Windermere House Independent Hospital

Quality Report

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

Ratings

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

Summary of findings

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

We rated Windermere House Independent Hospital as requires improvement because:

- Whilst a risk register document had been introduced following our last inspection, we found a no robust processes to effectively assess and manage the risks identified.
- Staff recruitment and retention was of on going concern, with turnover in the last year of 54%.
- When required to support direct patient care during what were due to be supernumerary hours, ward managers and charge nurses felt unable to complete their management responsibilities effectively.
- Compliance with bi-monthly staff supervision was 62% and staff appraisal 68%. This fell below the provider's target of 85%.
- Overall compliance with mandatory and legislative training was 69%. This was below the provider's target of 85%. For more than half of the modules staff were required to attend compliance was below 65%.
- Whilst recruitment was underway, the range of mental health disciplines in the multi-disciplinary team at the time of the inspection was limited to nursing and psychiatry.

However,

- Patients that were able to said they knew their key worker, care staff and the hospital manager, most felt staff cared, showed them respect and were polite. We saw genuine caring interactions between staff and patients.
- The hospital had adopted a positive approach to risk management. Patients had risk assessments and robust risk management plans that were individualised and updated regularly.
- Patients had comprehensive admission assessments and care plans showed assessments and reviews took place in a timely way following discussion with patients or people who knew the patient well.
- An externally validated learning programme offering courses that build on the strengths and interests of an individual was available to patients.
- Staff felt able to raise concerns without fear of victimisation, they knew about the organisations whistleblowing policy, and that they could contact external organisations.

Summary of findings

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long stay/rehabilitation mental health wards for working-age adults and a ward for older people with mental health problems.

Summary of this inspection

Background to Windermere House Independent Hospital

Windermere House Independent Hospital is a specialist independent mental health service based in Kingston-Upon-Hull. It is part of the Barchester hospital and complex care services division, which provides assessment and medical treatment for persons detained under the Mental Health Act and the treatment of disease, disorder or injury. It offers services for men with functional or organic diagnoses on an informal and a detained basis. The hospital accommodates up to 41 patients.

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

- Coniston, an 11 bed ward for men that provides slow stream recovery based care and treatment for working age men with either drug induced or treatment resistant functional mental health needs.
- Kendal, a 15 bed ward for men that provides slow stream recovery based care and treatment for men aged 50 and over who had either functional or organic mental health difficulties.
- Ullswater, a 15 bed ward that provides care and treatment for older aged men with complex dementia and mental health needs.

The hospital was registered with the Care Quality Commission to carry out two regulated activities (1) assessment or medical treatment for persons detained under the Mental Health Act 1983 and (2) treatment of disease, disorder or injury.

At the time of our inspection the registered manager, was also the controlled drugs accountable officer.

The Care Quality Commission has inspected Windermere House Independent Hospital five times; the last inspection was an announced comprehensive inspection that took place in December 2015.

Our inspection team

Our inspection team was led by Christine Barker, Care Quality Commission inspector

The team that inspected these services comprised of two CQC inspectors and two specialist advisors, a senior nurse and a psychologist with experience of working in mental health services.

Why we carried out this inspection

We undertook this inspection to find out whether Windermere House Independent Hospital had made improvements since our last comprehensive inspection of the provider which took place in December 2015 where we rated the hospital as requires improvement overall.

This was an unannounced follow up inspection.

At the last inspection, we rated the hospital overall as 'requires improvement'. We rated the service 'requires improvement' for Safe, 'requires improvement' for Effective, 'good' for Caring, 'requires improvement' for Responsive and 'requires improvement' for Well-led.

Following this inspection we told the provider that it must take the following actions to improve Windermere House:

- The provider must ensure the development of a care pathway that incorporates discharge planning.
- The provider must encase the spindles on the stairs identified as a 'high' ligature risk in October 2015.
- The provider must ensure there is an effective system in place to capture risks.
- The provider must ensure regular documented checks of medicines management are embedded into routine practice on all wards.
- The provider must ensure personal alarms are available to staff and the protocol in place is followed.

Summary of this inspection

- The provider must update both their policy and training to ensure compliance with the Mental Health Act Code of Practice that came into force in April 2015 and update both their policies Managing Disturbed Behaviour and Therapeutic Management of Violence and Aggression to ensure compliance with the Code.

We also told the provider that it should take the following actions to improve:

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

We issued the provider with four requirement notices, these related to:

Regulation 9 Health and Social Care Act (Regulated Activity) Regulations 2014

Person-centred care

Regulation 12 Health and Social Care Act (Regulated Activity) Regulations 2014

Safe care and treatment

Regulation 15 Health and Social Care Act (Regulated Activity) Regulations 2014

Premises and equipment

Regulation 17 Health and Social Care Act (Regulated Activity) Regulations 2014

Good governance

The provider submitted an action statement on 10 June 2016. We reviewed the requirement notices at this inspection and found that the hospital had addressed the specific requirements relating to regulations 9 (3)(e); 12 (2)(a); 12 (2)(g); 15 (1)(d) and 17(1).

However, we remain concerned that whilst the requirement for the hospital to have a risk register in place had occurred 12 (2)(b), the systems to monitor the identified risks had not been effectively implemented.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about this service and asked other organisations for information.

During the inspection visit, the inspection team:

- visited all three of the wards at the hospital site and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with six patients who were using the service
- spoke with seven carers of patients using the service

Summary of this inspection

- held focus groups for carers, qualified staff and support workers
- collected feedback from one patient, one carer and two staff members using comment cards
- attended and observed a care programme approach meeting and a multidisciplinary meeting
- observed activities taking place and a mealtime on each ward
- attended and observed two hand-over meetings and a hospital morning meeting
- interviewed the hospital director with responsibility for the service
- spoke to the managers for each of the wards
- spoke with 20 other staff members; including administrators, catering, doctors, housekeeping, maintenance, nurses, support workers and the divisional clinical lead nurse
- reviewed 15 care and treatment records of patients, including Mental Health Act paperwork where relevant
- carried out a specific check of the medication management on each ward including all prescription charts and physical health monitoring
- looked at a range of policies, procedures and other documents relating to the running of the service
- reviewed three staff records including details of appraisal, disciplinary issues, supervision and training
- spoke an external adult safeguarding social worker and a service commissioner.

What people who use the service say

We spoke with six patients and seven carers.

Patients that were able to told us they knew their key worker, care staff and the hospital manager. Four said they had been involved in planning their care and supported by staff to understand this.

The patients we spoke to were positive about the hospital and did not want to leave.

Most patients said staff showed them respect and were polite. One liked that staff always knocked to ask if they wanted to come in to their room. Three patients told us they felt safe at the hospital. They had their own belongings in their rooms and knew their property was safe. Four patients commented on the food, wanting more choices and a more varied menu.

Patients liked the staff especially those who had time to do activities with them. Particularly popular activities were going out shopping, to the pub and playing pool. Patients spoke of wishing they could go out more often. Within the hospital, patients liked cooking, listening to music, playing chess and some of the activity sessions on the ward.

Two patients said staff looked after their physical problems as well as their mental health. One patient liked being able to call his general practitioner to attend health care appointments locally when he found this necessary.

We heard that visiting was managed well. When visiting was not possible, patients spoke to relatives on the telephone.

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:

- Overall compliance for legislative and mandatory training was 69%. This was below the provider's target of 85%. For more than half of the modules staff were required to attend compliance was below 65%.
- Staff recruitment and retention was of on going concern, with turnover in the last year 54%.
- When ward managers and charge nurses were required to become involved in direct patient care during time planned as supernumerary they were unable to fulfil all their managerial duties.
- The cleaning rotas completed throughout the hospital showed gaps across one calendar month on 13 days due to shortages of staff, whilst efforts had been made to bring in agency staff they had been unsuccessful. Whilst the hospital appeared clean, this meant there was a greater risk of infection.
- Trolleys containing dirty laundry were stored in bathrooms.
- Barchester consultant psychiatrists that provided on-call cover for the hospital when the locally based consultant was on leave may not be able to attend in the event of a psychiatric emergency within 30 minutes.

However,

- Incidents involving the use of restraint were unusual, when a patient had been restrained this had occurred as a last resort following unsuccessful de-escalation.
- The hospital had adopted a positive approach to the risk management of patients. Each patient had a robust risk management plan.
- The hospital environment was assessed bi-monthly as part of the provider's quality first visits; health and safety and infection control audits took place monthly, all showed actions identified and reviewed.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Not all staff received regular supervision and an appraisal in line with the provider's policy that indicated a minimum of six

sessions of supervision and one appraisal each year. Only 62% of staff had received this level of supervision and 68% had completed an annual appraisal. This meant there had not been consistent oversight of staff performance.
- At the time of our inspection, nursing and psychiatry were the only mental health disciplines in the multi-disciplinary team. However, the hospital had recruited a psychologist for January 2017 and had an occupational therapy post re-advertised.
- Some patients' care plans did not contain evidence of the involvement of patients. A third of care plans had not been signed by patients and there was no information documented to explain the reason for this.
- The provider had updated their training on the Mental Health Act to include the updated code of practice however, only 55%, 43 out of 78 eligible staff had completed this training. Only 61%, 57 out of 94 eligible staff had completed training in the Mental Capacity Act.

However,

- Despite not all staff completed training in the Mental Capacity Act, s understanding of the five principles of the Mental Capacity Act and followed these; they could also refer
- Meetings that took place about patient care involved care co-ordinators for patients including those out of area. Staff used these meeting to positively focus on patients' needs and involve the patient.
- Care plans showed assessments and reviews took place in a timely way following discussion with patients or people who knew the patient well.
- Nursing staff on the wards held relevant qualifications and were experienced working with the patient groups at the hospital. Staff on the older peoples ward had trained to deliver improved dementia care.

Are services caring?

Good

We rated caring as good because:

- Patients that were able to said they knew their key worker, care staff and the hospital manager, most felt staff cared, showed them respect and were polite.
- We saw genuine caring interactions between staff and patients, staff engaged with patients in a respectful manner.
- Carers believed staff were courteous and professional. If they requested something, they found the staff responsive.
- The staff enabled carers to stay involved in the care of their loved one.

