Baldock Manor

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated Baldock Manor as inadequate because:

- Risk assessments lacked detail, were not fully completed, and did not include details of how staff would manage or mitigate risk.
- Care plans were generic and were not person centred, specific, measurable, achievable, relevant, or timely in line with guidance. Staff did not review care plans regularly or document changes in patient's progress or deterioration.
- Staff regularly used seclusion and restrictive interventions, senior staff did not identify that these practices were in use or record these as an incident or a safeguarding issue. We asked for information on seclusion and restraint before the inspection but managers did not provide this.
- Electronic incident reports were not fully completed. Incidents had taken place but staff had not recorded them in patients' case notes. When senior managers investigated serious incidents, they did not identify lessons learnt to minimise the risk of repeated incidents.
- Staff did not store, dispense, or administer medications in line with legislation and guidance.
- The lay out of the wards meant staff could not guarantee quick access to the emergency equipment.
- Staff did not assess the physical health needs of patients fully. They did not always monitor patients' blood for diabetes nor did they follow up abnormal blood test results. The fluid charts that staff completed showed eight patients' intake was below the recommended daily amount.
- Staff did not always provide care that was compassionate. For example, they left patients in protective clothing outside of meal times. During our visit, one patient did not have breakfast because there were too few staff on duty to assist them out of bed. Two patients told us that sometimes staff had arguments in front of them and did not always speak English on the wards.
- One ward did not promote comfort or dignity. There was only enough space for two patients to eat at a table, meaning the other patients had to eat their meals off a tray on their laps. Another ward compromised patient dignity and privacy because of glass panels in interlocking doors between a female and male ward and bedrooms.
- Patients with mobility problems could not access two garden areas due to steep steps although other areas were provided at the front of the hospital.
- The service had high vacancies and relied on agency staff. They did not hold accurate records for permanent staff or do full checks on agency staff. This all affected patient outcomes.
- 62% of staff had completed mandatory training.
- The layout of the service meant all wards had blind spots, so staff could not fully observe patients.
- Oakley ward did not comply with the Department of Health's guidance on same sex accommodation.
- Staff did not routinely carry out environmental audits.
- The provider could not give example of how audits, which clinical staff participated in, had led to improvements in the service.
- Staff did not receive specific training the Mental Health Act or undertake regular audits to ensure that they applied the MHA correctly.
- Fifty eight percent of staff had training in MCA. Staff did not assess individual capacity in relation to medical interventions.
- The procedure for patients to make complaints was not robust, efficient, or accurate.
- The provider did not operate an effective system to monitor or improve the quality of the service. The provider did not use key performance indicator and other indicators to measure the performance of the service.

However:

- All staff received supervision and 81% of staff had received training in Deprivation of Liberty Safeguards and Code of Practice changes.
- Patients had access to an independent mental health advocate. All wards and the reception area had information on treatments, local services, patient rights, and how to complain.

Summary of findings

- From the interactions we observed, staff interacted with patients in a caring and respectful manner. When patients were admitted to the service staff showed patients around and introduced them to other staff and patients.
- The kitchen provided a wide choice of meals for patients and this choice extended to catering for specific dietary requirements.
- Staff and patients told us that senior managers were approachable and visible to staff and patients. There were no reported bullying and harassment cases.
- Staff told us that morale on the wards was good. They reported that there was a good skill mix and staff worked together as a team.

Summary of findings

Contents

Inadequate

Baldock Manor

Services we looked at

Long stay/rehabilitation mental health wards for adults

Summary of this inspection

Background to Baldock Manor

Baldock Manor was a private hospital that provided a rehabilitation service to people who have needs related to their mental health and who are either detained under the Mental Health Act1983, or are voluntarily staying at the hospital.

There were four wards:

• Radley – Learning Disability ward with 10 beds

• Mulberry – Mental Health, male ward with 21 beds

• Burberry – Mental Health, female ward with 9 beds

• Oakley – Older People, mixed sex ward with 10 beds.

At the time of the inspection, there were 44 patients at Baldock Manor.

Nouvita Limited owns Baldock Manor. Nouvita Limited has two other services Howe Bell Manor and The Coach House, which provide adult social care.

The Care Quality Commission last inspected Baldock Manor on 12 November 2013 and found it to be compliant across the five assessed outcomes inspected.

Our inspection team

The team that inspected Baldock Manor consisted of an inspection manager, five inspectors, two mental health act reviewers, an inspection assistant, pharmacy inspector and a specialist professional advisor.

The team would like to thank all those who met and spoke to inspectors during the inspection.

