Lakeside View

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

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

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

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

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

Overall summary

- Governance systems at the service were not embedded or working to ensure continuous monitoring of quality and service improvement. Audits we reviewed for care note quality, ligature point checks and cleaning of the service, in all examples requested there were significant gaps.
- Risk assessments of patient need were not routinely updated following every incident or significant change to their wellbeing.
- Bedrooms in use by patients were not always fitted with necessary security or observation facilities. We found that where anti-barricade systems were in place, staff were unfamiliar with their use and were unable to demonstrate how to operate them.
- There was inconsistent use of the electronic record keeping system. Some senior medical staff reported that they were unable to access the system and instead documented their clinical entries using other staffs log in details, or had them typed up on paper and placed in a paper file.
- We found limited evidence of the use of debriefs following significant incidents, or a process for sharing and learning lessons to reduce future risk. Staff reported that debriefs happened in isolation, followed an inconsistent format and were not routinely recorded.
- Practices for the storage and dispensation of medication did not always ensure patient safety. We

Summary of findings

were given an example of a patient who had recently accessed the clinic room and obtained un-prescribed medication. We were not provided with any details of actions taken by the service or lessons learnt as a result of the incident occurring.

- Blanket restrictions were in place across both wards. There had been no consideration of the use of individualised risk assessments to support patients access facilities for activities of daily living.
- Morale amongst staff at the service was varied. Staff did not always wear the appropriate uniform and we were given examples where staff groups had chosen to work hours that were not in line with their contracts or the needs of the service.

Summary of findings

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Lakeside View

Services we looked at:
Acute wards for adults of working age.

Summary of this inspection

Background to Lakeside View

Information about the service:
Lakeside View cares for men and women with mental health needs in both an acute setting and a locked personality disorder treatment and rehabilitation setting.

The hospital has 32 beds comprising of 16 personality disorder rehabilitation beds and 16 acute mental health beds. During our responsive inspection of this service, only the acute mental health wards were reviewed.

Lakeside view is registered with the CQC to provide the following regulated activities:

- Assessment or treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Treatment for disease, disorder and injury.

Aims of the acute service:
The acute service provides dedicated mental health treatment for young women, aged 18 – 25 years and men of working age, across two separate buildings, separated by gender. Lodge ward is for male patients and Chestnut ward for female patients.

Lakeside states their aims to:

- Act as an extension to NHS care pathways during times of fluctuating capacity and flow.
- Allow more people to receive care and treatment closer to home.
- Provide continuity of care.
- Allow for minimum disruption to patients and their loved ones.

Summary of this inspection

Referral criteria:

- Women aged 18 - 25 years
- Men aged 18 - 65 years
- Mental illnesses and/or personality disorders
- Challenging behaviours, including self-harm
- Informal or formal patients detained under the Mental Health Act , subject to Ministry of Justice Restrictions or Deprivation Safeguards
- Requiring a period of stabilisation before commencing their rehabilitation programme
- Needing a safe and secure therapeutic environment to reduce risk to themselves and/or others and build the skills for independence
- Requiring structured treatment with the right balance between therapeutic and social activities

Previous inspections of this service:

Lakeside view was previously inspected by the CQC in 2016 and received an overall rating of good. However, the acute wards for adults of working age had not been commissioned at the time of the 2016 inspection and had been provided by the hospital from January 2018.

Summary of this inspection

Registered manager:
At the time of our inspection in July 2018, a registered manager was in place at the service and had been since 2016

Our inspection team

The team that inspected this service comprised two CQC inspectors.

Why we carried out this inspection

We inspected this service as a focused visit to follow up on concerns highlighted during a Mental Health Act review visit on 19 and 20 July 2018. Prior to this visit the CQC had also received notifications from the provider about an increased number of incidents on the acute wards. Concerns raised from the Mental Health Act review visit included poor care planning, lack of therapeutic focus, medication errors, high use of agency staff, in unprofessional staff behaviour and issues with leadership.

Focused inspections do not look across a whole service at all five key questions; they focus on the areas defined by the information that triggers the need for the focused inspection. On this visit, we examined areas within the safe and well led domain.

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?