However,

Summary of this inspection

- Carers and patients knew patients' key workers however, sometimes staff turnover had meant just as staff got to know a patient their key worker changed.

Are services responsive?

Good

We rated responsive as good because:

- The hospital had referral criteria and the admission of a patient involved a pre-assessment to ensure the hospital could meet the needs of the patient.
- Following an assessment period of 12 weeks, staff, patients and their carers agreed an individual treatment plan showing targets for progression and discharge.
- Carers believed that the hospital met the needs of patients well and as a result expressed concerns about discharge.
- Staff planned and managed discharges carefully to involve patients and their relatives. There had been no readmissions to the hospital following discharges from the service.
- Patients on each ward had access to quiet areas and a garden. The hospital had activity spaces on and off the wards and we saw activities took place seven days a week.
- Staff facilitated visits well, when visiting was not possible, patients spoke to relatives on the telephone.

However,

- The processes for staff to find out about lessons learned following complaints or investigations was not clear.

Are services well-led?

Requires improvement

We rated well led as requires improvement because:

- The hospital introduced a risk register in July 2016; this was marked for review in clinical governance meetings however, there was no evidence that individual items had been updated since its introduction. This meant that the risks identified were not effectively assessed and managed.
- Systems did not ensure that staff received mandatory and legislative training, nor receive the frequency of supervision and appraisal in line with the provider's 85% target and policy.
- The hospital struggled to recruit then retain staff; turnover across twelve months was 54%.
- Ward managers felt under pressure to complete management duties. Due to staff shortages, they were often required to provide direct care to patients. However, ward managers did have sufficient authority to undertake their role.

However,

Summary of this inspection

- Staff saw safeguarding as everyone's responsibility; and we found positive communication between the hospital and the local safeguarding authority.
- Staff felt able to raise concerns without fear of victimisation, they knew about the organisations whistleblowing policy, and that they could contact external organisations to report concerns.
- New divisional forms had been introduced to ensure consistency of reporting for a range of different occurrences including: violent incidents, restrictive interventions, complaints, concerns, whistleblowing, observation and medication balance discrepancies.
- The hospital offered patients the opportunity to complete accredited programmes of learning.

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 manager used the providers' hospital administration system to alert staff when detention renewals were due. Their role also included sending timely reminders about managers' hearings and tribunals, report deadlines, authorisation of medications and requesting a second opinion appointed doctor visit.

Detention documents were scrutinised by the Mental Health Act administrator. Each patient detained under the Mental Health Act had an audit of compliance completed every six months, by the Mental Health Act administrator and the ward manager. We were told any actions arising from these audits were completed immediately.

A full review of all Barchester hospital policies had been undertaken. Mental Health Act policies (including those at Annex B of the Code of Practice) had been rewritten to ensure they complied with the revised Mental Health Act Code of Practice 2015. Staff could access these policies through the hospital's intranet. A schedule was in place to ensure staff became familiar with each of the new policies. Copies of the Mental Health Act Code of Practice were available on all wards.

Mental Health Act training or update was mandatory for staff annually. This had been revised following the introduction of the revised Code of Practice. However, only 43 out of 78 eligible staff, 55% had completed this training. The providers target for compliance was 85%.

Detained patients were given information about their rights on a regular basis; this was documented within their notes. Easy read information about the rights of detained patients was available. Staff made the independent mental health advocate aware of all detained patients in the hospital, some chose to see someone from this external agency.

Mental Capacity Act and Deprivation of Liberty Safeguards

Patients were given assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it. People who might have impaired capacity had their capacity to consent assessed on a decision-specific basis. Staff had an understanding of the five principles of the Mental Capacity Act, used these in their thinking and knew where to refer to policy.

Staff supported patients to make decisions where appropriate. When they lacked capacity to do so, decisions were made in their best interests. Staff knowledge of patients allowed them to do this in line with their wishes, feelings, culture and history. Best interests meetings included a wide range of people to support individual patients.

Eight Deprivation of Liberty Safeguards applications had been made since May 2016, two had been agreed and completed, and the other six applications were awaiting decisions or assessments from local authority teams. The hospital were aware of these individuals and had made repeated representations to the relevant local authority teams for each of these older people. The hospital had been told these applications were not a priority for the local authorities concerned. In the meantime, the hospital were considering decisions in the best interest of the patients concerned, holding meetings and involving carers where appropriate.

The hospital had identified three aspects of safeguarding training that included training in the principles of the Mental Capacity Act, Deprivation of Liberty Safeguards and Duty of Candour. Understanding of training was measured using a self-assessment test at the end of the e-learning module and in the face-to-face update training. Only 57 out of 94, 61% eligible staff had completed training in the Mental Capacity Act, the providers target for compliance was 85%.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Requires improvement

Safe and clean environment

At our last inspection, there had been recognition from staff, senior managers and the provider that the hospital environment needed updating. Following a re-assessment of the environmental changes required a refurbishment plan was agreed. This was on schedule for completion by 28 February 2017. Ullswater ward had completed an extensive upgrade. The activities area had been upgraded and was in use by patients at the time of inspection. Coniston ward was due to complete redecoration before Christmas 2016, with structural changes and the redecoration of Kendal ward due for completion early in 2017. In addition, plans were in place to create a patient social area with space for visitors at the front of the hospital.

Across the hospital, all bedrooms had a toilet and sink facilities however; there was limited access to communal bathrooms. The hospital manager told us that increasing provision of bathroom facilities remained an aspiration for the hospital however, adding showers to the patients' en suite facilities would not to be in the next wave of spending at the hospital.

On Coniston and Kendal wards, there was one bath and one shower for 11 and 15 patients respectively. The standards for inpatient mental health rehabilitation services states that for rehabilitation one bathroom/shower room for every three patients is the standard that a service would be expected to meet.

On Ullswater ward, there was one shower and one adapted bathroom for 15 patients. Patients on this ward required regular access to bathing and toileting facilities due to physical health needs.

The three wards Coniston, Kendal and Ullswater were all for male patients. Every patient had his own bedroom, with an adjoining en suite toilet and washbasin. The doors on patients' rooms had viewing panels so staff were able to see patients requiring observation at night without disturbing their sleep. Unless patients were on higher levels of observation, scheduled checks at night took place at 0200 and 0400.

The bedrooms were off U shaped corridors with no mirrors to alleviate blind spots. Patients' not on higher levels of observation had unsupervised access to corridors and rooms that had some ligature points, fixtures or fittings to which an item could be tied in order to attempt hanging, for example, hand basin taps. Staff told us that the patient group within the hospital were at low risk of self-harm and that staff awareness of individuals, and risk assessments that included positive risk taking, were in place. In patients notes we saw individualised risk assessments and plans. Over a six-month period, no incidents of self-harm had been reported at the hospital.

Ligature cutters were available and accessible on each ward. The spindles on the stairs between floors identified as a high ligature risk at the last inspection had been encased. Outside, each ward had an external garden area for patient use: fencing panels, guttering, branches and a

pergola were all potential ligature points. Patients from Ullswater and Kendal wards could be accompanied or observed from the ward in their gardens, whilst some patients from Coniston ward had access to the garden with no supervision from staff. However, on Coniston ward we saw individual risk assessments for patients identifying potential hazards in the whole environment (including ligatures) completed at least monthly.

An annual environmental ligature risk audit completed on 29 September 2015 concluded that the ligature points identified at Windermere House could be addressed locally as part of on going refurbishment. Whilst most of this work had been completed at the time of inspection, other items had been identified as requiring replacement by a maintenance operative, these would be completed by 31 January 2017. We saw updated ligature risk audits with action plans for Ullswater and Kendal wards completed in October 2016, we did not see the updated action plan for Coniston ward.

The clinic rooms were all clean, tidy and well arranged. Each clinic room had blood pressure monitoring equipment and scales, none had an examination couch. Clinic room audits took place weekly, completed by the charge nurse; we saw no gaps in the records of these checks. Patients requiring physical examinations had these at the local general practice, or in their own bedroom.

Drugs cupboards and fridges were in order with fridge and room temperatures recorded daily. Records showed these temperatures within safe limits for the storage of drugs. Emergency drugs present, were checked and in date. Resuscitation equipment was available, recalibrated and well maintained.

The equipment we checked was clean and well maintained. Throughout the hospital, electrical items had evidence of portable appliance testing.

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

The environment presented some challenges in terms of maintaining cleanliness throughout an older building not originally built to be a hospital. The housekeeping staff had responsibility for communal areas, patients' bedrooms and the laundry all of which appeared clean on the day we inspected. We saw evidence that cleaning schedules were in use, completed by the housekeeping staff then checked and signed off by the housekeeper.

However, when we reviewed rotas for October 2016 with the housekeeper for each ward and specific hospital areas and found gaps on 13 of 31 days. Priority had been given to cleaning high-risk areas with other areas on wards being rotated to ensure as much was done as possible. Staff numbers had been low for a period of three months due to staff absence with no backfill available. The hospital manager was aware of this shortfall and had tried unsuccessfully to bring in agency cover.

The hospital had purchased trolleys to avoid putting dirty laundry on floor, previously identified as an infection risk, however; we saw these trolleys containing dirty laundry stored in bathrooms. Staff explained that this was due to lack of storage for the trolleys elsewhere on the ward, and that they were wheeled elsewhere when a bathroom was in use. We raised concerns about this practice with the hospital manager and were assured that an alternative arrangement would be made.

Staff compliance with infection control training was 62%. Staff demonstrated an awareness of effective handwashing and the facilities required to achieve this were available throughout the hospital.

The hospital environment was assessed bi-monthly as part of the provider's quality first visits. Outstanding actions identified in previous reports were reviewed with any new actions identified and included on a central action plan for the service. Health and safety and infection control audits took place monthly. Outcomes from these had included the hospital purchasing additional cleaning equipment.

In addition to the nurse call alarm system linked to the nurse's station, personal alarms for all staff were available on each ward. There was a protocol in place for staff to collect and sign for an alarm at the start of their shift. We saw this practice during morning handovers and found completed sheets on each ward.