Why we carried out this inspection

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

How we carried out this inspection

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

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

During the inspection visit, the inspection team:

- visited all four wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with seven patients who were using the service and collected feedback from 14 patients using comment cards, spoke with one carer, interviewed 23 staff including the senior managers and other staff members; doctors, nurses, occupational therapist, and a psychologist
- reviewed in detail 24 care and case records of patients
- carried out a specific check of the medication management on all wards
- inspected 15 medication prescription charts
- reviewed 27 incident reports
- looked at a range of policies, governance procedures, audits and other documents relating to the running of the service.

Summary of this inspection

What people who use the service say

- Three patients told us that the staff looked after their needs and they felt cared for and listened to.
- Patients told us when they were admitted to the ward staff showed them around the service and introduced them to other members of staff and patients.

However:

- Two patients reported that staff had arguments in front of them and this was supported by a notification from the provider.
- Patients told us that some staff communicated with each other in different languages at times which patients said they did not like

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?

Inadequate

We rated safe as inadequate because:

- Out of 15 risk assessments examined in detail, staff had only fully completed four. 11 lacked detail, did not provide details on how staff would manage or mitigate the risk and were not reviewed following incidents.
- Staff did not store, dispensed or administer medications in line with legislation and guidance.
- The layout of the wards meant staff could not guarantee quick access to the emergency equipment. The doors between the wards were keypad locked and staff needed to go through six doors to access the equipment.
- Staff used seclusion and restrictive interventions. Senior staff did not identify that these practices were in use and did not record them as an incident or manage them in line with the safeguards set out in the Mental Health Act code of practice.
- Senior managers did not provide information, when requested, about the use of seclusion and restraint.
- Senior managers investigated 32 serious incidents, but did not identify the lessons learnt to minimise the risk of repeated incidents.
- Electronic incident reports were not fully completed. We found evidence that incidents had taken place but staff had not recorded them in patients' case notes.
- The layout of the service meant all wards had blind spots, so staff could not fully observe patients.
- Oakley ward did not comply with Department of Health's guidance on same sex accommodation.
- Staff did not routinely carry out environmental risk assessment audits.
- The service had 29 staff vacancies, which meant that they relied on bank and agency staff. The provider did not hold accurate records for permanent staff or do full checks on agency staff. This all affected patient outcomes.
- 62% of staff had completed mandatory training.

Are services effective?

Inadequate

We rated effective as inadequate because:

- The provider did not assess the physical health care needs of patients. Patients had care plans which established the amount

Summary of this inspection

of monitoring required but staff had not adhered to the care plans. Staff did not follow up abnormal blood test results or carry out further investigations or provide treatments to safeguard the patients.
- Fluid charts did not accurately record the amount of fluid that patients drank on Oakley ward. The daily recorded fluid intake for eight patients was below the recommended daily amount of fluid per day.
- Staff did not assess capacity in relation to medical interventions.
- Care plans were generic and were not person centred, specific, measurable, achievable, relevant, or timely in line with guidance. Staff did not review care plans regularly or document changes in patient's progress or deterioration.
- Clinical staff participated in audits to monitor the effectiveness of the service. However, the provider was not able to give examples of how these processes had led to improvements in the service.
- Only 58% of staff had training in the Mental Capacity Act.

However:

- Eighty one percent of staff had received training in the Mental Health Act.
- Records showed that staff received supervision.
- Eighty one percent of staff had received training in Deprivation of Liberty Safeguards and Code of Practice updates.
- Patients had access to an independent mental health advocate.

Are services caring?

Requires improvement

We rated caring as requires improvement because:

We observed interactions between staff and patients;

- Staff were not always kind and caring towards patients. For example, staff left patients in protective clothing outside of meal times. One patient did not have access to their breakfast, as there was not enough staff on duty to assist them out of bed.
- Two patients reported that two staff had an argument in front of them and a notification received from the provider supported this.
- Two patients told us that some staff used different languages to communicate to each other at times which patients said they did not like.

However:

- We observed staff interact with patients in a caring and respectful manner when patients were distressed.

Summary of this inspection

- Three patients told us that staff looked after their needs and they felt cared for and listened to.
- Patients told us when they were admitted to the ward staff showed them around the service and introduced them to other members of staff and patients.

Are services responsive?

Inadequate

We rated responsive as inadequate because:

- The ground floor of Mulberry ward did not promote comfort or dignity. Due to the size of the ward area, only two patients could eat at a table at a time, so other patients had to eat their meals from a tray on their laps.
- Glass panels on an interlocking door between Mulberry (male) ward and Burberry (female) ward compromised patient dignity, as the glass was not opaque.
- Patients on Radley ward had no privacy because the bedroom doors had unobscured glass in the window panels. People walking along the corridor could look in to their bedrooms.
- Staff and patients on Mulberry ward could not make a drink as the ward kitchen was upstairs and the patients had limited access to it.
- The complaints procedure was not robust, efficient, or accurate.
- Not all care records reviewed included discharge care plans.

