital director did cover any gaps within the staffing on the ward when able. However, she was not a clinician so was unable to provide adequate cover for a qualified nurse. In addition, time spent on the ward in this way took time away from managerial duties.

Whilst the support workers were able to take breaks on day or night shifts, nurses spoke of being unable to take a break on a 12 hour shift when they were the only nurse on duty. Other issues related to being the only qualified nurse on shift included: being more vulnerable to medicine errors and needing to call a nurse from elsewhere to administer controlled drugs. The requirement to manage the ward meant nurses spending lengthy times in the office or clinic room, out of the line of sight of the communal ward areas. One to one time with patients was particularly difficult to ensure. We heard a more general concern that the workload at times seemed impossible for one nurse to achieve.

The recruitment of a clinical lead had been of ongoing concern to the nursing staff, particularly around

professional support and consistency of approach to care. The previous clinical lead had worked weekdays allowing the nurses more time out of the office delivering direct care.

In the absence of a clinical lead the hospital director had been offering additional support and supervision. She had recently asked a nurse practitioner from within the company to offer clinical supervision to the qualified nurses. During the inspection, we were told the on going recruitment to the clinical lead post was nearing completion and the role would be filled by April 2016.

When the door to the female side of the ward was shut, whilst recognising low patient numbers, support workers were concerned that at times they were lone working and therefore potentially vulnerable. Specific concerns were around the accessing immediate support should an incident take place, or being accused of something with no witness. Nurses confirmed that given their workload they had little time to check what was happening in all areas of the ward with a level of frequency that would mitigate these concerns. The hospital director did not see that the closure of this door meant these staff were lone working. Support staff told us they had escalated this concern to the provider's human resources department.

An activities coordinator was supernumerary, so planned activities on the ward usually took place when scheduled. Escorted leave and outings that were pre-planned usually took place.

The responsible clinician (RC) for all patients was a consultant psychiatrist. The responsible clinician visited the ward each week on a Tuesday for four hours. In addition, he told us he provided telephone cover to the hospital from Billingham Grange independent hospital 24 hours a day, seven days a week. When he was on leave, whoever was covering his duties covered Castle Lodge independent hospital. There was no junior doctor however, a nurse prescriber visited the hospital weekly. Her role included providing support to staff and liaison with the responsible clinician in relation to prescribed medication. She did not write patient prescriptions.

Physical health care emergencies were dealt with through the patient's general practitioner. This included out of area patients who had a temporary registration at a local practice. Mental health emergencies would be referred to the local crisis team.

If a patient needed to be detained this would be referred to the approved mental health professional (AMHP) within the local crisis team. Local approved mental health professionals expressed concerns regarding this process for patients at Castle Lodge. On more than one occasion, the psychiatrist who was the responsible clinician and who knew the patients wasn't available to undertake mental health assessments for the purpose of detention. Instead, two doctors approved as having special expertise in the diagnosis and treatment of mental disorders under section 12 of the Mental Health Act (MHA) 1983, were involved in the patient's assessment. Whilst this fulfilled the requirements of the Mental Health Act best practice suggests a doctor known to the patient is involved.

The hospital director accepted the current level of cover from the responsible clinician was not sufficient or flexible enough to ensure patient's needs were met fully. With the divisional director, she was looking at the possibility of additional cover from a psychiatrist.

Training figures were analysed for the twelve-month period 17 December 2015 to 17 February 2016.There were eight legislative training modules for all staff, with two additional modules for nurses. The compliance figure for legislative training was 91%. There were four mandatory training modules for all staff, with four additional modules for nurses. The compliance figure for mandatory training was 61%. The overall compliance figure for legislative and mandatory training at Castle Lodge independent hospital was 76%.

Whilst the majority of legislative training had a high compliance rates, infection control did not. Best practice outlined by the national patient safety agency recommended that this training was refreshed annually. This was the provider's requirement however staff compliance with this training was 45%.

Within mandatory training, no members of staff had completed equality and diversity training in the past year, and only 33% of staff complied with this training in 2013/14. The Equality Act 2010 states that the provider must take account of protected characteristics. Castle Lodge training figures did not support this. Compliance with documentation training was 36%. Good record keeping improving accountability and showing how decisions related to patient care were made (Nursing and Midwifery Council 2009) was not always evident in patients' notes.

Wards for older people with mental health problems

Additional mandatory training for qualified nurses included 'safe and therapeutic observation' whilst two nurses completed this training in 2014, only one nurse (20%) had done so since.

Assessing and managing risk to patients and staff

There were no seclusion facilities at Castle Lodge and we found no evidence of seclusion or long-term segregation taking place. Staff were trained in non-aggressive psychological and physical intervention (NAPPI), the focus of which was de-escalation. Training was annual and compliance for all staff was 93%. Agency staff covering shifts did not have this training. Some staff struggled to explain the term de-escalation. However, all staff were clear that when NAPPI was used the interventions involved talking gently to help patients calm, perhaps responding by using distraction, with any physical intervention rare. If physical intervention needed to be used, it would be the minimum required. Staff would never use prone (face down) restraint. We saw enough staff in the clinical area to carry out restraint if needed.

There were 11 incidents involving the use of restraint in the six months from June to November 2015. These incidents involved five different patients. We reviewed these records and found the interventions had involved minimal physical intervention, in the form of passive arm holds, alongside verbal reassurance from staff. Staff appeared to apply appropriate levels of restraint when required. We found no incidents of rapid tranquillisation in the last six months at Castle Lodge independent hospital.

We also reviewed a patient record for an individual who had four recorded incidents of restraint, the most recent from January 2016. The recording form included patient details, incident details, type of intervention, a factual account of the incident, whether medication was used and whether a weapon was used or the police called. The provider's incident form also provided for post incident actions to be recorded including: being checked by the responsible clinician; whether paramedics were called; any patient or staff injuries and a de-brief of the incident for staff. There were no records of the actions taken or addressed after the incident. The form was simply signed and dated by a member of staff who did not enter their designation. There was a separate record of the incident recorded in the care plan.

Staff told us that it was rare that patients become so agitated they need to be away from others. If this did happen, staff would take them to the quiet room described as 'low stimulation', at the end of the male side of the ward. Due to its location, this quiet room would not be suitable for female patients. Staff assured us that patients would not be left alone in this room unless this was their choice. Whilst staff showed limited understanding that if patients were required to be in this room, or their bedroom, and were unable to leave, this could be regarded as seclusion, we saw no evidence that this was happening. The hospital director stated that Barchester Healthcare does not have a seclusion policy.

Clinical risk management training was provided annually for qualified staff, all five nurses had completed this in January 2016. We examined patient records for seven patients, all had individual risk assessments completed on admission. However, due to the complexities of the care notes it was difficult in some cases to track when and where these had been updated.

A number of the patients at Castle Lodge had issues with mobility. All patients had a falls assessment. We saw specific falls risks linked to individual care planning for each patient.

There was a list of banned contraband items for visitors to the hospital, this included razor blades, sharps, and alcohol. Patients had access to a telephone in a private room within the ward with large number buttons. Patients who smoked had cigarettes and lighters locked away when on the ward. We were told this was linked to risk of fire.

Informal patients could leave the hospital at will, door codes were on each exit door. However, these were quite difficult to see as they were within decorative butterflies. If an individual patient did not know the code, staff gave this when asked. Patients who were able to confirmed there was no restriction when they wanted to leave.

CQC received 11 safeguarding concerns between 29 January 2014 and 13 November 2015 regarding Castle Lodge Independent Hospital. These concerns related to a medication error, physical assaults patient on patient, a patient threatening to kill another patient and fire safety. All of the safeguarding concerns were closed.