During the inspection visit, the inspection team:

- looked at the quality of the ward environment and observed how staff cared for patients.
- spoke with four patients using the service.
- spoke with fifteen staff members including the consultant psychiatrist, nurses, support workers and allied health professionals.
- looked at twelve care and treatment records.
- reviewed a range of policies, procedures and other documents relating to the running of the service.

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?

We rated safe as requires improvement because:

- Bedroom doors and windows were not always fitted with appropriate security or observation facilities. Multiple anti barricade systems were in use on bedroom doors and staff were not able to explain or demonstrate how they would be used in an emergency.
- Ligature risk assessments, cleaning records and patient risk assessments were not in date or fully completed by staff. Audits to provide assurance that assessments were taking place had not been completed routinely and action plans had not been developed to drive service improvement.
- Out of hours medical staff were not consistently using the provider electronic record keeping system to clerk new patients in to the hospital. We found examples where medical staff had used nurse log in details or provided admission summaries typed and stored in a paper folder.
- Blanket restrictions were in place preventing patients from using kitchen facilities to make hot and cold drinks and snacks. There had been no consideration of the use of individual risk management plans to support patients in maximising their independence.
- Safe medication storage and handling was not routinely followed by staff. This meant that patients at the service were able to access non prescribed medication.
- Debriefs and learning from incidents did not routinely happen and changes were not made to ensure patient safety. Senior leaders at the hospital had not considered analysis of incident data although incident reporting figures were significantly different between the two acute wards.

Are services effective?

This key question was not reviewed or rated during our responsive inspection of this service.

Are services caring?

This key question was not reviewed or rated during our responsive inspection of this service.

Are services responsive?

This key question was not reviewed or rated during our responsive inspection of this service.

Summary of this inspection

Are services well-led?

We rated well-led as requires improvement because:

- Most staff at the service reported that they felt the hospital was isolated and lacked oversight in comparison to the providers other locations across England.
- Governance systems at the service were not always in place or working to provide quality assurance and improvement. We found multiple examples where audits had not been completed and actions required to ensure patient safety had not been undertaken. This included ensuring risk assessments were complete and in date and ensuring that the hospital environment was safe and clean.
- Morale amongst most staff we spoke with at the service was varied. Most staff reported that their workload was stressful and that risk assessment of patient need was a concern due to patients being routinely admitted out of hours and only staying on the ward for a short period.
- Staff expressed concerns that when issues had been raised with senior leaders at the hospital actions were not taken as a result. This included lack of building safety and security and the use of blanket restrictions.
- Some staff at the service were wearing the previous providers uniform and corporate branding despite the hospital being under the management of The Priory Group.
- Housekeeping staff worked hours in variance to their contracted or needs of the service. This was raised with the providers senior leadership team following our inspection of the service.

Detailed findings from this inspection

Acute wards for adults of working age and psychiatric intensive care units

Safe	
Effective	
Caring	
Responsive	
Well-led	

Are acute wards for adults of working age and psychiatric intensive care unit services safe?

Safe and clean environment:

- The ward layout did not enable staff to observe all parts of the ward. On Lodge Ward we found two rooms had recently been commissioned for use as patient bedrooms, one of which had previously been in use as a clinic room and did not have an observation panel in the door. This would prevent staff from checking on patient wellbeing or to carry out night time checks without disturbing them. We raised this with senior staff at the service at the time of or inspection who were unable to provide details on why the bedroom was continuing to be in use, or what plans were in place to mitigate the lack of observation window.
- Ligature risk assessments had been completed for 22 clinical areas on Lodge and Chestnut Ward in the month prior to our inspection. Risk assessments identified areas of potential risk, mitigation in place to reduce risk and a checklist to be completed before the audit was submitted. However, 21 of the 22 checklists reviewed were blank and could not evidence items including two senior staff having been responsible for sign off or that the ligature point and room designation had been accurately rated.
- Bedrooms on Lodge and Chestnut Ward were on the ground floor, and mesh was used to ensure that contraband items including alcohol, weapons or illicit substance could not be passed through bedroom windows and into the ward environment. However, in one bedroom on Lodge Ward, staff alerted our inspection team that mesh was not in place and had not been for a number of weeks. Staff reported that this had been raised with senior staff at the hospital but actions had not been taken as a result.
- Anti barricade doors were in place on both acute wards. However, on Lodge Ward, two types of anti barricade mechanisms were in use and all staff were not familiar or able to demonstrate how they could be used to ensure patient safety. This meant there could be a delay in providing care and support to a patient who had chosen to restrict staff access to their bed space.
- Cleaning records were not maintained and up to date on Lodge Ward. During the month of July 2018 prior to our inspection ,records were complete for nine out of a possible 27 days. This meant that assurance could not be gained that the hospital had been cleaned in line with scheduled plans.