However:

- Patients could make phone calls in private by using office phones or their own mobile phones.
- The kitchen provided a wide choice of meals for patients, and we saw evidence that this choice extended to catering for specific dietary requirements.
- Information on treatments; local services; patient rights; advocacy and how to complain was available in the reception area and on the wards.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- The provider did not operate an effective system to monitor or improve the quality of the service. The provider could not demonstrate how processes such as audits, complaints and service user feedback led to improvements in the service.
- Senior managers did not demonstrate that they had reviewed actions from previous audits or made improvements to practice as a result.

Summary of this inspection

- Senior managers did not have robust monitoring systems in place for reviewing the use of restrictive interventions and safeguarding incidents.
- The provider did not use key performance indicators or other measures to gauge the performance of the service.

However:

- Staff and patients told us that senior managers were visible to them and they felt able to approach them.
- There were no reported bullying and harassment cases.
- Staff told us that morale on the wards was good. They reported that there was a good skill mix and that staff worked together as a team.

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.

- Eighty eight percent had received training in the Mental Health Act (MHA).
- Eighty one percent of staff had received training in Code of Practice changes.
- We looked at MHA documents across the service. Staff had filed the documents correctly in patient files and they had been completed correctly.
- Doctors granted some patients Section 17 leave. We saw that the forms included frequency and duration of the leave authorised for each individual patient however, it was not evident if patients had a copy of the form. Staff had not recorded and patients did not sign to say they had a copy.
- Staff completed consent to treatment forms. Staff attached copies of consent to treatment forms to medication charts. We saw that doctors discussed consent to treatment for medication with patients and recorded these in case records.
- Staff read patients their Section 132 rights on admission and routinely thereafter. Staff had easy read documentation to support the patients to understand their rights. Once completed, staff filed the forms in patients' case notes.
- Support and legal advice on implementation of the MHA and code of practice were available onsite or via the MHA administrator. Staff reported they would seek this support when required.
- Detention paperwork was filed correctly, up to date and stored within the patient case notes.
- The MHA administrator maintained a spreadsheet to ensure MHA paperwork was in date and correct.
- Patients had access to independent mental health advocate (IMHA) services. Staff were clear on how to access and support engagement with the service. We saw posters in the reception area and on wards advertising this service.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Fifty eight percent of staff had training in the Mental Capacity Act (MCA).
- Eight one percent of staff had received training in Deprivation of Liberty Safeguards.
- Senior managers told us they did not use Deprivation of Liberty Safeguards (DoLS) within the service. However, case notes for one patient recorded that they were subject to DoLS. We could not however locate the DoLS application for this patient in the case records.
- We interviewed staff and asked them about their knowledge of the MCA. They appeared to have a basic understanding of capacity issues but could not give examples of how they would transfer this knowledge in to their practice on the wards.
- The service had a policy on MCA including DoLS which staff could refer to when required.
- When we reviewed case records we saw that staff had not assessed patients' capacity. For example, a care plan highlighted that a patient required medical intervention due to physical health concerns with their feet, but due to their current mental state was refusing to have any treatment. The care plan outlined that staff were liaising with the local hospital to have this treatment given. There was no record of a capacity assessment or best interest meeting.

Inadequate

Long stay/rehabilitation mental health wards for adults

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

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

Inadequate

Safe and clean environment

- The layout of the buildings meant that all wards had blind spots. Staff could not observe areas of the wards at all times to keep patients safe. There were no mirrors to mitigate this risk, so staff relied on intermittent observations.
- We did not receive a comprehensive ligature assessment for Burberry ward and received no ligature audits for Mulberry and Radley wards. Oakley ward had a basic risk assessment with risk mitigation documented as staff intervention.
- Oakley was a mixed sex ward and did not comply with Department of Health guidance on same sex accommodation. Bedrooms were not on separate parts of the wards. Bedroom doors were propped open with furniture meaning patients of the opposite sex could walk past, or into, patients' bedrooms, as staff did not observe the bedroom corridor at all times. The propping open of doors was in breach of both health and safety, and fire regulations.
- Clinic rooms were fully equipped and stored emergency drugs. Nurses shared emergency equipment between wards and made sure they checked and recorded the equipment regularly.
- Staff found it difficult to access emergency equipment quickly because doors within the service had a keypad for staff to enter numbers, which changed weekly. Staff had to go through six doors, each with different numbers, to deliver the equipment to another ward in an emergency. Managers provided details of emergency drills undertaken since August 2015. However, these did not include details about the time to move emergency equipment to a required area.
- All ward areas were clean and had good furnishings that staff maintained well. However, we observed specialist furniture which had been purchased for a patient that staff had not assembled for the patient to use. We brought this to the attention of senior management during the inspection and they built the furniture for the patient.
- The hospital manager had carried out an infection control audit in 2015. The audit demonstrated that staff put patients at risk because they did not follow infection control principles. An action plan identified what actions staff needed to completed to achieve compliance but there was no timescales or records to demonstrate that staff had completed them.
- Cleaning records were up to date and demonstrated that the hospital was cleaned regularly. Although, during the inspection staff told us that due to lack of cleaning staff, nursing assistants carried out cleaning duties. The provider gave us documentation stating that five cleaning staff were employed. However, the provider did not tell us what the required level of cleaning staff was.
- Senior managers completed environmental risk assessment whilst we were on site. The assessment identified areas that managers needed to address. Although we asked to see earlier environmental audits we were not given these.
- Staff carried personal alarms and nurse call systems were in patients' bedrooms, which they could use to summon assistance if required.