Requires improvement

Wards for older people with mental health problems

The local authority confirmed that staff from Castle Lodge telephoned through safeguarding queries; however, any referrals considered low risk on the local authority matrix system would not always be recorded there as a concern.

Staff understood their responsibilities to safeguard the patients in their care. Four out of five nurses and 18 care staff out of 23 had completed training in safeguarding and duty of candour. However, at the time of the inspection the hospital manager, activities co-ordinator, domestic and administrative staff had not received this training.

Medication profiles for the patients were clear, and held up to date information. Medication clearly labelled with the patient's name was appropriately stored in the clinic room. A copy of the British National Formulary was available for reference.

Reference could be made to the mental health paperwork for detained patients regarding consent to medication. Consent to treatment forms were kept with the medication administration record charts.

When only one qualified nurse was on duty and administration of a controlled drug was required, a qualified nurse came from another ward on the same site after completing his or her own medicine round. The controlled drugs accountable officer was the hospital director.

Since mid-October there had been a change to the pharmacy contract with Castle Lodge. This contract included an annual review, to be completed in April 2016. We could find no record of a previous pharmacy audit. A recently completed internal medicines audit showed a compliance of 100% that related to compliance with consent to treatment forms T2 and T3.

The provider's nurse practitioner was a registered mental nurse with five years' experience as a nurse prescriber. She visited Castle Lodge weekly and was available to staff for advice on the telephone. Her role involved case and medication reviews.

A new pharmacy system with a different provider had been introduced in October 2015. Staff had received training from the pharmacy who had visited three times in the last six weeks however, nursing staff continued to have concerns. The qualified nurses found the new pharmacy system confusing. Prior to our inspection, they had raised issues with management about their role transcribing drugs onto medicines charts. Two nurses had been told by the hospital director the new system was fine and not to worry.

Key concerns from the nursing staff included the lack of a guidance document to refer to that would ensure the processes followed were accurate. Their greatest concern was that they had become inappropriately accountable for prescribed medication. For one newly admitted patient they had been required to transcribe prescriptions, written elsewhere by a doctor onto the patient's medicines card. Two nurses signed this transcribed prescription having understood from the hospital director that under the new arrangements they could do this. We checked the provider's medicine management policy and found no process involving nurses transcribing a patient's prescription following admission. This was raised with the hospital director immediately and following a robust discussion, she took action to change this by getting all such prescriptions re-written and signed by the doctor.

For two patients prescribed covert medication there was an assessment of capacity to consent to medication. From the 'record of the decision to administer medicines covertly' form, which refers to the site as a care home not hospital, it was not clear whether the patient's family had consented to treatment. Within the medicines management policy there was guidance to staff on covert medication however, this was difficult to find as the item numbers did not correlate. The section of the policy refers the reader to item 25 for covert medication, yet in the body of the document it is item 11.

The medication administration record (MAR) charts were not always stapled together and none were numbered as per policy. When we reviewed prescription charts it took a great deal of time to locate a third MAR chart which the staff nurse knew was in existence however, an agency staff nurse was unlikely to be aware of this.

The psychiatrist prescribed medication onto a MAR card. This was in line with the provider's medication management policy. However, the doctor had not signed all the prescriptions on the MAR charts. Neither was it clear who cancelled medication no longer prescribed. It appeared that to avoid a medicines error when medication had been changed, nurses were making notes on the MAR chart. An explanation for this was that the psychiatrist was only at the hospital weekly so could not always to do this.

Nurses faxed the psychiatrists prescription to the pharmacy provider to order the medication required. The pharmacy returned a different medication card with the medication required. Nurses used this medication chart to dispense medication. Nurses signed for all medication given to patients on this card and most of the time on the original MAR chart as well. It was not clear to nurses if this practice was required of them. There was concern it could read as though a double dose of medication had been given, which was not the case.

The psychiatrist did not countersign the prescriptions on the pharmacy's chart. This meant the prescribing doctor would not see an error if made. Prescriptions for physical healthcare medication from a patient's general practitioner (GP) were on the pharmacy card, but not the MAR chart. This meant when reviewing a patient's medication on the MAR chart the responsible clinician did not have an overview or awareness of all the medication prescribed to a patient, or any potential contraindications.

As a consequence of the complex systems in place the medicine folder contained a great deal of paperwork for each patient. The qualified nurses we spoke to all mentioned spending a great deal of time ensuring they gave the correct medicines to patients. To the credit of the staff managing these systems, there had not been a reported medicines error since March 2015.

We raised the concerns we had found and heard about with the hospital manager and divisional director. Immediate action was taken to ensure these processes did not continue. Where medication administration record (MAR) cards had not been fully completed by the responsible clinician this was done. The pharmacy provider changed their process of dispensing medication and charts to the hospital. They also agreed to provide additional training and a reference documentation to support the qualified nurses.

Child visiting procedures were in place and following a risk assessment these visits took place off the ward. Staff described safe arrangements for children as 'pond leave'. Patients on section 17 leave with visiting children could go to a pond within the grounds on the Castle's site away from the ward. A child visiting was not frequent however; it was not clear how well this might work in poor weather. Other visitors were able to visit patients on the ward provided there were no incidents occurring at the time. To ensure privacy for patients there was a visitor's room available to relatives and where appropriate some visits took place in patient's bedrooms.

Track record on safety

Castle Lodge Independent Hospital reported no serious incidents requiring investigation in the six months prior to inspection.

Reporting incidents and learning from when things go wrong

Signed recordings of an incident were within individual patient notes. Staff used the communication book to report incidents, complaints and accidents. The nurse in charge of each shift used and reviewed the communication book.

Following an incident staff felt they would receive individual support from colleagues and management. However, they believed there was no mechanism to receive feedback or learn from incidents. We saw no formalised process for supporting staff following incidents. We checked the minutes of staff meetings and saw no recording of lessons learned or evidence of change being made as result of feedback.

The hospital director explained that specific incidents were discussed at ward round and /or reviewed at clinical governance meetings. She also explained that the hospital had no central process for the recording of incidents. However, the provider was looking at the introduction of a system for use across the complex care sector of Barchester Healthcare.

Whilst observing the ward round a specific incident relating to a patient from five weeks ago was discussed. No plans were made, or lessons learned identified in relation to this. From the minutes of the clinical governance meetings we saw, there was no evidence that incident reviews were taking place.

Over a six month period from June to November 2015 there were 11 notifications of incidents recorded as verbal aggression or physical aggression towards other people and the environment. None of these incidents resulted in staff injury.

A policy document for duty of candour and staff responsibilities in relation to this had been discussed at a

Requires improvement

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staff meeting in July 2015. The staff present signed to say they had read and understood this policy. We spoke to seven staff members specifically about duty of candour, six people knew and understood their responsibilities and one did not. Staff spoke of wanting to be open and transparent however, two staff members were concerned they may 'get into trouble' if they were open and transparent with patients and carers without first checking this with the hospital director. We saw no examples of the application of duty of candour.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

The hospital director with a member of staff assessed the suitability of the hospital for an individual prior to admission to Castle Lodge. Patients had planned admissions, with a comprehensive admission assessment and a full care plan completed ahead of their arrival on the ward by a qualified nurse. The seven care records we reviewed all had assessments with physical health checks as part of this, along with evidence of on going physical care.

Completing care-planning documentation was seen as a nursing, rather than multi-disciplinary responsibility within Castle Lodge independent hospital. Nursing staff told us the care planning documents were not easy to navigate. Patient information was in two files with indexes and sections of the file not clearly numbered, this meant care plans were difficult to follow. This was especially concerning when agency staff were in charge of the ward.