Safe staffing:

- As of July 2017, Staffing establishment levels for whole time equivalent qualified nurses on Chestnut ward was 7.2, and there were three vacancies. Staffing establishment levels for whole time equivalent nursing assistants was 10.4 and there was one vacancy. Staffing establishment levels for whole time equivalent qualified nurses on Lodge ward was 7.2, and there were three vacancies. Staffing establishment levels for whole time equivalent nursing assistants was 7.2 and there was also one vacancy.
- During the period May 2018 to July 2018, a total of 503 shifts were filled by agency staff to cover an increase in patient need, staff sickness, absence or vacancies, there were no shifts left unfilled during this time period.
- Out of hours medical cover for the service was available via medics employed by the provider or an agency. However, during our inspection we found that medical staff admitting patients outside of core hours

were not always able to access the electronic record keeping system in place at the hospital. On Lodge ward, four out of the six patients had been admitted out of hours, Medical entries were included in paper notes either in a handwritten or typed format and not uploaded to the records system, or had been included as a medical entry and entered using a member of the nursing staff's log in details. This was brought to the attention of the hospital director at the time of our inspection.

Assessing and managing risks to patients and staff:

- During our responsive inspection of this service, we reviewed 12 records relating to the care and treatment of patients. Although staff at the service had completed a risk assessment for all patients at the point of admission, we did not find that they were updated regularly and following every incident that took place.
- Of the six care and treatment records reviewed on the female ward, one risk assessment that we reviewed had recently been updated with a date of July 2018 but only with information until April 2018, three months before our inspection of the service. Recent risk events had not been included including incidents of self injurious behaviour and absconding from the hospital grounds. A further two risk assessments had not been updated by staff following patients return to the service after requiring hospital admission and treatment having harmed themselves.
- We found that four out of six risk assessments completed on chestnut ward did not evidence patient involvement or consideration of their views or strategies to keep them safe. Of the remaining two care records, one risk assessment had not been completed and one had been completed in the patients absence from the unit and not updated following their return.
- Blanket restrictions were in place on Lodge ward and patients were unable to access the kitchen available on the ward for their use to make hot and cold drinks and snacks. Staff that we spoke with reported that access had been restricted earlier in the year due to concerns about a previous patients risk of using hot water to injure others. However, this patient had subsequently been discharged from the ward and there had been no consideration of the removal of the blanket restriction or the use of individual risk management plans to support patients to access the kitchen.
- Effective medication storage and dispensing practice was not routinely followed. Prior to our inspection an incident had occurred where un prescribed medication had been accessed by a patient in a clinic room that had not been secured by staff. The patient subsequently required admission and treatment at hospital as a result.

Track record on safety:

- There had been one recent serious incident in the six months that the acute wards had been open at Lakeside view. This was under investigation at the time of our inspection.

Reporting incidents and learning from when things go wrong:

- Most staff that we spoke with were able to describe their responsibilities to report incidents and near misses using the providers electronic incident reporting system.
- During the period March 2018 to July 2018 there were a total of 137 incidents that took place across both acute wards. However 126 of these incidents took place on Chestnut ward, compared to 11 on Lodge ward. We discussed this variation with the hospital director who acknowledged the significant difference between the two wards and attributed it to a higher acuity of patients on Chestnut ward. We also raised our concerns relating to the variation in reported incidents to the providers senior leadership team who were undertaking an analysis of the data following our inspection.
- We found limited evidence of learning lessons and changes being made as a result of incidents that took place at the hospital. We requested the electronic incident reporting forms for five of the most recent incidents that had happened on Lodge and Chestnut ward and found there had been delays in submitting them to the provider by the hospital manager. We were also requested but were not provided with any information relating to actions taken as a result of the incidents or changes made to ensure patient safety.
- We found that staff were debriefed and offered support following serious incidents although staff that we spoke to reported that debriefs happened in isolation involving only the staff members involved and were not shared widely with remaining members of the multi disciplinary team.