Inadequate

Long stay/rehabilitation mental health wards for adults

Safe staffing

- Throughout the inspection process, the provider and registered manager failed to provide fundamental information about the level of staffing for the service. On the follow up inspection, senior managers provided a list of staff that was inaccurate. This included staff who no longer worked at the hospital and staff who were due to but were yet to start work. The information provided showed that the established figure for qualified nurses was 25 with 13 currently in post. The established figure for unqualified staff was 47, with 30 currently in post. The service was actively recruiting staff and had four staff waiting for recruitment checks to be completed before they could start work.
- Senior managers used the Royal College of Nursing (RCN) guidance to calculate staffing levels.
- The service used agency staff across all areas. Managers preferred to use staff that were familiar to the ward. To achieve this, they block booked four agency qualified nurses and three support workers.
- We reviewed 24-hour daily report books from 01 October 2015 to 31 October 2015. There were 18 day shifts and two night shifts that did not meet the required levels of staffing. The reports did not highlight the ratio of agency staff to permanent staff.
- Senior managers were inconsistent in their reports of the number of agencies that the service used. First, they said they used 12 agencies, but later said nine. We requested contracts for agencies and were given terms and conditions for five. These did not detail full requirements to make sure staff had necessary training and background checks. Senior managers did not provide details of how the provider set out specific requirements for training of the agency staff to ensure they had the skills necessary to work with the patients.
- The provider stored staff human resource records on an electronic database. We looked at 12 records, eight for qualified staff, and four for unqualified staff. The records held inaccurate information and were incomplete.
- While ward managers could adjust staffing levels daily to take into account the patient need, they had to use agency staff if they needed additional support.
- The service had low staff sickness rates. Between May and November 2015 only 46 working days were missed due to staff sickness.
- Staffing levels affected outcomes for patients. For example, a patient fell and hurt themselves when on leave in the community. They phoned the ward and were told there was not enough staff on duty to give the patient support. The patient had to make their own way back to the ward.
- The service did not keep records when section 17 had been cancelled and we found no evidence that this was recorded in patients' notes.
- The consultant psychiatrists shared on call duties during the day and night to provide medical cover. Staff contacted the consultants if there was an emergency on the ward.
- 62% of staff completed mandatory training meaning they might not have received adequate training to help them care for patients effectively.

Assessing and managing risk to patients and staff

- Incident reports and patients case records showed that the service used restraint but senior managers said they did not. Although we requested data before the inspection about the number and types of restraints that had taken place, we did not receive this.
- Risk assessments lacked detail and staff did not review them following incidents. Where staff had identified risk, they did not provide details on how they would manage or mitigate the risk. Out of the 15 risk assessments we looked at, staff had only fully completed four and reviewed one more than once. The service policy states that after an incident staff should review the current risk assessment or undertake a new one. The records showed they did not review risk assessments when they should have.
- Staff reported that the six informal patients could leave at will. However, they received no information to inform them of this right.
- Only 56% of staff received training in restraint. Staff confirmed that they tried de-escalation and other interventions before using restraint techniques.
- Doctors prescribed rapid tranquilisation in line with NICE guidance.
- When the provider assessed risk, they did not have an understanding of how to mitigate the risks proportionately or using the least restrictive option. For example, we saw care plans for two patients stating that if they become agitated they were to go to their room or staff would take them to their room. The patients had to stay in their bedroom to reflect on their behaviour. Another care plan recorded that if the patient became agitated, staff should remove their walking aid. These