We did find an overarching care plan containing information for each patient that was more succinct. It included a patient's preferred name, room location and personal evacuation plan. Following this were any identified behavioural needs and what staff response needed to be. Support workers saw this care plan as accessible and particularly helpful for new or agency staff. However, it had the potential that important details and patient choices could be missed. For example, we read within a care plan that a patient preferred a shower; staff told us he always had a bath. It seemed likely that if the staff delivering direct care had been aware of the detail within the care plan they would have made that choice.

We saw small files of notes in individual bedrooms; the content of these files held varying information including patients' rights. However, they did not include a patient focussed care plan that would be accessible to the patient or their family. We were told that previously full care plans were in patient's bedrooms but that some of this documentation had gone missing. Due to concerns around potential breaches of confidentiality care plans had been removed.

We saw evidence of care plan reviews taking place however, one care plan had remained the same from 20 May 2015 until 10 November 2015. Another had an undated review that simply advised 'continue care plan'. Qualified nursing staff were aware there was additional work to do to improve care documentation. However, when in charge of the ward getting one to one time with patients to review a care plan comprehensively was rarely possible.

The hospital used a paper-based system with patient notes kept securely in cabinets a locked room with no patient names on display. Staff who needed to could access information from notes when required.

Best practice in treatment and care

The mix of patients at Castle Lodge made it difficult to develop a model of care across the hospital, which managed as one ward, had a mix of age and gender for patients with both functional and organic illness.

The psychiatrist spoke of a bio psychosocial model of treatment and a multi-disciplinary model of care at Castle Lodge. This treatment model describes the need for biological, psychological, and social need to be taken into account in every health care task. Whilst this model of treatment may be appropriate to the delivery of care at Castle Lodge, no other member of staff was aware of it.

The hospital manager told us she would like to see staff develop the '6Cs' (nursing values adopted across the whole National Health Service to reflect compassion in practice) across the delivery of care at Castle Lodge. The values are care, compassion, courage, communication, commitment and competence. This seemed aspirational with no staff awareness of this at the time of our inspection.

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We saw no access to psychological therapies for patients at Castle Lodge. There was no access to psychology at the time of our inspection, nurses had no specialist training or time to offer this type of intervention and the occupational therapist only did two sessions a week and one of these required their attendance at the ward round.

The physical healthcare needs of individual patients were identified in care planning. To meet these needs we saw access for patients to a physiotherapist, dietician and a speech and language therapist as needed.

Patient's food and hydration needs were assessed by nurses who completed a malnutrition screening tool and a choking risk assessment for patients. Patients had a nutritional profile that was reviewed, though not necessarily changed, monthly. Care plans in relation to nutrition included dietary guidelines with individual preferences likes/dislikes and recommendations in relation to specific needs. We observed a mealtime having looked at the detailed care plans for individuals. Talking to the staff supporting lunchtime, whilst aware of patients' specific dietary needs some seemed unaware they could reference likes and dislikes for patients who could not articulate their preferences in the moment.

Liaison with the head chef ensured specific dietary needs were met appropriately. For support staff to ensure that patients received the correct diet, fluid consistency guidelines were available in the dining room however, food texture guidelines were not.

The clinical outcome measure health of the nation outcome scales monitored change for service users with severe mental illness. Clinical staff rated and documented this for individual patients at assessment. It was not clear from patient's notes or discussion with staff what criteria was used to repeat and update this measure.

The occupational therapist used the model of human occupation screening tool to provide a baseline assessment and document progress towards occupational therapy intervention goals. For patients with dementia the pool activity level tool was used as a baseline to inform activity-based care. This included patient's likes and dislikes which informed the activity schedule.

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

Skilled staff to deliver care

The range of mental health disciplines and workers at Castle Lodge Independent hospital providing input to patients was limited.

The consultant psychiatrist, who was the responsible clinician, visited the ward each week on a Tuesday for four hours when he saw patients at ward round and attended clinical governance meetings every two months. In addition, he provided telephone cover to the hospital from Billingham 24 hours a day, seven days a week. When he was on leave, whoever was covering his duties covered Castle Lodge independent hospital. The impact of this was limited direct contact with the responsible clinician for patients and carers, staff feeling, rushed in clinical discussions and if a patient required detention this became the responsibility of local services.

The staff nurses employed were all registered in mental health. Whilst supported by the hospital director and the visiting nurse prescriber, in the extended absence of a clinical lead the nurses had lacked clinical support.

An occupational therapist (OT) employed on a service level agreement with the local NHS trust provided two sessions a week. He received supervision and some bespoke training through the trust. The occupational therapist attended the ward round and prioritised sessions with patients on information given by staff. He also supervised and supported the activities co-ordinator.

During the provider's presentation to the inspection team, we heard of a music therapist offering one session a week at Castle Lodge. The occupational therapist was not aware of this, nor did we hear from staff that music therapy took place.

The consultant psychiatrist, OT and all five staff nurses had current re-validation from their professional bodies.

There was no access to psychology at the time of our inspection. The hospital manager had considered the need for this and told us she was obtaining quotes for psychology input at Castle Lodge.

It was not clear at the time of our inspection how frequently visits by the external pharmacist to look at medication issues under the new pharmacy contract would occur. There was an annual audit planned, however, this would not be frequent enough to identify and correct any concerns about medication practice at Castle Lodge.

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If a patient had their own care co-ordinator or a social work known to them prior to admission, they were invited to planned reviews. If not, and social work was needed, we were told this would be accessed through the local authority. We saw no examples of this in practice.

The hospital's contract with a private physiotherapist had recently ended. Cover was in place through a service level agreement with a NHS physiotherapist with a background in learning disabilities.

The hospital had an arrangement with an agency offering independent mental health advocacy (IMHA) for detained patients and independent mental capacity advocacy (IMCA) for patients if they lack capacity to make an informed decision.

The provider had a training programme for all new starters that introduced common induction standards, which all staff employed by Barchester had completed.

Castle Lodge offered annual appraisal to staff, records were seen and in date. Figures showed appraisal for all staff was 100%.

The hospital director provided managerial supervision every two months to the qualified nurses, occupational therapist, administrators and housekeeper. Barchester's management team had specific responsibility to supervise the wider maintenance and catering teams across the site that served the hospital. Nurses had individual responsibility to supervise identified group of support workers. We found this was taking place in a timely way, with an adherence to the provider's target of supervision for staff every two months.

In the absence of a clinical lead additional supervision had been available to staff nurses from the hospital director, however she was not a registered clinician. We were told informal clinical supervision had been available to nursing staff over the past two years from the nurse practitioner who visits Castle Lodge. A more formal arrangement for clinical supervision of the five staff nurses had been agreed three weeks prior to inspection. Nursing staff were pleased and we saw evidence that each qualified nurse had already accessed this.

There was a positive commitment to training in the hospital. However, it was difficult to compile accurate data from the systems in place to monitor compliance. Castle Lodge submitted an overall training compliance rate prior to the inspection of 84%.In these training figures, it was apparent that some attendees had been counted twice, and training courses and staff roles reported together, skewing the results. During our inspection, the provider supplied individual training rates per role for all staff from 01 January 2013 to 17 February 2016. The overall compliance figure for legislative and mandatory training at Castle Lodge independent hospital was 76%.

Legislative training included eight modules for all staff: management of aggression; safeguarding, mental capacity act and deprivation of liberty safeguard training; moving and handling; infection control; health and safety; fire; food safety and MI skin (an awareness course around the risk of patients developing pressure damage). With the exception of infection control training, all legislative modules had compliance rates of 70% or more. Nurses were required to complete two additional modules of legislative training: mental health act and cardiopulmonary resuscitation, their compliance with this was 100%. The combined legislative training compliance figure was 91%, the trainer had a target of 100% by the end of March 2016.

Non-abusive psychological and psychical interventions (NAPPI) was the system in place to manage challenging behaviour of patients, the hospital director told us of plans in line with other Barchester hospitals to change the system to the management of actual or potential aggression (MAPA), this had not yet happened.