Acute wards for adults of working age and psychiatric intensive care units

Are acute wards for adults of working age and psychiatric intensive care unit services effective?
(for example, treatment is effective)

This key question was not reviewed or rated during our responsive inspection of this service.

Are acute wards for adults of working age and psychiatric intensive care unit services caring?

This key question was not reviewed or rated during our responsive inspection of this service.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs?
(for example, to feedback?)

This key question was not reviewed or rated during our responsive inspection of this service.

Are acute wards for adults of working age and psychiatric intensive care unit services well-led?

Vision and values:

- Staff at the service reported that although the hospital director visited the wards frequently there had not been visits to the service by the provider senior management team external to the hospital. Most staff that we spoke with said that they felt the hospital was isolated and lacked oversight in comparison to the providers other locations across England.

Good governance :

- Governance systems were not always in place at the service including the completion of ligature and cleaning audits. We also found that investigations into incidents had not been completed where required and lessons learnt to ensure the safety of patients had not been implemented.
- We were not assured that the provider oversight and governance frameworks were sufficiently robust or embedded at the service. Previous quality checks by the provider had not identified issues that were found during our inspection and which had been present during audits completed by the provider quality and governance team.

Leadership, morale and staff engagement:

- Morale amongst staff that we spoke with at the service was varied. Most staff reported that their work role had been stressful in recent months due to the high acuity of patients admitted to the service out of hours, particularly on Lodge ward.
- Staff that we spoke with expressed frustration that concerns raised by them had not been acted on by senior staff at the hospital, this included concerns about security, lack of auditing and improvement of risk assessments and blanket restrictions used with patients.
- Staff that we spoke with raised concerns that leadership at the hospital was not always effective. During our inspection we found examples of staff groups working in isolation, with a lack of oversight from senior managers. Housekeeping staff at the service had chosen to work hours that suited their personal needs, rather than their contracted hours and those which suited the service. Actions had not been taken to resolve this at the time of our inspection and our concerns were raised with the providers senior leadership team.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that governance systems and audits at the service are routinely used for the monitoring of service performance and service improvement.
- The provider must ensure that all bedrooms are fitted with appropriate safety mechanisms and that staff are familiar with their operation.
- The provider must ensure that all staff are able to access the hospitals electronic record keeping system.
- The provider must ensure that blanket restrictions are not in place without due cause and that patients receive individual risk assessments to maximise their independence.
- The provider must ensure safe procedures are in place for medication storage and dispensation.
- The provider must ensure that debriefs are routinely completed following incidents and that lessons learnt are communicated effectively with the clinical team to reduce risk of reoccurrence.

Action the provider SHOULD take to improve

- The provider should ensure that all staff work within contracted hours and wear correct uniform.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Governance systems at the service were not embedded or working effectively to ensure continuous monitoring of quality or service improvement. Medical staff at the hospital were not always able to access the electronic record keeping system. This meant an accurate, complete and contemporaneous record in respect of every service user could not be maintained. This was a breach of Regulation 17 (2) (a, b, c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not maintain accurate, complete and detailed records in respect of each person using the service. Risk assessments for people receiving care were absent or did not contain detailed and up to date information. The provider did not ensure that premises used by the service provider were safe for their intended purpose. Observation windows on bedroom doors were not always in place and safety devices were not in use on all windows. The provider did not ensure there were safe medicine storage and dispensing practices in use by staff. Debriefs did not routinely take place following incidents or actions identified and implemented by staff to reduce risk of reoccurrence. This was a breach of regulation 12 (2) (a, b, d, g)

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment Blanket restrictions were in place across both acute wards. These were not proportionate to patient need. This was a breach of Regulation 13 (4) (d)