practices constituted seclusion and restrictive interventions as defined in the Mental Health Act code of practice. Staff did not record either of these practices as an incident or manage them in line with the safeguards set out in the code of practice.
- 62% of staff were trained in safeguarding. Staff could explain what a safeguarding incident was and how to make an alert.
- The provider did not ensure the safe management of medicines. Medications were not stored, prepared, dispensed, or administered in line with legislation and guidance. We reviewed three patients' prescription charts that had medication administered covertly on Oakley ward. While they had covert medicine checklists, there were no care plans, consent or best interest assessment or record of the decision making process for the administration for covert medication since their admission.
- A prescription chart had a control drug solution prescribed, but on the day of inspection, the ward only had tablets in stock. A nurse confirmed that they administered the medication in tablet form without the correct prescription in place. We noted that the prescription chart had been corrected during the inspection on 18 November 2015.
- The provider did not have an audit process to account for all movement of stock medication or to identify any inappropriate losses.
- The controlled drug register on Mulberry ward had not been completed correctly. For example, staff wrote the patient's name instead of the drug name, form and strength. We found a discrepancy in entering 120mls methadone into the register. So, staff could not follow the subsequent entries and make sure that the medication reconciled.
- Medication was not stored securely at all times. Oakley ward's medication trolley was in the dining area. Although staff had locked the trolley, they had not securely attached it to the wall. Staff could not lock fridges used to store medication, as they were domestic fridges.
- Staff knew how to record patient falls or pressure ulcers. Staff had identified patients with pressure ulcers, completed a body map of where the pressure sore was, and had graded these. However, staff did not take any further action to ensure the pressure ulcer did not get worse.
- The provider did not allow children to visit the main ward areas but they did make rooms available for visits within the service.

Track record on safety

- The service had 32 serious incidents requiring investigation between 26 September 2014 and 17 August 2015. Nine incidents related to physical abuse, two to sexual abuse and one to emotional abuse For 20 incidents the category of abuse had not been identified. Managers investigated these, but did not identify lesson learnt or the actions to minimise the risk of repeated incidents. During the inspection, we found discrepancies in the number of incidents that had occurred. We were concerned that we identified other incidents staff did not report.
- Monthly clinical governance and senior management meetings discussed the risk incidents. We reviewed the minutes of these meetings and found that although they did discuss serious incidents, they were not in detail or include lessons learnt.

Reporting incidents and learning from when things go wrong

- The information we received before and during the inspection, on the number of incidents was not consistent. What we received from the provider was not the same as the information from hospital managers.
- Staff did not follow the internal procedure for reporting incidents and senior managers did not make sure that staff had followed it correctly. Staff said they knew how to use the electronic reporting system but when seniors manager provided a 'Lesson Learnt' document, which listed incidents with stated outcomes, it listed three incidents that staff had not recorded on the system.
- Some patients told us that senior managers did not offer apologies when serious incidents happened.
- While there were regular staff meetings, the minutes we saw did not show that they shared lessons learned from investigations of incidents across the service.

Inadequate

Long stay/rehabilitation mental health wards for adults

Are long stay/rehabilitation mental health wards for adults effective?
(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

- The provider did not accurately record in patients care plans what care and treatment was provided to ensure the physical health needs of patients was being met. Data provided prior to the inspection showed that 89% of patients received a physical health check. We reviewed in detail four patient case records to look at how the provider monitored and met ongoing physical health needs of the patients.
- The patients did not have access to a GP. Senior managers were working with external agencies to address this. However, one of the consultants provided a GP service for the patients. Patients had routine physical examinations, for example electro cardiograms off site. If patients became physically unwell, they were referred to the local hospital for treatment.
- Staff did not carry out diabetic blood monitoring in line with patients' care plans. Evidence received from the provider showed that additional actions were taken to respond to the physical health needs. However, there were inconsistencies in the recording of the information in patient's records. Care plans, medication records and case notes did not therefore always reflect accurately the care and treatment that the patient required.
- When monitoring the physical health of patients staff did not follow up abnormal results after they carried out routine blood tests. We found no evidence in case notes that staff had repeated the test or if they made other investigations. Patients risked having undiagnosed and untreated physical health issues, which would affect their long-term physical health.
- We found that one patient refused to have a physical examination. There was no entry on the case notes that staff had offered any further physical examinations after the refusal. Staff had not discussed any therapeutic interventions that might build a positive therapeutic alliance to achieve a positive outcome for the patient's health.
- Not all care plans were specific, measureable, achievable, relevant and timely (SMART goals) in line with guidance. We reviewed 19 care plans during the inspection, and the majority appeared to be generic. The delivery of care was not always person centred or focussed on the individual needs, as interventions were the same on the majority of care plans. The care plans did not highlight who would provide the intervention, within the multi-disciplinary team. Staff had completed the majority of the care plans in October 2015.
- Information needed for delivering patient care and treatment was not always filed correctly. It was paper based and not stored on the ward. This meant accessing the records in an emergency was difficult.