Safe staffing

Establishment levels (whole time equivalent):

- Six nurse managers (deputy hospital director, two unit managers and three charge nurses) all holding a mental health registration

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

- 13 staff nurses registered mental health nurses, registered nurse learning disabilities and registered general nurses
- 53 support workers

Vacancies:

- one registered mental health nurse
- 14 support workers, with eight due to start once disclosure and barring service clearance had come through

The number of shifts to cover sickness, absence or vacancies 01 August to 31 October 2016 was 168.

The number of shifts that could not be filled by bank or agency staff where there was sickness, absence or vacancies 01 August to 31 October 2016 were 64.

When shifts could not be covered, ward managers and charge nurses who were not within the numbers on the staffing rotas, worked more directly to provide cover. However, this had an impact on their managerial duties.

Note: by shift, it is meant a period of time worked by an individual nurse/ support worker within the shift length

Total staffing figures in November 2016:

- Substantive staff 85.5
- Substantive leavers 46 in the last twelve months
- Total vacancies 26 in the last twelve months

Staff turnover in the period December 2015 to November 2016 was 54%. Staff recruitment and retention was of on going concern. In addition to care staff vacancies, we heard concerns from catering, housekeeping and maintenance about lack of staff to fulfil their roles and responsibilities. However, the hospital director assured us that at Windermere House all support services were working in line with the organisations core-staffing levels.

The hospital reported a staff sickness rate over a year amounting to 8473 hours, making 737 shifts.

When they were able to, staff worked extra hours to cover shortfall. The hospital administrator and ward managers monitored this to ensure staff had a regular day off. Staff commented that a change in management approach had meant they felt under less pressure to work extra shifts than previously. Regular bank staff covered about half of the vacant shifts. If agency staff were required, the hospital used the same agency and whenever possible regular agency staff were brought in that knew the patients.

Shifts not covered were due to short notice absences in the case of staff sickness. In these cases, ward managers and charge nurses dropped into the numbers. However, if this happened it had an impact on the completion of managerial duties, for example staff supervision.

Barchester hospital and complex care services division used a target-operating model, a system to identify the roles, numbers of people in each role, and skills, capabilities and knowledge required to determine core-staffing levels. From this, based on the ward patient group and the number of beds, core staff numbers and skill mix were determined. The core staffing hours based on this target-operating model were reviewed annually in September to set the budget for the year.

Core staffing based on this model for each ward was one ward manager working supernumerary hours, and one charge nurse planned to be supernumerary for eight of their 40 hours each week for each of the three wards. During the day, one registered nurse with four support workers and one activities co-ordinator, and at night one registered nurse with three support workers.

This meant the hospital required 42 staff nurse shifts across long days and nights each week. 2184 in a year. Each qualified nurse worked alternating shift patterns of four and three a week, 46 weeks of the year (allowing 6 weeks for annual leave and training) the hospital required 15.8 whole time equivalent staff nurses. It had 13 nurses and one vacancy. However, additionally each of the three charge nurses worked 32 hours over 40 weeks as part of core staffing to provide the qualified nurse cover required.

The number of shifts long days and nights each week for support workers was 147, 7644 in a year. With each support worker worked alternating shift patterns of three or four long shifts a week, allowing for annual leave and training, the hospital required 55.4 whole time equivalent support workers, which it had.

Patients' needing additional support outside the core staffing were individually assessed. Extra staffing required to support individuals was based on this assessment of need. Usually funded by the clinical commissioning group, this required regular reporting and reviews to ensure the

objectives and outcomes identified for the patient continued to be met. Staff confirmed that when a patient required one to one observation additional staffing was available. During our inspection, across the hospital nine patients were on one to one constant observation, however for two patients staff were working to reduce the level of observations as this was seen as restrictive.

We saw at least one qualified nurse available on each ward at all times. We reviewed staffing rotas that showed this was the case on every shift, day and night, however at times we saw this was the charge nurse or ward manager. Managers and staff confirmed one to one time for patients with key workers was possible within a shift.

Escorted leave and ward activities were primarily offered by support workers and we were told rarely cancelled because of too few staff. However, whilst patients confirmed this, they also told us they would like to do more outside of the ward environment.

Multi-disciplinary team establishment (whole time equivalent):

- 0.8 consultant psychiatrist
- 0.5 psychologist (appointed not yet in post)
- one psychology assistant (appointed not yet in post)
- one occupational therapist (not yet appointed)
- three support workers identified for activities with aspirations to train as occupational therapy assistants
- nurses (including ward managers and charge nurses)

Vacancies for psychology and occupational therapy occurred following the termination of service level agreements for psychology in September 2016, and for occupational therapy in October 2016. However the provider had recruited staff as follows:

- 0.5 psychologist recruited, due to commence in January 2017
- psychology assistant recruited, due to start as support worker in December until psychologist in post, when their role would transfer
- occupational therapist post with recruitment agencies, first round of interviews held in October 2016 found no successful candidate.

Staff on the wards spoke of working well together to ensure the physical needs of patients were met. On Ullswater all the nurses were qualified in mental health and general nursing enabling them to offer holistic care to the older patients on the ward.

All patients were registered with a local general practitioner who provided out of hours on call cover. Physical health care emergencies were dealt with through the general practitioner, the national health service 111 telephone advice line, or in a medical emergency by calling 999.

The consultant psychiatrist, the responsible clinician for all patients, would respond to crisis or urgent matters for patients unless on leave. They could be contacted outside of their hospital based session times for mental health emergencies or support.

For periods when the locally based consultant was on annual leave, Barchester consultant psychiatrists provided cover for the hospital, this was across the geographical area of the north east of England. Arrangements were pre-planned so staff knew whom to contact. Whilst staff could discuss their concerns immediately with a consultant psychiatrist it was unclear how long it would take for the on-call psychiatrist to attend the hospital should the need arise. The standards for inpatient mental health rehabilitation services state that it is a fundamental standard of care for an identified duty doctor to be available to attend within 30 minutes in the event of a psychiatric emergency.

Senior managers provided out of hours support on a rota that rotated four weekly, this was done by staff at charge nurse level and above. We saw rotas across the whole year displayed in ward offices and held centrally on reception so all staff were aware of whom to contact if clinical support was needed. The hospital director was on call for senior managers unless on annual leave. In this circumstance, a nominated person was identified, for example the hospital director from a nearby hospital, to provide additional support. As the registered manager, the hospital director held 24-hour responsibility for the service and would be available if the on-call manager could not be contacted.

Issues, patterns or concerns out of hours including lessons learnt were shared at the weekday stand up meetings with the hospital team.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

All staff had completed their common induction standards training. In addition to this, there were 17 legislative and mandatory training modules for staff with five additional modules for nurses only.

On 24 November 2016, training compliance was 69%. The providers target was 85%.

The lowest compliance with training were:

- Moving and handling 52%
- Management of aggression 55%
- Mental Health Act including the Code of Practice 55%
- Health and safety 56%
- Supervision training 56%
- Fire training and drills 58%
- Footsteps training 58%
- Infection control 61%
- Safeguarding abuse awareness and the protection of adults 61%
- Safeguarding duty of candour 61%
- Safeguarding the Mental Capacity Act 61%
- MI Skin 74%

Training where staff compliance met the provider's target were:

- Effective communication 84%
- Equality and diversity 89%
- Documentation 90%
- Dysphasia and choking 93%
- Food safety 94%

Training for qualified nurses only:

- Clinical risk management 31%
- Safe and therapeutic observation 44%
- Cardiopulmonary resuscitation 88%
- Anaphalysis 94%
- Unexpected death 94%

The hospital manager was aware the training figures fell below expected targets. Prior to the inspection, the hospital had identified that mandatory training compliance was a significant issue. The hospital and complex care services division of Barchester had made a decision to review training across the sector considering additional areas required for the specific patient group with the learning and development team. Unfortunately, before this was in place, in August 2016 the training previously provided was suspended. Whilst the hospital manager had ensured staff had access to some of the training required the change of systems had left a gap in other training available. The earliest the newly appointed regional trainers would be available was the beginning of November 2016.

Assessing and managing risk to patients and staff

We found no evidence of seclusion or long-term segregation taking place.

There were only 12 reported incidents involving the use of restraint in the year 1 November to 31 October 2016. All had been recorded as level two holds, standing only. Staff reported that patients could become aggressive at times, but they could identify their triggers and usually intervene effectively at an early stage. Low restraint figures were a positive reflection that staff knew patients well and worked to de-escalate a situation. The staff we spoke to were clear that if a situation needed any physical intervention they would not use prone restraint. Managers confirmed no prone restraint was used within the hospital. Practice within the hospital complied with the National Institute for Health and Care Excellence guidance, principles for managing violence and aggression. Nine different patients had been restrained; four on Kendal, four on Coniston and one on Ullswater ward. In each case, restraint had been a last resort following unsuccessful de-escalation.

The hospital had recently changed its model for the management of aggression from non-abusive psychological and physical interventions to the management of actual or potential aggression. The provider had trained an in house trainer, but they were unable to continue delivery of the training to all staff due to injury. However, arrangements to bring in an external trainer to ensure this staff training continued. We heard confusion from five staff about which system would take the lead whilst everyone completed their new training. Managers and other staff were clear that the preferred techniques in any restraint intervention would be the management of actual or potential aggression. During the inspection, we saw a protocol clearly identifying this that was circulated to staff. Ward managers were confident that if restraint were required there would be enough appropriately trained staff across the hospital site to respond.

In the year, 1 November to 31 October 2016 rapid tranquillisation had been used on Kendal ward once. We

saw this care planned, prescribed and reviewed. Staff had undertaken the appropriate physical health monitoring after rapid tranquilisation in line with the National Institute for Health and Care Excellence guidance.

The hospital had adopted a positive approach to risk management for its current patient population. We found risk assessments using the Galatean risk and safety tool with detailed risk management plans that drew on staff knowledge of individuals. We reviewed 13 treatment records of patients, all had up to date risk assessments with robust risk management plans in place that were individualised. We also saw individual risk assessments and care plans for patients where specific concerns had been identified, for example falls and choking.