Mandatory training included four modules for all staff. Whilst compliance figures for customer care and footsteps training were over 75%, those for documentation and equality and diversity training were under 40%. Nurses were required to complete four additional modules of clinical mandatory training. We saw compliance rates of 80% upwards for anaphylaxis; clinical risk management and unexpected death but only 20% for safe and therapeutic observation training. The combined mandatory training compliance figure was 61%, the trainer had a target of 85% by the end of March 2016.

The training administrator delivered some of the training, and supported the hospital director to monitor compliance. The training administrator was aware staff prefer for face to face training to online modules and has been working with others to further develop the mental capacity act training which was previously web based. Internal trainers aimed to tailor their delivery to meet the needs of staff within their role. Sometimes with mixed

groups of qualified and unqualified staff this can be challenging. If a staff member had a specific difficulty accessing training materials support would be given to ensure the training was understood.

We saw the training administrator coming in early to alert night staff to legislative and mandatory training they were to that due to complete. This included a discussion with the staff concerned about when, where and how this training could be undertaken. Staff working on day shifts told us of a similar dialogue to ensure their training maintained.

Staff spoke about the current mix of patients on the ward being difficult to care for effectively as they require knowledge and experience of female patients with functional illness and male patients with organic illness. If this patient mix continued, staff spoke of needing more specific dementia training in addition to training related to personality disorder. Nursing staff believed for changes to legislation, for example the code of practice for the mental health act, they required a higher level of training than was currently available.

The 'So Kind' is a training programme of eight workshops designed to 'build a knowledge of dementia'. One nurse and two support workers had attended workshop seven: 'supporting and understanding behaviours that we find challenging'. When we asked, it was unclear why only one module of the course was completed. The trainer said it was possible, though not definitely decided, that this programme would become the basis of training in dementia at Castle Lodge. If implemented she envisaged staff would complete all of the eight workshops.

Alongside their mental health needs, some of the patients at Castle Lodge had complex medical conditions. Nurses and support workers expressed concerns they were not trained to carry out some of the physical interventions that had been required, for example the care of a patient on a syringe drive (a portable infusion device used to administer a continuous infusion of drugs). In this case advice and support had been sought and obtained from district nursing staff locally.

There seemed to be degree of anxiety about what might be expected of the staff at Castle Lodge in the future, which may have been connected with the uncertainty about the patient group staff would care for when the planned move to another building on the same site took place.

Staff saw team meetings as information sharing from management. We saw minutes from staff team meetings held in February, May and July, with separate meetings for qualified nurses in May and a night staff meeting held in September 2015. These minutes documented information shared. It was not always clear who had attended these meetings, or if any discussion had taken place.

The hospital manager had a strong presence on the ward at Castle Lodge. Following what was she described as 'mess and untidiness on the unit' she conducted an informal fact finding mission before deciding how to address the issue with staff. A more formal process in line with the provider's procedure was described for an issue reported relating to clinical performance.

Multi-disciplinary and inter-agency team work

General practitioners (GPs) had no regular planned sessions at the hospital, however there were good links between the hospital staff and the practices where patients were registered; this included those from out of area who had temporary registration with a local GP. The psychiatrist made specific requests for a patient to access their GP during ward round; the nursing staff followed these up. Qualified nurses also referred issues directly to the GP as they arose. The patient's GP arranged blood and electrocardiogram tests, which measured the electrical activity of the heart. If required, referrals to physical healthcare consultants, speech and language therapists, dieticians, chiropodists and district nurses were made through the GP. Staff supported patients to attend appointments at the local general hospital when this was possible.

Qualified staff delivering the service included the consultant psychiatrist, a nurse prescriber, an occupational therapist all offering one day a week, and five qualified nurses covering a rota of 24 hour care. In addition, there was one activities co-ordinator and 23 support workers. Although the consultant psychiatrist was only on site four hours each week, staff described the service as consultant led.

Reference was made to the multi-disciplinary team (MDT), and this was an aspiration for staff, in practice the team did not contain enough professional input to meet this description. There were no examples of multi-disciplinary assessments that drew together recommendations following specific assessments.

Requires improvement

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Senior managers recognised that the range of professionals within the MDT was not broad enough to be effective and expressed a commitment to work towards improvement. This included extending cover from a psychiatrist and bringing in psychology.

We were told it was not usual for patients to be part of the ward round, nor were their relatives routinely invited. The reason given was the high level of cognitive impairment many patients experienced would make this difficult for them. It was less clear why relatives could not attend. Patients care co-ordinators, relatives and/or advocates were invited to care programme approach meetings.

Ward rounds were described as the main decision making meeting about care. Several members of staff reported difficulties in communication between staff involved in ward rounds. Two members of the inspection team attended a ward round during the inspection. A standard agenda was followed, with minutes taken by an administrator to be typed up and put into patient notes. The responsible clinician, a registered nurse, the occupational therapist and the hospital director were all present. One patient attended their part of the ward round and became involved to the level of their ability and understanding. No relatives or external professionals attended.

For each patient we heard an initial verbal handover from the nurse however; there was no corroboration from patient notes or reference made to care plans. This suggested the care plans were not a working document for the patient and the wider team delivering care. The responsible clinician neither checked nor signed the medication cards. Section 17 leave for detained patients was not reviewed during this ward round. The hospital director took a lead, presenting the wishes of the patients and commenting in a directive manner about both therapeutic need and treatment. We witnessed the occupational therapist cut across and dismissed when attempting to offer advice about appropriate activity. The main decision maker at this meeting was the responsible clinician.

In spite of the complex mix of physical and mental health needs some of the patients had at Castle Lodge there was no review of individual patients physical health nor was there any verbal or written representation at ward round from the general practitioner (GP). When we asked about formal liaison with the GP, we were told by the responsible clinician that he did not get involved in physical health care. This separation between physical and mental health needs meant the patients in Castle Lodge with dual needs were not receiving holistic health care. For patients on psychiatric medication where regular physical health monitoring was required, they accepted that the national institute for health and care excellence guidance stated the prescribing psychiatrist had a responsibility to ensure monitoring takes place.

Handovers lasting 15 minutes took place morning and evening between shifts. The short length of time meant staff could not easily reference individual care plans during handover.

We attended a handover from the staff nurse on nights to the staff nurse on days plus six support workers. Information shared about all patients included a summary of their mood, sleep pattern and key details from the previous handover. The nurse in charge used the ward diary and information from the handover to allocate specific duties to her team. Support staff knew the patients and what was expected and they seemed keen to begin their work. The support staff going off duty spoke positively about their work and the support they received from the staff nurses on night duty.

We spoke to Hull clinical commissioning group and the local authority adult safeguarding team about effective working relationships with Castle Lodge.

The local authority team had had concerns about the appropriateness of all the referrals made for deprivation of liberty safeguards. However, following discussion with the hospital director this situation had improved.

The clinical commissioning group had a specific concern about the need to re-request parts of the evidence they required from the hospital to ensure patient funding was returned in a timely manner. They also had on going concerns about the lack of clinical leadership and direction for Castle Lodge. This was identified with the hospital director in the summer of 2015, and was still unresolved.

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

The Mental Health Act 1983 Code of Practice (MHA Code) states that it is important that persons (approved clinicians, managers and staff of providers) had training on the Code of Practice and to ensure that they were familiar with its

requirements. Castle Lodge reported 100% compliance in annual mandatory training for qualified nurses in legislative Mental Health Act 1983 (MHA). However, this training had not included the Mental Health Act Code of Practice that came into force in April 2015.

The qualified nurses we spoke to were aware they did not have a good working knowledge of the Mental Health Act Code of Practice and had requested additional training. During the inspection it was also identified that 13 out of 23 (57%) of support staff had completed an introduction to Mental Health Act facilitated by the hospital director.