Best practice in treatment and care

- The service did not follow National institute for health and care excellence (NICE) guidance when prescribing medication. There were significant lapses and monitoring of people's medication that departed from NICE guidelines.
- A psychologist and an assistant psychologist provided patients with psychological therapies as recommended by NICE in a group or individual sessions.
- On Oakley ward, staff monitored eight patients' nutrition and hydration needs. We reviewed fluid charts from 27 October 2015 to 12 November 2015. However, the provider could not locate or produce the charts from 01 to 05 November when requested. We found that the eight fluid charts, dated from 27 to 30 October 2015 and from 06 to 12 November 2015, did not accurately record the amount of fluid that the patients drank. Some records stated the type of fluid given but not the amount. The daily-recorded fluid intake for the eight patients ranged from 360mls to 1150mls in a day. This was below the Association of UK Dietitians (BDA) recommendations of 1.6 litres to 2.0 litres of fluid per day depending on gender. There was no evidence in case records that patients' fluid intake had been discussed or reviewed within the multidisciplinary team.
- The provider used health of the nation outcome scales (HONOS) to monitor outcomes for patients.
- Clinical staff participated in audits to monitor the effectiveness of the service. However, the provider was not able to give examples of how these processes had led to improvements in the service.

Skilled staff to deliver care

Inadequate

Long stay/rehabilitation mental health wards for adults

- The multi-disciplinary team consisted of nurses, occupational therapists, doctors, support workers psychologists and a social worker. Outside agencies carried out specialist assessments such as physiotherapy and speech and language therapy when required.
- Senior managers told us staff completed an induction before starting work on the wards. They provided information about how many staff attended and the topics covered.
- The provider's supervision policy states that staff were to attend supervision bi monthly or six times a year. Records showed 100% compliance although this was a tick box exercise. The supervisee and supervisor had not signed the forms. There were no supervision contracts on staff's files.
- Data showed that 16 staff had completed their yearly appraisal. However, the majority of staff were not due to have them completed, as they were new to the service.
- Although data showed the service offered specialised training, the training records only showed one specialised training session which was for autism. 15 staff had attended this training as they were working with a patient with autism.

Multi-disciplinary and inter-agency team work

- The weekly multidisciplinary team meetings were recorded inconsistently in the case records.
- Shift to shift handovers took place within the wards. Staff discussed each patient individually and they handed over all relevant information, as well as any outstanding actions that needed following up. Staff documented handovers so that they could refer to the information if needed.

Adherence to the MHA and the MHA Code of Practice

- Eighty eight percent of staff had received training in the Mental Health Act (MHA).
- Eighty one percent of staff received training in Code of Practice changes.
- We looked at MHA documents across the service. Staff had filed the documents correctly in patient files and they completed them correctly. Doctors granted some patients Section 17 leave. We saw that the forms included frequency and duration of the leave authorised for each individual patient however, it was not evident if patients had a copy of the form. Staff had not recorded and patients did not sign to say they had a copy.
- Staff completed consent to treatment forms and attached copies to medication charts. We saw that doctors discussed consent to treatment for medication with patients and recorded these in case records.
- Staff read patients their Section 132 rights on admission and routinely after. Staff had easy read documentation to support the patients to understand their rights. Once completed, staff filed the forms in patients' case notes.
- Support and legal advice on implementation of the MHA and code of practice were available onsite or via the MHA administrator. Staff said they would ask for support they needed it.
- Detention paperwork was filed correctly, up to date and stored within the patient case notes.
- The MHA administrator maintained a spreadsheet to ensure MHA paperwork was in date and correct.
- Patients had access to independent mental health advocate (IMHA) services. Staff knew how to access and support engagement with the service. We saw posters in the reception area and on wards advertising this service.

Good practice in applying the MCA

- Fifty eight per cent of staff had training in the Mental Capacity Act (MCA).
- Eight one percent of staff received training in Deprivation of Liberty Safeguards.
- Senior managers told us they do not use Deprivation of Liberty Safeguards (DoLS) within the service. However, case notes for one patient recorded that they were subject to DoLS. We found no DoLS application in the case records.
- We spoke with nine staff about their knowledge of the MCA. They informed us that they had completed training. One member of staff had a good understanding. However, eight staff could not describe how the service would formally assess patients' capacity if required.
- The service had a policy on MCA, including DoLS, which staff could refer to when needed.
- When we reviewed case records and saw that staff had not assessed patients' capacity. For example, a care plan highlighted that a patient needed medical intervention due to physical health concerns with their feet but due to their current mental state refused to have any treatment. The care plan showed staff were working with the local hospital to treat the patient but not capacity had been sought. There was no record of a capacity assessment or best interest meeting.