Patients who were able to and wished to could have a mobile phone following an individual risk assessment. Other patients had access to a hand held phone on the ward that they could use in a private space, or a telephone in the visitors room. Patients had locked drawers within their own rooms where phones and other personal belongings could be stored.

Alcohol was a banned item throughout the hospital. Cigarettes were not banned and whilst there was no smoking within the hospital patients, who wished to could smoke outside. Following individual risk assessments staff held patients' lighters centrally. Knowledge of patients and the quality of relationships with staff meant lighters were handed voluntarily to staff by patients returning to the ward. Staff were aware there was a policy for searching patients in place; however, no staff member could remember a time when a patient had been searched.

Informal patients could leave the hospital at will, with door codes known by individual patients, or given to them by staff when asked. We found the bathroom doors on the wards locked. We were assured, and saw that patients could access them at any time following a request to staff. In part, staff told us this was linked to the storage of dirty laundry trolleys in bathrooms; and that once this was resolved this restrictive practice would be reviewed. Patients had unrestricted access to toilet and sink facilities in their bedrooms.

Staff awareness of their responsibilities to report adult safeguarding was high however, only 61% were in date with annual safeguarding training. The staff we asked knew how to raise a safeguarding alert with the local authority safeguarding team.

We saw information leaflets available to all in the hospital waiting area explaining what abuse is and how to report this. In a twelve-month period, 19 safeguarding referrals had been recorded. The severity of any adult safeguarding concern was measured against a matrix given to providers by the local authority safeguarding team, which gave a consistency of reporting to safeguarding.

Ahead of inspection, the local authority team told us the hospital had systems in place to capture any incident, and that staff appropriately reported and followed through. When specific investigations had taken place, clear action plans (with a rationale) had been submitted/discussed. Aside from the direct reports from the hospital, neither families nor any professional staff going in to review patients in the last six months had raised safeguarding concerns.

Medicines were stored securely in locked treatment rooms and the keys held by the nurse in charge. Each patient had his own-labelled supply of medicines. The charge nurse completed a medication audit on their ward each month and an audit of stock for as required medication weekly.

All expired or unwanted medicines were in the appropriate pharmaceutical waste bins, to be disposed of according to current legislation. A change of external contractors to dispose of drugs had meant there was some delay in the collection of boxes of expired medication. However, these were securely sealed and stored within the clinic room with their contents documented in a disposal book.

The controlled drugs accountable officer was the registered manager. Controlled drugs were stored in separate cupboards on each ward. Access to these drugs was restricted and the keys held securely. Staff routinely checked the balances of controlled drugs held in line with policy and an audit of controlled drugs was completed each month.

All patients had a separate medication file with their profile including a photograph. How they preferred to have medication administered and any relevant documentation, for example capacity assessments, best interest decisions and or legal status were included in this file.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Prescription charts were clearly written by the psychiatrist with a clear indication of what 'as needed', medication could be used for. There was a separate blue card for mental health medicines and a white card for general medicines. The medicines administration records we checked had been completed correctly however, for three patients' information about medication was not accurately reflected in their individual care plan.

As responsible clinician, the psychiatrist had overall responsibility to check for contraindications, signs that someone should not continue with a particular medicine or treatment because it might be harmful. In practice we saw he worked closely with the patients' general practitioner.

For patients detained under the Mental Health Act certificates of consent to treatment T2 and confirmation of authorised medication certificate of second opinion T3 forms were in place. Internal audits to check compliance of treatment forms took place quarterly.

We saw examples of covert administration where mental capacity assessments and best interests meetings had taken place. For patients without capacity to consent covert medication was being administered within a legal framework.

Changes to medicines made by the psychiatrist were faxed to the patients' general practitioner who produced a prescription that was then supplied to the hospital through an external pharmacy contractor. Whilst the general practitioners were responsive to requests for urgent medicines and staff collected prescriptions to hasten the process. We saw the system as it was working effectively however, the hospital could not access medication immediately. We were told pharmacy provision was an issue was being considered across all locations in the hospital and complex care services division by Barchester healthcare.

The hospital's external pharmacy provider completed a medication audit on 11 October 2016. The original contract with this pharmacy had been for an annual audit as was their normal practice however, the hospital did not feel this gave sufficient scrutiny so had commissioned an additional audit and were negotiating a new service level agreement involving quarterly oversight from an external pharmacist.

Child visiting procedures were in place and these visits took place off the ward. It was envisaged that when the hospital refurbishment was completed there would be a safe space within the new reception area available to children visiting the hospital. Other visitors were able to visit patients on the ward provided there were no incidents occurring at the time.

Track record on safety

There had been nine serious incidents requiring investigation reported in the twelve months prior to inspection. The hospital had followed internal procedures including investigation, reported these to the local authority and where relevant notified the Care Quality Commission.

- Three medication errors had been made
- Two patients had fractures
- Two patients had died suddenly
- Two assaults resulted in injury to staff

Evidence of safety improvements following incidents included:

- The introduction of personal alarms on all units and for visitors to the hospital with an agreed protocol that all staff, visitors and allied professionals within the service are required to wear these at all times when on duty with the service.
- Response support workers identified on all shifts to respond to any activation of a personal alarm and/or an emergency.
- Door keypad codes changed a minimum of six monthly on all entry doors to main building entrance, staff only areas and units to prevent patients wandering onto other units without support from staff.
- Following incident involving error in administration of medication, two qualified nurses are required to check before all administration of medication.
- New enhanced observation prescriptions introduced in conjunction with observation records reviewed at least once by the nurse in charge on each shift.

Reporting incidents and learning from when things go wrong

Everybody could report an incident and all staff could complete an incident form. The staff we spoke to knew how to report and record incidents. Ward managers reviewed recordings of all incidents relating to patients on their ward. Following this, the hospital director reviewed and signed off each incident.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The information from paper forms was uploaded on to a central electronic system within 48 hours. This central register of data formed the hospitals log. An incident and accidents trend analysis ran each month; overall, this showed a reduction in incidents involving patients.

We saw incidents reviewed and learning documented at the weekday morning meeting, and each month at clinical governance. Lessons learned relating to individual patients were discussed at their multi-disciplinary team meeting with care plans updated accordingly, with any changes shared with staff at daily handovers. Not all staff felt lessons learned relating to incidents across the hospital were effectively shared.

A form was available to support debrief following an incident. Individual staff spoke to us about supportive debrief following an incident, that had usually been done by the nurse in charge.

Duty of Candour

There was a policy in place to support duty of candour and this was available on each ward and centrally to staff through the intranet. Staff told us they were aware of their responsibilities to be open and explain to patients if something goes wrong. An example of this in practice was following a medication error, the nurses responsible informed the patient and their relative both verbally and in writing. However, whilst staff awareness of their responsibilities seemed high we found only 61% of staff in date with this legislative training.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

Patients had comprehensive admission assessments. Of the 15 care records we reviewed, three on Kendal ward had physical health checks as part of their assessment. Staff assured us that they completed annual physical healthcare checks however; records of these were not accessible in the hospital notes. Staff believed the general practitioner kept these records.

All records showed evidence of on going monitoring of physical health care. Staff weighed patients at a minimum of once monthly and more frequently if weight loss or weight gain identified as a care issue. Staff used specific risk assessments for example, the malnutrition universal screening tool with care plans to follow up any concerns found. We also saw falls, pressure ulcer and choking risk assessments with relevant care planning. Staff completed referrals to the dietician and speech and language therapist when required. All patients having their nutrition monitored had their progress entered onto the clinical governance database for review at monthly meetings.

Care records contained up to date individual risk assessments using the Galatean risk and safety tool. This mental health risk assessment tool covers suicide, self-harm, harm to others, self-neglect, and vulnerability. Individual risk management plans were in place following these assessments.

Patients' care and treatment records had examples of specific assessments from psychology, occupational therapy and nurses in patient files. We found that staff used these to inform individual care planning. The hospital had no psychologist since September 2016 and no occupational therapist since October 2016 when their service level agreements had terminated. From the records reviewed, it was apparent that the last written entries in the notes from the occupational therapist were in late September 2016 where a number of reports had been updated. Psychology input appeared to have stopped prior to that with entries seen from March 2016. There was evidence of both professions providing assessments and reports during their time in post. Most patients had been admitted to the hospital for some time, which meant that they had experienced involvement from the occupational therapist and psychologist at an earlier stage of their stay.

The hospital used the mental health recovery star to identify outcome areas to focus on and inform care planning. On Kendal ward, care plans referred to statements made by the patients about shared and agreed goals, with interventions to support these. On Coniston ward, we saw a commitment within care plans for staff to support patients to follow their individual interests. Staff wrote specific care plans for patients' mental health needs, physical care needs and social needs. These showed extensive knowledge of the patients and their

rehabilitation aims. Whilst there was little evidence of patient discussion on Ullswater ward, care plans showed assessments completed following discussion with people who knew the patient well.

Care plan reviews took place regularly. Patient involvement in reviews through one to one sessions with their named nurse happened on at least a monthly basis. For some patients, particularly on Ullswater ward, a relative might support this process. If required an advocate could be present to support care planning. Staff documented these reviews and those following a multi-disciplinary team or care programme approach meetings with care plans updated accordingly.

Four patients said they had been involved in planning their care and supported by staff to understand this. We found evidence of this for other patients in their notes. Staff told us all patients were offered their care plan to sign and if they were unable to sign or refused to sign this was documented. However, a third of the care plans we saw remained unsigned with no comment as to why. Staff offered patients copies of their care plan, however they told us few patients wanted one. Carers saw care plans at meetings and reviews, but had not been given copies following admission. On Coniston and Kendal wards, patients were keen to know about their individual activities, and we saw programmes for these. Patients, relatives and their representatives could access records under the access to medical records policy guidelines.

Care records in paper files with indexes had a description and photograph of each patient (with clear permission for this) and some key details on the first page. Not all records showed the legal status of the patient on this page. Patient notes and care plans were stored in locked cabinets in the ward offices. Clinical team members and visiting professionals involved directly in the care and treatment of the patient had access to these records.