Barchester policies had not been updated or re-written to ensure compliance with the Mental Health Act Code of Practice. The Department of Health deadline for providers to complete this work was October 2015. The hospital did not have a scheme of delegation. The mental health lead planned to raise this with senior managers within the company.

At the time of our inspection, administrative support and legal advice on the implementation of the Mental Health Act 1983 was available from the provider's mental health lead based in Billingham. The ward staff designated to receive detention documents had not received training in the receipt and scrutiny of documents.

The hospital had recently appointed a mental health administrator 20 hours a week. The provider's mental health lead was due to begin a teaching and mentoring programme to develop their ability to fulfil the administrative processes required at the Castle Lodge in March 2016. Until then support would continue to be offered to staff at Castle Lodge from an administrative colleague at Forest Hospital and the mental health lead.

Detention paperwork was filled in correctly, up to date and stored appropriately. The approved mental health professional's reports were on file. We were shown a Mental Health Act audit file, including two recent audits completed by Barchester's nurse practitioner. We saw evidence of assessments of capacity to consent to treatment and copies of consent to treatment forms attached to medicine charts.

There was evidence of attempts to explain rights to patients recorded in the patients care notes. Repeated attempts were recorded, although there were some inconsistency between the dates this had taken place between the two recording forms used.

Detained patients had access to an independent mental health advocate (IMHA). This contract was through an independent advocacy company, whose service supported detained patients to understand their rights, including any restrictions or conditions on them.

In one patient's bedroom, we saw a file containing a 'provision of information to detained patients and nearest relatives' form. This specifically designed form records that a patient has been given an explanation of their rights if detained under the Mental Health Act 1983 (MHA). In this case the form was being used to give the patient an explanation of their rights under deprivation of liberty safeguards (DoLS). There was also a mix of deprivation of liberty safeguards and Mental Health Act information in the patient's file. We could not understand why this information was being kept in the patient's bedroom in this format. Staff could not explain the content to us. This illustrates that whilst committed to working positively with patients within appropriate legislative frameworks there was some confusion about how to do this.

We identified a culture whereby patients were moved from a section under the mental health act 1983 (MHA) onto deprivation of liberty safeguard (DoLS). This was not appropriate. We heard from the hospital manager that when a patient came off a section under the Mental Health Act an application for deprivation of liberty safeguards was made on the same day. On further discussion, with the psychiatrist the hospital's discharge pathway was described as trying to get detained patients off their section as quickly as possible to be placed on deprivation of liberty safeguards as this was least restrictive practice.

The local authority told us they had previously expressed concerns to the hospital director about requests for DoLS assessments for individuals who were consenting to treatment or for patients needing covert medication who needed to be detained under the Mental Health Act.

During the ward round, the responsible clinician discussed discharging a patient detained under section of the Mental Health Act and then possibly applying deprivation of liberty safeguards because this was perceived to be the least restrictive legal regime. None of the staff present at the meeting challenged this.

We were concerned that this reflected an inappropriate understanding of the two legal regimes and was at variance with current Mental Health Act Code of Practice 13.58 guidance which states:

The choice of legal regime should never be based on a general preference for one regime or the other, or because one regime is more familiar to the decision-maker than the other. Such considerations are not legally relevant and lead to arbitrary decision-making. In addition decision-makers should not proceed on the basis that one regime is generally less restrictive than the other. Both regimes are based on the need to impose as few restrictions on the liberty and autonomy of patients as possible. In the particular circumstances of an individual case, it may be apparent that one regime is likely to prove less restrictive. If so, this should be balanced against any potential benefits associated with the other regime.

Decision-makers should not therefore proceed on the basis that one regime generally provides greater safeguards than the other. However, the nature of the safeguards provided under the two regimes are different and decision makers will wish to exercise their professional judgement in determining which safeguards are more likely to best protect the interests of the patient in the particular circumstances of each individual case.

Good practice in applying the Mental Capacity Act

Mental Capacity Act (MCA) training was included with deprivation of liberty safeguard (DoLS), safeguarding and duty of candour as mandatory each year. Four out of five (80%) nurses and 18 out of 23 (78%) care staff had completed this. However, whilst being able to articulate the principles of the act understanding was poor in relation to the application of the Mental Capacity Act in practice.

The trainer delivering the Mental Capacity Act was not confident in their ability to answer all the questions raised from practice. For example, they did not know how to advise support workers raising questions about delivering day-to-day care to patients. The training slides we viewed, which included DoLS and duty of candour, seemed a little confusing. It was not clear if there was an individual within the wider organisation where staff could get advice regarding the Mental Capacity Act including deprivation of liberty safeguards.

Staff seemed confused about the two different policies the provider had. The Mental Capacity Act (MCA) policy required an update and the Deprivation of Liberty Safeguards (DoLS) policy was in date until August 2016. The Mental Capacity Act policy referred to 'decisions under the act include those to be made about matters of personal health, consent to medical intervention, care, general welfare and finance'. It does not refer to everyday decision making which impacts on the day-to-day care of patients.

Staff had an understanding of the five principles of the mental capacity act (MCA) and could refer to policies. Not all staff had fully embedded the application of the Mental Capacity Act in their practice. Staff were able to say what the abbreviation DoLS stood for but unable to differentiate or articulate what least restrictive approaches were. Staff believed there was a culture of applying best interests in patient care.

Patients appeared to be supported day-to-day with decision-making and staff spoke of routinely involving patients in their care. Staff gained verbal permission for interventions in the moment where possible; however, we heard confusion about the differences between this and informed consent. During a discussion about gaining patients' consent, the responsible clinician gave us a smiley/sad face document he advised us he had devised to assist in this process. The occupational therapist told us he had never seen this document before, nor did we find any completed copies in patients' notes.

We saw best interest assessments for significant decisions, but the narrative as to how the assessment was conducted was not evident from the documentation seen. During the ward round the responsible clinician made and documented a best interest decision with no input from relatives or an advocate. No staff present challenged this. We were told by staff that family or other carers were given a copy of the record of major decisions based on the best interests of a patient who lacks capacity. None of the carers we spoke to were aware of this.

The consultant psychiatrist, took the lead completing capacity assessments. Capacity to consent was assessed and recorded. However, a tick box form was used without any narrative about how the assessment was undertaken or how the decisions had been reached. It was not clear from the records we saw what assistance was given to patients to help them make their own decisions.

The Mental Capacity Act Code of Practice 5.15 states that: 'any staff involved in the care of a person who lacks

capacity should make sure a record is kept of the process of working out the best interests of that person for each relevant decision.' A record should remain in the patient's file setting out: how the decision about the person's best interests was reached; what the reasons for making the decision were; who was consulted to help work out the best interests and what particular factors were taken into account.

There were five Deprivation of Liberty Safeguards (DoLS) applications made between June and November 2015. We were told any Deprivation of Liberty Safeguards applications required for patients at the hospital had been submitted or were waiting for authorisation in accordance with the legislation.

We did not see evidence of any audit or other process in place to monitor adherence to the Mental Capacity Act.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

Staff knew patients well, and responded to their needs. The four patients we spoke with were positive about the staff and the care they received. They believed the staff knew them well and understood their likes, dislikes and needs. Their physical health needs were being met and their privacy maintained. Drinks were always available and the food was good. Some patients had concerns there was nowhere peaceful to be and relax, especially in the wintertime when access to the outside spaces became more limited. For patients far from home the absence of visitors could be upsetting.

For patients less able to talk with us we observed interactions with staff. Staff treated individuals with respect offering genuine caring interactions. Staff offered reassurance and support to patients who were showing signs of distress. Patients received dedicated time with staff, talking or engaging in activities.