Inadequate

Long stay/rehabilitation mental health wards for adults

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

Requires improvement

Kindness, dignity, respect and support

- Staff interactions with patients were not always kind or caring. Staff were not always consistent in their engagement with patients. For example, staff had left patients in protective clothing an hour after meal times. A patient told us that staff had left them in bed, as there was not enough staff to get them out of bed. On Oakley ward, we saw that a patient was still in bed in bed at 10.15hrs and had not eaten breakfast because there were not enough staff available to help them out of bed.
- Two patients told us that staff sometimes spoke to each other in different languages and they did not like this. They also reported that two staff had argued in front of them. The provider had addressed this issue formally with staff.
- Staff told us that they were aware of individual needs.

The involvement of people in the care they receive

- Patients told us when they were admitted to the ward staff showed them around the service and introduced them to other members of staff and patients.
- Some patients told us that they had discussions with members of the multidisciplinary team about their individual treatment plans. A few patients completed their care plans with staff, while others signed their care plans after staff completed them.
- Patients had access to an independent advocacy service, who visited weekly.
- Although patient satisfaction surveys were completed in June 2015, the service had not analysed their outcomes. They did not have action plans to improve the service for staff and patients based on the information from the surveys.

Are long stay/rehabilitation mental health wards for adults responsive to people's needs?

(for example, to feedback?)

Inadequate

Access and discharge

- During the inspection there were 44 patients in the service.
- Managers transferred patients between wards, where they identified individual clinical need.
- Not all care records reviewed included discharge care plans. However, a patient told us that they were being discharged and they had visited their placement and met their community support worker.
- Senior managers were not monitoring the discharge process as the service had not had any and therefore no information was available.

The facilities promote recovery, comfort, dignity and confidentiality

- A range of equipment was available to support treatment and care of patients. However, clinic rooms were small and they did not have examination couches to examine patients if required.
- Wards had meetings rooms for patients to meet visitors or staff. Although we were shown activity rooms these rooms were not equipped as activity rooms. There was no evidence that activities were taking place in these rooms, such as board games, art and crafts.
- The ground floor of Mulberry ward was a six-bed ward. The bedrooms were adequate in size. However, the corridor was narrow and the communal area was a converted bedroom so unsuitable to use as a day and dining area. The toilet did not have enough space to move, or for staff to support patients in an emergency.
- On two wards, patients' dignity was not protected. The all-male ground floor of Mulberry ward and the all-female Burberry wards had an interlocking door at the end of the bedroom corridor, with glass panels. Staff ensured that the door was locked. However, female and male patients could look directly into each other's bedroom corridors.
- On Radley ward, bedroom doors had clear glass in the window panels. This meant that when walking along the bedroom corridor staff, patients and visitors could see into patients' bedrooms. This breached the patients' privacy and dignity.

Inadequate

Long stay/rehabilitation mental health wards for adults

- Patients could make phone calls in private by using office phones or their own mobile phones.
- Wards had access to outside space, on Oakley and Radley wards patients had limited access to the garden because of steep steps. For people with limited mobility this posed a risk of falls. However, patients would use the garden area at the front of the hospital to reduce the risk of falls.
- The kitchen provided a wide choice of meals for patients, and we saw evidence that this choice extended to catering for specific dietary requirements. We saw patients asked for food different form the menu, because they did not like the choices on offer, and staff accepted their requests.
- Patients could make drinks independently or staff helped them to. Staff provided snacks throughout the day. However, Mulberry ward (downstairs) did not have a kitchen so staff had to leave the ward to make drinks for the patients. Staff made sure cold drinks were available in the lounge.
- Some patients had personalised their bedrooms with the choice of furniture, posters and bedding.
- Patients could store their belongings securely in their rooms, based on risk assessments.
- Programmes of weekly activities were on display in main ward areas. The only activities that we saw taking place during the inspections were carried out by the gym instructor. The service did not timetable activities at weekends for patients.

Meeting the needs of all people who use the service

- The service provided disabled access and had lifts onsite to ensure access to upper floors.
- Information on treatments, local services, patient rights, advocacy, and how to complain was available in reception area and on the wards. The information was available in an easy read version. If patients needed interpreters or people trained in sign language for meetings, the service provided them.

Listening to and learning from concerns and complaints

- The complaints process was not robust, efficient, or accurate. We asked for data about complaints on three occasions and received different figures each time. The provider gave inaccurate information about the number of complaints. The provider showed no evidence that they learnt lessons from complaints or reduced the risk of the issue happening again.
- Although patients knew how to complain and received feedback, they reported that staff did not apologise to them when complaints were upheld.
- Two staff we spoke with told us that complaints were discussed at MDT meetings.