Best practice in treatment and care

We saw 27 examples of evidence-based practice across the hospital that referred to guidance from the National Institute for Health and Care. These included falls, medicine adherence, common mental health problems and dementia.

Sine our last inspection, the hospital had completed specific work to ensure patient involvement and least restrictive principles became the day-to-day practice of staff and embedded into the hospital. The hospital had robust processes around best interest decisions and meetings. We saw evidence of both in use.

Following training already completed, Ullswater ward staff planned to improve dementia care using a collection of measurement tools to support interventions to improve the quality of patients' lives. This evidence-based strategy was developed through the 10/66 dementia research group.

Clinical staff used the health of the nation outcome scales to rate the progress of patients with severe mental illness. They documented individual ratings and then repeated after a course of treatment or intervention, to monitor change and progress. This clinical outcome measure was in use on all wards. Staff also used the mental health recovery star. This was designed to support adults to manage their own mental health. Plans followed assessments of ten specific points: living skills, social networks, work, relationships, addictive behaviour, responsibilities, identity and self-esteem, trust and hope, managing mental health, physical health and self-care.

Patients had limited recent involved from psychology. Some patients had the aims of treatment and a formulation recorded in their notes. However, the most recent entry we saw in notes from psychology was from March 2016. At the time of our inspection, there was no psychological input into the hospital.

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

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

For inpatient mental health rehabilitation services the fundamental standard of care states that patients are offered evidence based psychological interventions and have access to occupational therapy. For inpatient older adults mental health services that admit patients living with dementia we would expect to see regular occupational therapy and sessional input from psychology.

Access to the patients' general practitioners was in the community when possible. A number of patients arranged their own appointments. When this was not the case, staff supported individuals to attend, or the doctor agreed to see patients on the ward. Two patients said staff looked after their physical problems as well as their mental health. One patient liked being able to call his general practitioner to attend health care appointments locally when he found this necessary. Referrals to other professionals: speech and language therapists, district nurses and physiotherapy were made through the patient's general practitioner. A dietician, optician, chiropodist and dentist would accept direct referrals and would visit patients at the hospital if required.

Staff weighted patients monthly with the malnutrition universal screening tool used to identify any adult, who could be malnourished, at risk of malnutrition, or obese. Where issues were found care plans were written to guide staff to support food and or fluid intake as required.

On Ullswater ward, each patient had a nutritional and falls assessments completed and care plans reflected specific individual needs. Named nurses and key workers worked closely with families to understand more about patients likes and dislikes.

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

An externally validated learning programme offering courses that build on the strengths and interests of an individual was available to patients. Staff on site supported its delivery enabling individual patients to work at their own pace to achieve accredited programmes and qualifications in skills for learning, skills for employment and skills for life.

The purpose of Kendal ward was to provide slow stream recovery based care and treatment for men aged 50 and over who had either functional or organic mental health difficulties. On this ward we met a complex mix of male patients. The care we saw and heard about on this ward was individualised by staff to meet patient's needs.

Barchester hospital and complex care services division did not participate in any nationally recognised clinical audit when we inspected. However, in the last year, clinical staff had been involved in nutrition and hydration; medication, clinic rooms and patients' care profile audits.

Skilled staff to deliver care

At the point we inspected the hospital, the mental health disciplines in the multidisciplinary team was limited to nursing and psychiatry. Two posts had been recruited with a half time psychologist and full time psychology assistant starting due to commence in January 2017. The occupational therapist post was with recruitment agencies, as the first round of interviews held in October 2016 found no successful candidates.

Nursing staff on the wards held relevant qualifications and were experienced working with the patient groups at the hospital. All the nurses on the ward for older adults were qualified in mental health and general nursing, giving them a breadth of knowledge and skills to work with these patients.

The consultant psychiatrist was the responsible clinician for all patients and was employed full time across Windermere House and another Barchester hospital in Hull. This had been a significant increase in on site psychiatry, which staff and patients commented on positively. However, the fundamental standard of care for inpatient mental health rehabilitation services states staffing levels of 0.5 whole time equivalent consultant psychiatrist for every 14 beds. The consultant psychiatrist in post worked 0.8 whole time equivalent, covering 26 rehabilitation beds and 15 beds for older adults for the hospital.

Three experienced support workers co-ordinated activities programmes one on each ward. The development of this

role towards becoming occupational therapy assistants was being supported with the longer-term plan, to offer training to technician standard. This role would be supervised by the occupational therapist once in post.

The hospital had an induction for new starters that incorporated the care certificate for support workers. Face to face and online training formed part of staff induction. Historically paper versions of key topics for example: safeguarding, Mental Capacity Act and communication were given to bank staff and new starters to provide a basic induction, some wards continued this practice however, it was not clear this was done systematically.

Leadership training was available to ward managers; this was last done for staff within the hospital four months prior to our inspection.

The management of actual or potential aggression had recently become the system to manage challenging behaviour of patients. The provider had funded a member of staff to deliver this training on site to staff. Support was available for other staff to train externally if gaining a specific qualification would enhance their role for example; the Mental Health Act administrator was undertaking a Mental Health Act law and practice certificate at Northumbria university.

The provider had made a decision that training was moving from delivery at hospital level to a more uniform approach across the directorate, this was causing staff some anxieties. Whilst accepting that part of their worry was about change, staff did have significant concerns about the impact of the lengthy gap between the two systems.

Staff were supervised however, in June 2016 low compliance was raised following an internal quality first visit. Staff told us they did not always have the capacity to provide the supervision required.

The provider's policy stated that staff should receive a minimum of six sessions of supervision per year. By November 2016, the supervision compliance rate had increased to 62%. This was still below the provider's target of 85%. Staff commented that less reflective group supervision was available and this was connected to the deputy manager changing his role. The ward managers had clinical staff training records for individual members of their team, to be reviewed at supervision, however if supervision did not happen then this would not occur. This meant that this was not a robust process.

Staff were appraised annually; the provider's target for this was 85%. In June 2016, the appraisal rate was 17%. Updated appraisal figures at the time of inspection showed the compliance rate had risen to 68%.

Multi-disciplinary and inter-agency team work

At the time of the inspection, nursing staff and the psychiatrist attended multidisciplinary team meetings twice weekly on each ward. We attended a multi-disciplinary team meeting for two patients with the doctor, ward manager and charge nurse. All staff worked hard to include the patients concerned; when they refused, it was clear from the discussions that followed they had extensive knowledge of these patients and their views. Positive and thorough reviews took place. However, the meeting was lacking other disciplines perspective.

Staff planned care programme approach meetings to ensure maximum attendance by care co-ordinators for patients both from the locality and from out of area. The care programme approach documentation used was written for the patient, with information about the help, care and treatment received during their stay at Windermere House. Notes from meetings identified and recorded specific action points for individuals to achieve before the next review.

We attended a care programme approach meeting during inspection. The staff team included the consultant psychiatrist; named nurse; key worker and deputy manager with an external social care practitioner from social services. All knew the patient concerned well and were aware of their needs. The patient was treated with kindness, dignity, respect and compassion. The patients' detention under the Mental Health Act, care pathway and future were discussed with reference made to his capacity and best interests.

We attended the handovers on two wards from night to day shifts. Handovers lasted 15 minutes, during which the nurse in charge of the night shift handed over information verbally about all patients on their ward. This took place in the nursing offices, which was a small space for the number of people involved. Information shared included key details from the previous handover, patients' mood, risk, and levels of observation. The short length of time meant staff could not easily reference patient care plans. The immediate focus following handover was to allocate duties to the staff arriving on shift. On Ullswater ward, all staff

working on the new shift were present, on Kendal one staff member arrived slightly late missing information about the first patient discussed. Staff members coming on duty checked the communication book and diary for information before leaving the office.

Each weekday morning there was a meeting that included ward managers, housekeeping, maintenance, administration, and the hospital director. Its purpose was to update and review any urgent issues, including a check on staffing levels, and to improve communication across the hospital. An agenda was followed and minutes of the meeting taken. We saw that each person was given time for his or her update at this meeting.

There were links with two local general practitioner surgeries where patients were registered. Whenever possible, staff supported patients to arrange and attend appointments in the community. For patients who could not do this we heard general practitioners were responsive to staff requests for them to visit the hospital. We saw two general practitioners seeing patients on Ullswater ward during the inspection. Other professionals involved in delivering care, for example district nurses, liaised with staff on the wards to update them of a patient's progress.

We heard that the hospital had positive communication with the local safeguarding adults' team from staff at the hospital and the team itself. We spoke with two external workers attending a formal meeting for an out of area patient. They were complimentary about both communication from the hospital and the care delivered on site.

Adherence to the MHA and the MHA Code of Practice

Mental Health Act training or update was mandatory for staff annually; this had been revised with an additional module introduced to cover the updated Mental Health Act Code of Practice. For new staff the expectation was these modules would be completed within three months of their start date. Compliance with this training was 55.13%. This was below the provider's target of 85%.

Staff awareness of the Code of practice was high and most had an understanding of the guiding principles of the Act. Copies of the Mental Health Act Code of Practice were available on all wards.

A full review of all Barchester hospital policies had been undertaken. Mental Health Act policies (including those at Annex B of the Code of Practice) had been rewritten to ensure they complied with the Mental Health Act Code of Practice 2015. Staff could access these policies through the hospital's intranet. A schedule was in place to ensure staff became familiar with each of the new policies. Next to each of the 45 policies was a completion date by which staff understanding was to be checked through a short question and answer session. Ward managers would monitor individual staff compliance with this roll out. The schedule ran over 15 weeks from November 2016 to February 2017.

Detained patients were given information about their rights on admission and at least monthly; this was documented within their notes. Easy read information about the rights of detained patients was available.

The Mental Health Act administrator could access additional support and advice if needed by telephone or email from a Mental Health Act manager based at a different hospital within the Barchester group.