Patients could access their rooms, some requiring the assistance of staff, when they wanted to. From lounges on either side of the ward, an outside garden area with seating was available. To leave the ward, a code was required to open a keypad lock. The numbers of the code were written within a butterfly adjacent to the door.

Three members of the inspection team observed lunchtime that took place in three different areas of the ward, the dining room, the dining area within the female lounge and the male patients lounge. There were a number of patients requiring significant assistance with eating and drinking, with enough staff available to give this.

In the main dining room, there were tables laid with cloths and cutlery. Wine glasses on the table remained in situ throughout, yet un-used created a visual expectation of something that did not happen. Dining chairs with or without arms were available, and the floor was easy clean. There were menus on each table with days and meal choices however, the print was small and unlikely to be easily understood by the patients.

The number of patients eating in this dining room was low, in spite of this being an area that would promote association with mealtimes. The largest group of patients eating did so in the men's lounge; we were told they had all declined a move into the dining room. Both patients in the ladies dining area ate at the table at their own pace.

Staff assisting patients wore aprons. Each patient had the correct consistency and choice of food for lunch. Staff were attentive and ensured communication with patients throughout the mealtime.

We collected feedback from five carers at a focus group, by telephone and during the inspection on the ward. Carers found the support staff friendly and caring, but some found some nursing staff could be unapproachable, particularly when busy. However, they spoke highly about the care their loved ones received and were reluctant for them to move on from Castle Lodge.

The carers we spoke to said they would approach staff with concerns they had, all knew who the hospital director was should a concern need to be escalated. Lack of communication following changes was the most difficult issue identified by carers. An example of this was when visitors could no longer see their loved on in the main lounge.

The provider submitted a privacy and dignity policy ahead of inspection. Staff awareness of the policy was low however; we saw patients treated with privacy and dignity thought our inspection.

The involvement of people in the care they receive

Admissions to Castle Lodge were planned, with pre-admission assessments completed that were shared with staff, including those on nights, ahead of a patient arriving on the ward. We saw evidence of involvement from patients and carers in initial assessment and care planning.

Following admission there was little evidence of ongoing participation of patients or their relatives in care planning. Care plans recorded that patients would be encouraged to maintain their independence where possible.

Whilst invited to formal care programme approach (CPA) meetings, representation of patients, their relatives or an advocate at ward rounds was rare.

Staff orientated patients, and where possible their relatives, to the ward. We were told one family had not been able to see the ward because the hospital director had not been available to do this. It was not clear to the relatives concerned why the staff on duty could not fulfil this role.

Each patient had his or her own bedroom that could be personalised. For patients with an organic illness, since spring 2015 person centred memory boxes had been encouraged outside each bedroom. We were told family and friends had been involved alongside patients in creating these.

A local advocacy service, Cloverleaf provided access to advocacy services for patients at Castle Lodge. A document and a poster were seen detailing the key facts about independent mental health advocacy. Staff and the hospital manager assured us that they referred to Cloverleaf when required. We saw evidence in notes of detained patients having access to an independent mental health advocate (IMHA). Whilst some best interest meetings held had involved family, it was less clear that patients who required this had had access to an independent mental capacity advocate (IMCA) when capacity or best interest decisions were made.

At the time of inspection, patients and carers had no formal involvement in decision making about the service they received. It was an aspiration of the hospital director that patients would help recruit staff in the future. Patients from Castle Lodge did not currently participate in local patients groups.

The hospital director had a strong presence on the ward where she asked individuals about what they would like. We saw minutes with pictures, from community meetings held in August, September and October 2015. These contained information about: support from staff; the visibility of the hospital director; activities; catering; housekeeping and anyone due to visit the hospital.

The hospital director had disbanded the carers group whilst setting up other forums early in 2015. Carers who had known this meeting spoke of missing the support it gave. The hospital director had heard this and was considering reinstating this group.

We saw minutes of residents and relatives meetings from March and August 2015 that two relatives attended. The meetings chaired by the hospital director had standing agenda items: food, hospitality, laundry, care plan, communication, maintenance, activities and any other business.

Staff told us that advanced decisions were discussed with patients and relatives when possible. The forms to record advanced decisions were primarily tick boxes with little room for narrative.

In a patient's record on an appropriately completed best interests form about a specific intervention, we found in response to the question 'is there an advanced decision/ statement?' a written statement. It said 'there is a DNR in place', we could not find a do not resuscitate (DNR) form, mental capacity assessment or best interest form regarding this. We asked the nurse in charge to find any of these documents for us but they could not locate the documentation. This meant that staff might not resuscitate a patient in the belief that they followed an instruction, where there was no evidence of due process in place.

We looked at the care plan of a different patient who was detained under the Mental Health Act 1983, the do not resuscitate form did not appear to be correctly completed. The form did not indicate why the patient could not be involved in the decision not to resuscitate, nor had the doctor responsible for the patients care signed it.

Requires improvement

Wards for older people with mental health problems

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

Requires improvement

Access and discharge

The bed occupancy at Castle Lodge independent hospital reported figures over the six-month period June to November 2015 were an average of 76%. When a patient went on leave, other patients never used their bed at Castle Lodge.

The hospital did not submit any information regarding referral, assessment or admission times. When we checked with the responsible clinician, we heard there was no clear criteria for admission to nor discharge from the service.

On discussion with the hospital director, it was clear that the hospital only took planned admissions. Pre-admission assessments took place to check Castle Lodge could meet specific patient needs. When completing a pre-assessment consideration was given to patient mix. The hospital director could refuse an admission if a referral was not appropriate.

Beds for the catchment area were available if needed. Three patients out of nine were from out of area placements, this had potential difficulties for regular contact with their families. Involvement of patient care co-ordinators at meetings could also be more difficult for patients from out of area.

For patients admitted to Castle Lodge, discharge planning had not commenced on admission. There were no clear care pathways for patients admitted to Castle Lodge. Discharge plans were not evident in patient's notes. The hospital and divisional directors told us the provider was looking at creating a pathway for patients across a number of their services in the local area. There was little detail about how this care pathway would work however, consideration was being given to a step-down provision to meet the needs of patients admitted for rehabilitation for whom finding suitable supported accommodation was particularly difficult.

At the time of our inspection, four patients at Castle Lodge were awaiting discharge. The lack of suitable alternative placements was the reason given for these patients remaining at the hospital. When discharge was successful, older patients had moved on to care homes able to meet their mental health needs. There had been an additional delayed discharge when a placement had been secured for a patient who was then unable to move as planned due to deterioration in their physical health.

The facilities promote recovery, comfort, dignity and confidentiality

Both wards had large separate lounges with windows overlooking gardens. The gardens were separate and accessible. On the male side of the ward was a quiet room at the end of the corridor. Male patients wanting to get away from the communal lounge area where the noise level was high could use this. The female patients we spoke to said they had never used this room, nor would they wish to as it was located at the far end of the male ward. If they wanted quiet they would use their own room or the garden area.

The dining room had facilities to make drinks and snacks 24 hours a day. This room was locked when not in use to prevent the risk of someone scalding themselves on the hot water boiler.

The clinic room did not have an examination couch; when a physical examination was required, patients were examined in their own bedroom. Blood pressure monitoring equipment and scales were available in the clinic.

Patients could go to their room for quiet and privacy. The bedrooms had personalised door signs. Patients or their relatives were able to personalise individual bedrooms.

Bedrooms could be locked and patients given keys, following a risk assessment. Individuals' rooms also had lockable drawers or cupboards. It was unusual that patients had their own key. Previously when keys had been given out, staff told us they were lost. One patient said they did not want a key because everything was safe. Carers had spoken about difficulties with personal items going missing. When reported to staff they had assisted carers to look for specific items, sometimes successfully, other times not.

Requires improvement

Wards for older people with mental health problems

There was a visitors' room opposite the ward office where patients could meet with visitors in private. If more than one visitor was on the ward there was a room just outside the ward that was sometimes available, or if appropriate visitors saw patients in their bedroom.

Patients could make private phone calls using a large dial push button telephone in the visitors' room, or one of two ward telephones available free of charge.

Food was seen as important, a priority for patients. Staff knew patients dietary preferences and needs. Patients made choices about their own food and were supported to eat and drink regularly. Patients could have drinks and snacks made throughout the day and night. The quality and choices of food were on the agenda of both the community and resident/relatives meetings. The verbal feedback we received from patients and their carers about food was positive.

Patients who were physically able to could, if they wished to go out of the hospital. Other patients could only leave the hospital site when accessible transport was available. The bus was available to Castle Lodge one day in seven and there was only one driver in the hospital, this meant patient access to this transport was less than weekly.

During ward round, we heard blanket statement from the responsible clinician that 'no one can go out in case of getting unwell due to bad weather'. This did not refer to individual patient needs or preferences.

The occupational therapist wrote activity guidance, which included level of activity and patient preferences. Activities took place in patient lounges, outside the ward and occasionally in patient bedrooms. Alongside the activities co-ordinator, support staff delivered activities, which included one to one and group sessions with patients.

The aim of the activities programme was to provide stimulation and social engagement for all patients. We saw activities delivered by care staff in a person centred way. The activities were leisure focussed; they did not focus on maintaining independence through activities of daily living.

Caring staff who knew patients well supported patients, at times doing things for them they may have been able to achieve themselves. Whilst patients liked this, it meant missing opportunities for rehabilitation.

Patients and staff saw trips out from the hospital as positive. However, we heard frustration with the limited availability of accessible transport and need to return to the ward for medication.

Staff had voiced concern about activities being available primarily during the week but not at weekends. At the time of the inspection the activities co-ordinator had begun to work alternate Saturdays to address this.

Meeting the needs of all people who use the service

In spite of some patients having complex physical needs all the crockery and cutlery we saw at mealtimes was generic. If following individual assessment adaptive crockery and cutlery were in use, patients may be more able to eat independently.

The hospital was all on one level and most doorways were wide enough for disability access. However, it was not possible for a wheelchair user to access the garden from the ladies lounge area without support from staff.

We saw specialist equipment including a wheelchair with pressure relief and an electronically adjustable bed in situ for patients who needed them. Air mattresses to help prevent pressure sores were in place, with crash mats on the floor.

Each bedroom had an accessible en suite shower room. However, there were no hose attachments for the showers, which meant staff could not support a patient to shower without getting very wet themselves. This meant staff had a reluctance to support patients to use the shower rooms, preferring to assist patients to bathe.

A number of shower rooms did not seem to have been used for a lengthy period of time. One was a storage area for belongings. We were particularly concerned that for this patient, staff may unwittingly be undermining the patient's ability to wash independently which may become problematic at the time of discharge.

An assisted bath was available on both the male and female sides of the hospital ward, to support patients to bathe. These bathrooms were in regular use, even when a patient's preference identified in the care plan was to take a shower. Hoists were available, in use and tested.

Notice boards displayed information about detention in hospital and advocacy. There were easy read versions available. We saw a nineteen page 'information for

patients' booklet containing a breadth of information about the hospital. Whilst holding useful information for carers and some patients, this would not have been accessible to many of the current patients on the ward.

We saw no leaflets translated into different languages but were assured that if there was a need, this would be done. Staff were confident that through the office interpreters or signers could be found if required.

The head chef worked closely with staff to ensure that specific dietary needs were met, for example patients on the ward requiring a diabetic diet. There was an awareness of patient's likes and dislikes, and where possible these were catered for. The chef was clear that he had access to a range of food in the kitchens to meet the dietary requirements of religious and ethnic groups.

Staff told us they would support individuals to meet their spiritual needs if requested to do so, and that links to local chaplains and churches were available to individual patients. We heard from one patient they had been supported by staff to attend church.

Listening to and learning from concerns and complaints

Patients and carers told us they would complain verbally to the hospital director if they had a complaint about something within the hospital. If they needed to complain about the hospital director, they were not sure who to go to within Barchester Healthcare. Information about contacting the Care Quality Commission was at the entrance to the ward.

We saw no formal complaints within the pre-inspection data submitted by the provider. There was a comments and complaints book on the ward and a more formal comments and complaints folder in the hospital director's office. Staff told us that when comments or complaints were made in the ward book, the hospital director dealt with these directly.

Castle Lodge provided the folder of comments and complaints for our team to review. It contained four complaints from carers, one from a professional, one compliment and one confirmation of a pharmacy contract cancellation.

There was no evidence in the complaints folder that the face-to-face discussions we were told had happened in response to complaints were recorded. Nor did we see any evidence of lessons learned. Staff did not receive feedback on the outcome of complaints.

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

Requires improvement

Vision and values

Barchester Healthcare Homes Limited had a mission statement and eight values:

- Do what is important
- Work together
- Respect, support and strive to improve the communities they serve
- To be honest, fair and ethical in everything
- Recognise and appreciate individuality
- Accept responsibility for their actions
- Make life and work meaningful and enjoyable for all
- To support and encourage initiative and creativity
- To focus on an individual's ability and aspirations

We found limited knowledge of these with staff unable to describe the values. We saw no reference to the vision and values within the hospital and found no evidence that senior managers framed the work of the hospital around these or the mission statement.

Most staff were positive about the hospitals physical move to what they described as larger premises. However, a number of staff discussed uncertainty and anxiety about the direction for this hospital in the future. Hull Clinical Commissioning Group had raised concerns that the hospital needed to have clear plans to meet the needs of a specific patient group over a year ago. The provider hoped a clear direction and the development of a patient pathway would be part of this move.

The planned move of Castle Lodge to the Castle Green site had secured building development funding within Barchester. This meant funding was in place to ensure the building was fit for purpose ahead of any relocation.

Requires improvement

Wards for older people with mental health problems

The staff team knew the divisional director who visited the ward when at Castle Lodge. The hospital manager was very involved in care on the ward. Staff, patients and carers all knew her. Her presence had been high profile in the absence of a clinical lead.

Good governance

Castle Lodge was part of Barchester's complex care and independent hospital services division. We saw clear governance structures in place. Every two months a clinical governance meeting was attended by the hospital director, consultant psychiatrist, occupational therapist, a staff member and when possible a patient representative and a local general practitioner. Issues raised were fed into a divisional clinical governance meeting held alternative months. The divisional director had responsibility to escalate any issues concerning Castle Lodge.

The hospital director reported to the divisional director, however additional support was available from peers at other hospitals. It was hoped that in the near future a divisional clinical lead would be appointed to provide specific clinical support to managers and staff. The hospital director felt confident she had the authority and administrative support to fulfil her role. She was very committed to the positive development of the hospital. However, she had been striving to fulfil her own role and whilst offering additional support to cover the role of clinical lead since the summer of 2015.

Information systems at Castle Lodge independent hospital were a mix of paper based and computerised. For some statistics, for example training, it seemed it had been difficult to collate this information to ensure accurate reporting.

The staff files we reviewed were easy to navigate. They contained personal information, including next of kin and for most a photograph. We saw the employee's original application form, job description, details of contract and probationary period sign off. Within these files we saw appraisal, bi-monthly managerial supervision and individual training and development records documentation.