The Mental Health Act administrator scrutinised detention documents. The detention paperwork was filled in correctly, in date and stored appropriately. Section 17 leave forms were signed by patients who had the capacity to do so. Staff offered patients a copy of these forms, where this was refused this was documented. Leave conditions were specified and a record was made of how leave had gone.

Each record for patients detained under the Mental Health Act had an audit of compliance completed every three months. The administrator told us that any actions arising from these audits were completed immediately.

The audit processes for Mental Health Act documents were fed centrally into the Barchester hospital and complex care services division. The Mental Health Act manager reviewed these to improve the application of the Mental Health Act across the sector.

The providers' administration system had a range of prompts for required activities to alert staff when renewals were due. The Mental Health Act administrator used this system to send out timely reminders to alert the medical and ward staff when detention renewals, managers' hearings, tribunals, report deadlines, authorisation of medications and requesting a second opinion appointed doctor visits were due.

Information about access to an independent mental health advocate was seen on each ward and in reception. Two

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

patients knew their advocate. The services of the independent advocacy company supported detained patients to understand their rights, including any restrictions or conditions on them. The independent mental health advocate assisted patients to prepare for attendance at hospital mangers meetings and mental health review tribunals. They attended these, care programme approach and multi-disciplinary team meetings to support patients. For patients unable to self-refer a best interest meeting was held before making a decision to invite the independent mental health advocate in to explain their role.

Good practice in applying the MCA

The hospital had identified three levels of safeguarding training that included training in the principles of the Mental Capacity Act, deprivation of liberty safeguards and duty of candour. Compliance with this training was 61%. This was below the provider's target of 85%. Understanding of training was measured using a self-assessment test at the end of the e-learning module and in the face-to-face update training.

In the six months since May 2016, the hospital applied for eight deprivation of liberty safeguards authorisations. Two applications had been agreed and completed; the other six were awaiting decisions or assessments from local authority teams. The hospital was aware of these individuals and had made representations to the local authorities requesting a decision. Across the hospital at the time of our inspection, ten patients had deprivation of liberty safeguards in place. This status was reviewed regularly at multi-disciplinary meetings.

Staff had an understanding of the five principles of the Mental Capacity Act and followed these; they could also refer to the provider's policy. Patients who might have impaired capacity were given assistance to make a specific decision for themselves before they were assessed to lack the mental capacity to make it. Staff told us they did not assume an individual could not make a decision. Where following assessment, patients were found to have impaired capacity; their capacity to consent was recorded on a decision-specific basis.

Staff supported patients to make decisions where appropriate. When they lacked capacity to do so decisions were made in their best interests. Best interests meetings included a wide range of people to support individual patients. Staff knowledge of patients allowed them to make decisions in line with a patient's wishes, feelings, culture and history, which followed the principles of the Act. The only regular monitoring of practice we saw was best interest decisions processes reviewed as part of the care file audit.

Staff sought advice on regarding the Mental Capacity Act from each other, senior or ward managers and trainers.

Advocacy information was available at the main reception and on all wards. Patients who did not have capacity to choose this could be referred following a best interest discussion by staff to an independent mental capacity advocate.

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

Good

Kindness, dignity, respect and support

We observed staff and patient interaction including activities taking place and a mealtime on each ward. We saw genuine caring interactions between staff and patients. Staff engaged with patients in a respectful manner, offered reassurance and support to patients who were showing signs of distress. We saw that patients received dedicated one to one time with staff. This involved either talking or engaging in an activity. When staff dispensed medicines to individuals, they took time and completed this with support and care.

We spoke to ten qualified nurses, three occupational therapy assistants and ten support workers across the three wards all of whom could describe patients' care needs and their background in detail.

We spoke with six patients; three patients told us they felt safe at the hospital. Patients that were able to told us they knew their key worker, care staff and the hospital manager. Most patients said staff cared, showed them respect and were polite. Patients could access their rooms when they wanted to. One patient liked that staff always knocked to ask if they wanted to come in to their room.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Patients spoke about staff helping to calm things down between patients if any disturbances began. A carer told us that if an issue arose between two patients, staff were discreet, encouraging, and not confrontational.

We collected feedback from seven carers individually and at a focus group during the inspection. Their feedback was positive; carers believed staff were always courteous and professional. If they requested something, they found the staff responsive. Carers of patients less able to tell us about their care felt involved in care, and said communication with staff was good. They spoke of being listened to on the ward and at regular meetings. At meetings, we heard that staff were caring and thought about the whole person.

The involvement of people in the care they receive

The hospital provided patients with a 17 page document prior to their admission. This contained written information about the hospital, its aims and objectives, how individual needs could be met, the rights of patients and specific arrangements for example, maintaining contact with relatives. Following admission patients received one to one support to orientate them to the ward. Their named nurse and key worker were identified at an early stage and when possible were on shifts whilst the patient settled.

Care plans showed evidence of patients and where relevant their carers involvement in care planning, risk assessment and decisions about activities. We saw variation in the level of involvement for individual patients in their care plans. Carers knew the patients key workers and told us they asked about a patients' routines, likes and dislikes. However, relatives told us that sometimes high staff turnover had meant just as staff got to know a patient their key worker changed so repetition of information was needed.

Patients and their relatives attended care programme approach and multidisciplinary team meetings. Carers indicated they felt involved in the care of relatives and confirmed they were part of discussions at or following meetings. Carers who found it hard to visit commented that staff telephoned to keep them informed and discuss any changes.

We heard and saw on Ullswater ward, the staff enabled carers to stay involved in the direct care of their loved one.

Carers liked being able to be on the ward to eat with their relative at mealtimes. Staff made an effort to make sure patients who could do so attended events for special occasions, or had a celebration on the ward.

Noticeboards displayed a range of information about how to complain, the Mental Health Act, activities, menus and how to raise a safeguarding concern to the local authority and the advocacy service. Patients had available both a specialist independent mental health advocate and an independent mental capacity advocate through an independent advocacy service.

Patients on Coniston ward attended a community meeting, where patients could raise issues. Four carers spoke of receiving support from staff and one another at the family and friends group facilitated by hospital staff. This offered a safe place to meet other carers, share their stories and experience peer support. The meeting was bi-monthly and staff attending listened and offered support.

Hospital developments were shared and discussed both at patients and relatives meetings. These offered the opportunity for comments, suggestions and feedback. More informally, patients could make suggestions at any time to staff to be fed back through the daily meeting or directly to the hospital manager.

The provider undertook customer satisfaction surveys to see what patients and relatives thought about provision, however, no recent results were seen. At the time of our inspection, none of the patients at Windermere House were involved in the recruitment of staff.

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

Good

Access and discharge

The average bed occupancy rate across the three wards at Windermere House figures over the period 1 May 2016 to 31 October 2016 was 88%.This meant that the hospital had beds available if needed for people living in the catchment area. At the time of our inspection, the hospital had eight

beds available: one on Coniston, three on Kendal and four on Ullswater. Others did not use a patient's bed if they were on leave. Patients only moved wards within the hospital on clinical grounds.

The hospital referral criteria specified different age groups for each ward. Patients also needed to:

- suffer from mental health problems
- be liable to detention under the Mental Health Act 1983 or subject to deprivation of liberty safeguards
- be compliant with prescribed medication
- be incident free for a minimum period of 3 months (have had no episodes of serious physical assaults to persons or property
- be able to comply with the hospital's alcohol and substance use policy
- be able to engage with services and therapeutic programmes
- require rehabilitation prior to a community or less restrictive residential placement.

From a referral, to the admission of a patient to the hospital took around two weeks. This involved a pre-assessment to ensure the hospital could meet the needs of the patient and a funding agreement. The hospital had a target time of 14 days unless the admissions required ministry of justice permission, which could take longer.

From admission, patients had an assessment period of 12 weeks to ensure that the patient, their relatives, staff and the commissioners could agree an individual treatment plan for the next six months. Treatment plans showed targets for progression in recovery and discharge. For patients more recently admitted to the service these were being met.

The hospital had existing patients from when Windermere House was a residential care home 10 years ago, for whom it was agreed hospital care was needed. For these patients discharge planning had not commenced on admission, but was now being considered at each review. For patients admitted to Windermere House more recently, discharge planning commenced on admission and was consistently reviewed. Discharge planning was evident in each of the 15 care records we checked. The majority of patients were from Hull or the East Riding of Yorkshire. The hospital had 9% of patients from out of area.

The hospital manager spoke about building up a different care profile for new admissions, predicting lengths of stay within 2-5 years as a maximum. The average length of stay for patients was 236 weeks (four and a half years). Twenty patients had been identified in May 2016 for discharge, since when nine had left the hospital. Discharges involved patients and their relatives; staff planned and managed discharge carefully to ensure this happened as and when agreed. The hospital had no readmissions following discharges from the service.

We heard from staff that a key difficulty in working towards discharge was finding suitable alternative placements. The patients we spoke to provided positive feedback about the hospital and did not want to leave. Carers believed the hospital and staff kept patients safe and well looked after. They expressed concerns about patients moving elsewhere. Their biggest concern was when facing discharge finding a placement elsewhere that met the needs of their loved one as well as they thought Windermere House did.

The hospital reported three delayed discharges in the previous six months. A delayed discharge occurs when a patient judged clinically ready for transfer or discharge continues to occupy a bed in the service. The provider reported that the first delayed discharge was due to difficulty identifying a move on placement, the second had discharge plans halted due to relapse and the third required an alternative placement due to a sudden deterioration in physical healthcare needs. The commissioners worked with the hospital team to ensure delayed discharges were minimal.

The facilities promote recovery, comfort, dignity and confidentiality

Since our last inspection, the provider had agreed to invest in décor and facilities to improve the ward environments.

At the time of our inspection, the hospital had upgraded Ullswater ward. This had meant the ward was brighter and cleaner. The rooms within the ward were refurbished and re-carpeted. Three staff shared concerns that whilst the ward was much improved it had lost some of its dementia friendly initiatives for example, contrasting coloured doors into bedrooms. However, the hospital had looked at guidance from the Kings Fund and Stirling University around dementia friendly identification and applied this in the refurbishment. Some bedroom doors had a framed collection of personal items reflecting the individual patient that may aid their recognition, though the main

purpose was to ensure staff not known to the patient knew something about them as a person. The hospital manager told us that as part of the implementation to improve the quality of patients' lives on Ullswater a dementia care expert would be brought in to check the ward environment early in 2017.