When we visited in August 2015, there had been two qualified nurses in the clinical area. During this inspection the rotas showed one qualified nurse in the clinical area most of the time. There was a difference of views between the qualified staff and the hospital director. The staff nurses felt overburdened by the clinical workload on a 12 hour shift. Their particular concern being they spent too little time with patients to ensure appropriately planned care was taking place. The hospital director who calculated staffing using Barchester's dependency tool, believed there to be enough staff on the ward. In terms of number of people, the qualified nurses agreed with their manager that there were enough staff however, they felt unheard about the skill mix required to nurse this complex patient group effectively.

The divisional and hospital directors recognised concerns about the level of cover from the responsible clinician and were working towards changing this. We also heard acknowledgement that the development of a multi-disciplinary team was important for patients at Castle Lodge.

We found issues with the pharmacy contract in place since October 2015 that had not been picked up. Whilst these were resolved during the time of the inspection, this highlighted the need for strong clinical leadership in addition to management at Castle Lodge. Across the complex care and independent hospital services division the divisional director had planned a pharmacy review was to take place in the near future with the aim of ensuring safe and consistent practice.

Every two months quality first visits undertaken by external senior staff provided the provider with oversight of the hospital. This included specific planned audits, for example in January/February 2016 a nutritional quality audit had been undertaken at Castle Lodge as part of this process. We asked to see the reports for Castle Lodge from the visits in October and December 2015 but were given a generic update of the quality assurance processes. Castle Lodge Independent Hospital had not been involved in any external clinical audit.

Whilst the reporting of incidents took place, there were no structures to ensure staff and managers received feedback. We did not find lessons learned from incidents or complaints.

Staff knew about safeguarding procedures and reported to the local authority as required. There had been an issue that meant notifications reported through to the care quality commission had not been received. It was unclear how this had happened however, this issue was subsequently resolved to allow effective monitoring by the

portfolio holder. Compliance with the administration of the mental health act paperwork was good and we saw the development of a staff member to ensure more local administration at Castle Lodge. The mental capacity act training and application required more oversight; although training compliance was high this had not ensured staff had the level of understanding required in practice.

Most of the provider's policy documents were overdue review at the time of our inspection. This should have taken place by 1August 2015. The divisional director was fully aware this overview was outstanding. She was able to tell us funding had been secured for an external company to re-write these documents in line with current legislation commencing in March 2016.

The hospital was unable to provide a local risk register and it was unclear how risk was monitored. We reviewed clinical governance meeting minutes, these did not have risk management as an item on the agenda.

Castle Lodge Independent Hospital stated that they did not have risk register arrangement within the company, but the health and the corporate health and safety team coordinated safety. This team conducted monitoring visits and audits in addition to providing a comprehensive risk assessment manual and policies.

We saw minutes from Castle Lodge's monthly health and safety committee meetings with reference made to the need to invite the health and safety co-ordinator quarterly to this meeting. We saw a health and safety statement and other required statutory notices displayed in the reception area of the hospital. We observed visitors signing in and out, and a contractors signing in book in place.

The provider had offered a bonus, to be shared with staff, if Castle Lodge achieved required levels for six identified key performance indicators including training. We found management and staff happy to engage in this process.

Leadership, morale and staff engagement

Castle Lodge submitted employee staff survey results from June 2015. The survey was conducted at an organisational level and did not specifically highlight the responses for Castle Lodge. During the inspection we requested for these results to be filtered down, but these were not provided.

Staff turnover in the six-month period June to November 2015 was 16%, with a sickness rate of 4%. The only post where recruitment had not taken place was the clinical lead. There had been no disciplinary action since the arrival of the current hospital director at Castle Lodge.

There was information on whistleblowing with an external phone number and reference to Barchester's policy and procedure for staff. The document detailed contact information for reporting any potentially unsafe conduct. The staff we spoke to were also fully aware they could raise concerns directly through CQC. There had been three whistleblowing concerns in 2015, which had led to investigations by the provider, Hull clinical commissioning group and a responsive inspection by CQC. Two staff said they would be concerned to raise an issue internally for fear of victimisation.

Staff morale varied across the hospital. The qualified nurses clearly felt the absence of a clinical lead not only in additional workload but also in terms of clinical support and direction. Support workers on day shift enjoyed positive relationships with patients, carers and each other. They focussed on delivering care but were somewhat separate to the nurse in charge. The night staff spoke of being a happy team, liking their work and being supported by the nurse in charge. They also valued increased direct communication with them in recent months, both from the hospital director and the training administrator.

Some staff spoke of the hospital director being overly involved and defensive if challenged. Staff 'knew' they would never win any argument. We witnessed the dismissal of a professional opinion during inspection. We also saw high levels of commitment to make things right. Other staff spoke of receiving support from the hospital director and believed the future would be clearer under her direction. None of the staff we spoke to had considered raising their concerns or praise with the divisional director.

The cleaning and housekeeping staff felt valued and an important part of the hospital team. The team worked to support each other, and if needed would be able to raise concerns. They were supported by management and had access to the resources needed to complete their work. The head chef spoke of positive communication with staff on the ward.

Staff understood their responsibility in relation to duty of candour and described being open with patients and their

carers when things go wrong. Carers believed they were informed if something was amiss. However, we were concerned to hear of an incident when a staff member had discussed something with relatives that had not gone smoothly being subsequently 'told off' by the hospital director for raising it with them.

Staff employed at the hospital for a lengthy period of time reported having twelve managers in six years. Whilst believing they were flexible and able to change, they hoped for clarity of direction and consistency. They recognised that having the same hospital director for nearly a year had already offered more consistency. Aware that changes were likely when the ward moved into different premises, but not knowing what these would be was unsettling for staff.

Commitment to quality improvement and innovation

Castle Lodge Independent Hospital plans to be involved with Accreditation for Inpatient Mental Services (AIMS) accreditation in the future.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

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

Action the provider SHOULD take to improve

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

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 How the regulation was not being met: Patients did not follow a care pathway which incorporated discharge planning. This was a breach of regulation 9 (3a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: There was a lack of understanding about the application of the Mental Capacity Act 2005 in practice. Capacity to consent and best interest decisions were not comprehensively completed. Where assessments had been completed we saw limited evidence that family members were involved. Formal Mental Capacity Act documentation was available, but the narrative as to how the assessment was conducted was not evident within this documentation. This was a breach of regulation 11(2)

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The hospital had no risk register in place, to list, monitor and rate any identified risks across the hospital. This was a breach of 12 (2b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Due to the complex systems in place the medicine folder for each patient contained a great deal of paperwork increasing the risk of a medicines error. There was a lack of guidance for staff to refer to for a pharmacy system introduced in October 2015. The system to dispose of pharmaceutical waste meant three full bins of waste medication remained uncollected within the locked clinic room. This medication was not fully secure as it was outside the cupboard on the clinic floor. This was a breach of regulation 12 (2g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Only 15 of 33 (45%) staff had completed infection control training in the past year. Within the clinic room we saw issues which increased the likelihood of cross infection occurring. This was a breach of regulation 12 (2h)

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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 How the regulation was not being met: 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)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met:Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Shifts with only one qualified nurse on duty were frequent, this was low in a hospital environment with a mix of patient needs. Qualified staff numbers were increased on days when meetings took place, however this did not always happen when the diary was busy. Nurses were unable to take a break in a 12 hour shift when they were the only nurse on duty and needed to call a nurse from elsewhere on the site to administer controlled drugs. The hospital director had a presence on the ward to cover gaps, however she was not a clinician and this took time away from her managerial duties. When the door to the female side of the ward was shut, support workers were concerned that at times they were lone working and therefore potentially vulnerable. There was a lack of onsite cover from the responsible clinician. He visited the ward each week on a Tuesday for 4 hours. In addition, he provided telephone cover to the

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hospital from Billingham 24 hours a day, 7 days a week. The hospital director accepted the current level of cover from the responsible clinician was not sufficient or flexible enough to ensure patient's needs were met fully.

This was a breach of regulation 18 (1)