The hospital had replaced bedroom doors on Kendal and Coniston wards with doors containing viewing panels. Staff used these to see patients requiring observation at night so staff no longer needed to open doors causing a disturbance. The hospital had plans to redecorate Coniston ward and the activities room by Christmas 2016. For Kendal ward, some structural alterations and redecoration had been scheduled for early in 2017.

Patients had their own belongings in their rooms and they told us they felt their property was safe. Patients had personalised their rooms, however, the hospital provided standardised white bed linen across the hospital. Whilst some staff embraced these changes, others were concerned about the more corporate look of the hospital.

Each ward had access to both quiet areas and a garden. Patients had access to activity spaces on and off the wards and we saw activities took place seven days a week. The planned refurbishment of the front of the hospital included a patient social area and a more open and visitor friendly reception area. The two patients who spoke to us about this change were looking forward to its completion in February 2017.

The hospital provided activities on the wards, in the occupational therapy rooms and where possible in the community. Senior support workers co-ordinated a programme of activities on each ward. Within the hospital, patients liked cooking, listening to music, playing chess and some of the group activity sessions on their ward. Ward staff ensured individual patients completed activities they enjoyed including: going out shopping, to the pub and playing pool. Patients liked the staff, especially those who had time to do activities with them. However, patients told us that they wished they could go out of the hospital more often. No activities had been cancelled in the three months prior to our inspection.

During the summer time, the hospital had invited families to join themed days. These had included a beach party held outside with stalls games and quizzes. Other activities involved patients connecting with the wider community.

One of the patients was as a volunteer dog walker for a local rescue centre and more recently, patients raised money by baking and holding a Macmillan coffee morning event.

Patients and carers told us that visiting was well managed and staff showed a commitment to patient staying in touch with family and friends. When visiting was not possible, patients spoke to relatives on the telephone. Individual patients had their own mobile phones, though most used the ward telephone that could be taken into a private space.

Patients had access to drinks and snacks 24-hours a day. Some patients prepared their own drinks and snacks, but needed staff to allow them access to the kitchen to do so. The hospital had an occupational therapy kitchen where patients cooked food after shopping. Four patients commented on the food and told us they wanted more choices and a more varied menu. Staff told us food was high on the agenda at most meetings patients attended.

The acting head chef managed the kitchen. However, the hospital had a shortage of staff and the hospital manager had struggled to find cover or relief whilst a new chef was appointed. Staff and patients prepared breakfast as and when they patients wanted this. The kitchen offered two menu choices each day at lunchtime and for an evening meal. Patients chose their menu options two days ahead. In addition, the kitchen provided two meals for staff working long days.

The hospital had a feedback system for all patients to express dietary preferences. The chef was aware of specific dietary requirements and ensured these were met. Staff transported meals on food trollies; staff checked and recorded meal temperatures before leaving the kitchen and when being served on the ward. Mealtimes seemed relaxed with patients supported to eat by staff as required. For birthdays and special occasions, the kitchen provided individualised cakes and a buffet. This was chosen following consultation with patients, their relatives and key staff.

Meeting the needs of all people who use the service

Patients had access to three assisted baths and showers with pull down seats and handrails. The provision of

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

accessible bathing facilities was limited. However, individual patients' washrooms had aids and equipment to assist with the management of continence and patients' rooms had privacy screens on the windows. .

Doorways within the hospital were wide enough to allow disabled access. Some patients had individually assessed aids and adaptations, for example, wheelchairs, raisers and adapted cutlery. However, most seating on the wards was generic and did not take into account individual needs.

Notice boards on the wards and in the main reception area displayed information about mental health problems, detention in hospital, how to complain, advocacy and safeguarding. Some of these posters and leaflets were in formats that would be easy to follow or understand by all patients.

At the time of our inspection, English was the first language for all patients. Staff assured us that if there was a need to translate information into different languages the provider could do this.

Staff had a high awareness of individual patients' specific spiritual needs. Chaplains of any religion relevant to the individual would be welcomed into the hospital. Staff encouraged patients to maintain community links and supported patients to attend their local faith service when possible. In addition, patients had access onsite to a Christian based church service each month. The chef and ward staff assured us that if required the hospital could accommodate any specific dietary requirements patients had for religious reasons.

Listening to and learning from concerns and complaints

Patients tended to raise concerns verbally to the staff member in charge of the ward or directly to the hospital manager. Staff discussed these concerns and recorded these in the minutes of the weekday stand up meeting. During this meeting, the person with responsibility to respond to the patient would be identified. Feedback regarding complaints was given verbally to patients and if it might aid understanding, in writing to individuals.

Between 01 November 2015 and 31 October 2016, the hospital had received two complaints and two concerns, all in October 2016. We reviewed these and saw the provider had responded appropriately to investigate and resolve complaints.

Staff had also raised concerns about the allocation of work on one of the wards, and a patient left unattended for over two hours. Whilst we saw a record of these complaints and concerns we did not see the processes gone through to investigate and resolved these, nor the actions taken and lessons learned following investigation.

Staff told us complaints from patients or their relatives were very unusual. Following a complaint they understood that lessons learned would be shared at the monthly team meetings but none could recall this happening.

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

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

Requires improvement

Vision and values

The hospital had adopted Barchester's vision, mission and values statements.

The provider's vision statement was:

- By putting quality first into everything we do for individuals we support, their families and our teams, we aspire to be the most respected and successful care provider.

The mission was to always focus on improving and developing the quality of:

- the care, hospitality and choice we offer the people we support
- our employees, their experience, development and behaviour
- the environments we create and the buildings we operate
- our systems and our financial performance.

The values were:

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Requires improvement

- We work together to make quality our way of life.
- We respect, support and strive to improve the communities we serve.
- We are honest, fair and ethical in everything we do.
- We recognise and appreciate individuality.
- We accept responsibility for our actions.
- We make life and work meaningful and enjoyable for all.
- We support and encourage initiative and creativity.
- We focus on an individual's ability and aspirations.

We did not see that the vision, values and mission were visible during our inspection at the hospital. The supervision and appraisal records did not correspond to the organisational values. Whilst staff did not seem familiar with the provider's statements they spoke about their work at the hospital in terms of honesty, integrity and encouraging patients to have a quality of life that was the best it could be.

Staff knew who the senior managers in the organisation were and these managers had visited the wards.

Good governance

Prior to the inspection, the hospital had identified that mandatory training compliance was a significant issue. The hospital risk register recorded that in July 2016 only 20% of staff had completed training in management of actual or potential aggression interventions. At the time of the inspection in November 2016, 55% of staff had completed this training. Staff told that this had been in part due to changing the system from one to another. Staff training compliance rates for moving and handling; the Mental Health Act including the Code of Practice; health and safety; fire training; infection control and safeguarding were not up to date. Overall compliance with mandatory and legislative training was 70%, below the provider's target of 85%.

Barchester had started a process of reviewing mandatory training requirements for all hospital staff. The provider had recruited specialist trainers with the aim of centralising and standardising training at the provider level. Staff told us that this was due to be launched shortly after our inspection however, there had been a gap in training provision for staff whilst this was rolled out. Staff had been concerned that they had had limited access to training since the previous provision, much of which had been delivered internally, ceased in the summer of 2016. The low compliance figures for training reflect this.

We saw a clear structure within the hospital with individual staff members identified as supervisors for clinical and ancillary staff. In June 2016, the hospital received a quality first visit from the divisional director. The report of this visit noted that the supervision rate at the time was 42%. The provider's policy stated that staff should receive a minimum of six sessions of supervision per year. The same report found that the appraisal rate was 17%. We asked for updated figures on supervision and appraisal compliance. By November 2016, the supervision rate had risen to 62% and the appraisal rate to 68%. The provider's target for both was 85%.

Staff turnover in the period between December 2015 to November 2016 was 54%.The hospital risk register noted that the high use of agency staff had been a severe risk. Rotas showed that the highest area of concern were gaps in qualified nurses when unit managers and charge nurses dropped into the numbers. Whilst this ensured the rotas were covered it meant other duties unit managers and charge nurses had may not be completed. Staff recruitment and retention was of on going concern. In addition to clinical staff, catering, housekeeping and maintenance told us they had concerns about the lack of staff to fulfil their roles and responsibilities. The hospital had significant gaps in the multidisciplinary team. On the day of inspection, the multidisciplinary team was composed of medical and nursing staff. The hospital was in the process of recruiting to vacancies for a psychologist and an occupational therapist.

Two internal quality visits raised that the accuracy of recording across all care records, including risk assessments and observation records as an issue. Staff had been working towards improvements consistency of recording the care delivered whilst maintaining their focus on direct patient care.

The hospital did not participate in any nationally recognised clinical audits into the procedures used for diagnosis, care and treatment. Local clinical governance minutes noted that staff completed audits on care records, medication charts and ligature risks on an ad hoc basis. In addition, quality review visits in June and September 2016 raised concerns that pharmacy audits were not being regularly completed. In response to these concerns, we saw the introduction of an audit schedule in October 2016 covering 19 different audits for the hospital across twelve months all identified both the frequency and the month for

completion. The pharmacy provider had agreed to provide quarterly audits and to attend the hospital clinical governance meeting quarterly to share their findings commencing 1st January 2017.We saw completed audits of medication, prescription cards, controlled drugs and the clinic room.

Staff knew what and how to report incidents and complaints. Following reporting, staff understood that lessons learned would be shared at the monthly team meetings however, we found no evidence of this happening.

From April 2016, the hospital had adopted a standard agenda for clinical governance meetings. This agenda included clinical effectiveness, audit, risk, staffing, and complaints. We saw in minutes that the hospital had taken action because of care quality commission inspections of other hospital sites within the Barchester group. The hospital had audited medication charts after issues were found with charts at other sites. Following concerns about privacy and dignity at another site, the hospital had replicated the action taken by installing privacy screens for patient bedrooms. This showed the hospital was responsive to lessons learned within the organisation.

Staff saw safeguarding as everyone's responsibility; and we found positive communication between the hospital and the local safeguarding authority. Staff had an understanding of the five principles of the Mental Capacity Act and followed these. We found staff particularly focussed on least restrictive practice with staff supporting patients to make decisions where appropriate. Staff provided patients who might have impaired capacity with assistance to make a specific decision for themselves before they were assessed to lack the mental capacity to make it.

During the previous inspection, we found that the hospital had not updated its policies to reflect the changes in the revised Mental Health Act Code of Practice introduced in 2015. We issued the hospital with a requirement notice requiring the hospital to update local policies and training to reflect the changes in the code of practice. We found that the provider had 48 policies requiring updates; these had all been ratified by the end of the inspection period. We saw a training plan to commence on 21 November 2016 that identified the order in which staff would receive training on the updated policies.

Staff performance was measured using feedback from supervisors and mentors as well as peers. This included key worker responsibilities and patient outcomes. Managers measured performance by referring to: attendance and timekeeping, sickness and absence, training compliance, appraisal, and supervision. Managers would address poor performance through supervision and additional training prior to more formal framework of performance management where critical improvements targets and expectations would be set. However, with low compliance figures for supervision and appraisal it was not clear that these systems could be robust. Disciplinary action was used when all other actions had been exhausted. Following absence from work attendance was managed through return to work interviews. These may trigger increased action in line with procedures from human resources for staff with persistent poor attendance and timekeeping.

The three ward managers all felt they had sufficient authority to undertake their role. Although at times, particularly when required to work within the numbers and provide care to patients they felt under pressure to complete their management responsibilities effectively. A central administration team within the hospital supported their work.

The hospital introduced a risk register in July 2016, senior staff were aware of this register; with staff within the wards clear they would report risks directly to ward managers. The risk register contained 14 risks. Eight risks were rated as severe. These were: low bed occupancy rates, the business continuity plan was out of date, medication supply / pharmacy service, ineffective multidisciplinary team process, potential ligature points, security – personal/ property/premises, lone working – escorting patients in the community and agency use.

On the hospital risk register eleven risks were identified as requiring individual review in August 2016 and three in October 2016. Minutes from the hospitals clinical governance meetings in August and October did not show evidence that these individual risks had been reviewed. There was no evidence that individual items had been updated since the introduction of the register in July 2016. Whilst the hospital had a risk register in place it was not being used as an effective system to assess, review and manage risk.

Barchester hospital and complex care services division had introduced a new format in October 2016 that followed the

national patient safety agencies framework and risk assessment matrix in line with NHS guidelines. Following review at the hospitals clinical governance meetings, risk was due to be reviewed and ratified at the divisional clinical governance meeting each quarter. At the time of our inspection we did not see this system working effectively.

Leadership, morale and staff engagement

The provider had introduced an employee app that encouraged staff to undertake a survey to feedback their experience of working for on the provider as an employee and their working conditions. At the time of inspection the hospital were awaiting data from the latest staff survey.

Staff sickness in the six-month period 01 May 2016 to 31 October 2016 was 5%.

Staff turnover in the period December 2015 to November 2016 was 54%.

The staff we spoke with felt able to raise concerns without fear of victimisation. In the twelve-month period between November 2015 to October 2016, there was one reported case of alleged bullying. Independent staff from Barchester completed a full investigation. This allegation was not upheld.

We were told staff are made aware of whistle blowing policy on induction. The staff we spoke to knew about the organisation's whistleblowing policy, and knew they could contact external organisations if they felt unable to go directly to managers within the hospital. We saw posters about whistle blowing on all wards, in the main reception and the staff room.

The staff we spoke to were committed to their work, and wanted to deliver patient care that was the best it could be. Staff who had been within the service a number of years reported low morale amongst the staff group. They specifically identified the loss from ward teams of committed and experienced staff.

Within each ward, the provider gave opportunities for staff to develop and extend their roles. Staff told us they are supportive of one another however, four staff commented on the need to accept that sometimes things need to change. They identified that the reluctance of some staff to do this created unnecessary tension within the hospital. Whilst staff felt empowered by changes happening across the hospital, others felt things happened too quickly and without adequate consultation.

Most staff reported they felt supported by their supervisor and within their ward team. At the time of our inspection, the hospital manager, who was not an occupational therapy clinician, supervised the work of the occupational therapy assistants. However, the occupational therapy assistants felt supported in their role by this.

We saw a policy relation to duty of candour, staff received training and told us they would need to be open and transparent and explain to patients if or when something goes wrong.

Staff communication took place on each ward at monthly team meetings. General staff meetings took place every two months for all staff with the hospital director. Senior management team meetings were held monthly and attended by all heads of department. Staff could give input and feedback into the service through these forums and at morning meetings. There was also a suggestion box in the reception area with slips for both staff and patients to complete. The hospital director told us he had an open door policy so staff could raise issues and suggestions within the service. Whilst about half the staff we spoke to said they felt heard by senior managers, others felt their ideas had been overridden in some of the recent changes made.

Commitment to quality improvement and innovation

The hospital supported its administrative staff in external learning programmes. Their administrator won Barchester's divisional award for best hospital administrator in 2016.

In the four months up to 31 October 2016, processes had been reviewed and new divisional forms had been introduced to the hospital to ensure consistency of reporting, for violent incident/restrictive intervention; complaints/concerns/whistleblowing; observation and medication balance discrepancies.

Patients were involved in meetings with Hull commissioners. Hospital staff attended a quarterly meeting for providers of services with Hull adults safeguarding protection board, at these meetings staff shared experiences and discussed benchmark reporting. The accountable officer from the service was involved in meetings with the local intelligence network for controlled drugs.

Staff had received the training in an initiative to deliver improved dementia care using a collection of

Long stay/rehabilitation mental health wards for working age adults

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measurement tools to support interventions that improve the quality of patients' lives. This included the involvement of the patient and their family, improving an individual's well-being, help after diagnosis, meaningful activity, orientation within the ward environment, medication, legislation and end of life care. Plans had been made to introduce the programme on Ullswater ward at the beginning of 2017.

Outstanding practice and areas for improvement

Outstanding practice

The hospital offers patients the opportunity to complete accredited programmes of learning through the Award Scheme Development and Accreditation Network. This external curriculum development organisation and awarding body, is a charity offering programmes and qualifications that explicitly grow skills for learning, skills for employment and skills for life. Courses were overseen by an external trainer, with hospital staff who had undertaken specific training from the organisation supporting patients to complete their programmes of learning.

At the time of our inspection, five patients were participating in this program. Two had already completed and passed an independent living module and three had portfolios ready to be marked. The courses offered through this education provider build on the strengths and interests of individual patients.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff have the opportunity to complete mandatory and legislative training in a timely manner.
- The provider must ensure ward managers have sufficient time to complete regular and effective supervision and appraisal of staff.
- The provider must prioritise staff recruitment and retention.
- The provider must 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 must ensure cleaning throughout the hospital is consistently comprehensive.
- The provider must ensure that dirty linen trollies are stored away from patient areas.
- The provider must ensure there is a robust processes to assess, review and manage risk.

Action the provider SHOULD take to improve

- The provider should ensure in wards that admit patients living with dementia identification within the environment is dementia friendly.
- The provider should ensure that a consultant psychiatrist can attend the hospital in the event of a psychiatric emergency within 30 minutes.
- The provider should ensure effective processes to disseminate lessons learned following complaints or investigations.

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 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not met: Cleaning throughout the hospital was not consistently comprehensive. The cleaning rotas completed throughout the hospital showed gaps across one calendar month on 13 days due to shortages of staff, whilst efforts had been made to bring in agency staff these had been unsuccessful. The hospital had purchased trolleys to avoid putting dirty laundry on floor, previously identified as an infection risk however, we saw these trolleys containing dirty laundry inappropriately stored in bathrooms. Whilst wheeled elsewhere when a bathroom was in use, this was not an appropriate location for these trolleys. This was a breach of regulation 15 (1)(a)(f)

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 met: Whilst a hospital risk register had been in place since July 2016, there was no evidence that individual items had been updated since its introduction. The risk register was marked for review in clinical governance meetings. Eleven risks were identified as requiring individual review in August 2016 and three in October 2016. Minutes from the clinical governance meetings in August and October did not show evidence that any of these the individual risks had been reviewed.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17(2)(b)

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 met: Staff recruitment and retention was of on going concern, with turnover in the last year 54%. This meant repeated changes of key worker for patients and the loss of experienced staff from ward teams. At times when ward managers and charge nurses spent their supernumerary hours delivering direct patient care they were unable to fulfil all their managerial duties. There was neither a psychologist, nor an occupational therapist in post at the time of the inspection. For inpatient mental health rehabilitation services the fundamental standard of care states that patients are offered evidence based psychological interventions and have access to occupational therapy. For older adult patients living with dementia we would expect regular input from an occupational therapist and sessional input from psychology. This meant that the range of disciplines involved in care was not wide enough to be effective in meeting patient's psychological and physical care needs. Having reviewed mandatory training requirements the provider had recruited specialist trainers with the aim of centralising and standardising training at the provider level. Whilst this was due to be launched after our inspection there had been a gap in training provision for staff since the summer 2016. Staff were concerned they had had limited access to training since the previous provision training much of which had been delivered internally ceased. The low compliance figures for training reflect these concerns. Overall training compliance for legislative and mandatory was 70% this fell below the provider's target of 85%. For seven of the 16 modules compliance was below 60%.

This section is primarily information for the provider

Requirement notices

Staff did not receive a minimum of six sessions of supervision per year. The provider's target for this was 85%; the supervision compliance rate was 62%.

Staff were not appraised annually, the provider's target for this was 85%, and the appraisal rate showed the compliance rate was 68%.

This meant staff did not have sufficient up to date training, supervision or appraisal to meet all the needs of the individual patients in their care.

This was a breach of regulation 18 (1) (2)(a)