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

Inadequate

Vision and values

- The provider did not give us their organisational values and objectives when requested. However the provider's website listed their aims and objectives. We observed these values and objectives were displayed on the wall in the reception area of the service:

Nouvita's Aims

1.To nurture, encourage and support our residents, by delivering care via highly trained and dedicated staff.

2.To work in partnership with service users, their families, carers, primary health care colleagues and other professionals in the provision of care.

3.To ensure availability of relevant services to meet clinically defined needs in order to promote independence and wellbeing.

4.To operate within the statutory and professional bodies' obligations, policies, procedures and guidelines.

5.To support residents through acknowledgment of their personal lifestyle choices

Nouvita's Objectives

1.Provide care that is consistent with meeting individual needs of residents.

2.Review the needs in order to maximise service quality.

3.Review and monitor quality standards and address issues as they arise.

4.Train and develop staff skills and knowledge base.

Inadequate

Long stay/rehabilitation mental health wards for adults

5.Manage resources efficiently to provide a wide range of effective care.

- Staff knew who the senior managers were and reported that they were approachable and supportive.

Good governance

- The provider did not operate an effective system to monitor or improve the quality of the service. The provider could not demonstrate how processes such as audits, complaints and service user feedback led to improvements in the service. They were not able to identify and assess risks to the health and safety or welfare of patients who use the service. Patients' contemporaneous records were not maintained and accurate for each service user, this included incidents. Staff records were not up to date or accurate for staff carrying out regulated activities.
- Records showed us that staff had access to clinical supervision and completed appraisals on time.
- Senior managers did not provide the inspection team with all documents requested during the inspection. However, they did provide the majority of documents when later requested formally by letter.
- Vacancies were high. The provider staffed shifts to the establishment levels of nurses most of the time but they achieved this by using agency staff.
- The service audits and governance processes were not robust. Audits they had completed were a tick box data collection process and they had only completed them just prior to the inspection. The provider could not give examples of how these processes led to improvement in the services.
- The provider did not operate an effective system to monitor or improve the quality of the service. Clinical governance meetings included minimal discussion of audits. Senior managers did not demonstrate that actions from previous audits had been reviewed and improvements had been made to practice.
- Senior managers did not have robust monitoring systems in place for reviewing and reducing the use of restrictive interventions.
- Senior staff discussed safeguarding and serious incidents, but not in detail. Minutes were brief, did not identify the issue, and did not describe the lessons learned.
- Between 26 September 2014 and 17 August 2015, the hospital reported 32 incidents. Nine incidents related to physical abuse, two to sexual abuse and one to emotional abuse. 20 incidents had not had the category of abuse identified. On analysis, four of these incidents required notification to the CQC and no notification had been received by the Commission.
- Ward managers meetings took place but minutes did not evidence that incident, complaints, or audits were discussed.
- The provider did not use key performance indicators to measure the performance of this service.
- The provider's risk register dated August – December 2015 identified staffing and access to GP services as a risk. The register did not identify the outcomes of audits that they completed where actions had been identified, to improve the quality of the service or the environment and physical healthcare concerns that we found during the inspection.

Leadership, morale and staff engagement

- Staff missed forty-six working days due to sickness from May 2015 to November 2015, which was low.
- Staff and patients told us that senior managers were approachable and visible to staff and patients.
- There were no recorded staff bullying and harassment cases.
- Staff told us that they knew how to use the hospital's whistleblowing procedure. They were confident to use the procedure or to raise concerns with senior managers if required.
- Staff told us that morale on the wards was good. They reported there was a good skill mix and that staff worked together as a team.
- Some staff reported having opportunities for development within their role. However, we found no evidence of this within their individual training records that we reviewed.
- Staff completed a satisfaction survey in June 2015. However, the outcome of the survey had not been analysed. There was no action plans set on the information collated to improve the service for staff and patients.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that blind spots on wards are mitigated.
- The provider must ensure that they comply with Department of Health guidance on same sex guidance.
- The provider must ensure that they have up to date and accurate staff files.
- The provider must ensure that risk assessments are fully completed and reviewed regularly.
- The provider must ensure that seclusion and restrictive intervention are recorded as outlined in the Mental Health Act code of practice.
- The provider must ensure that all medications are stored, dispensed, or administered in line with legislation and guidance.
- The provider must ensure that staff can access emergency equipment quickly when required.
- The provider must ensure lessons learnt and action plans are in place after incidents.
- The provider must ensure that incident reports are fully completed.
- The provider must ensure that the physical healthcare needs of individual patients are monitored and assessed regularly including following up abnormal results.
- The provider must ensure that individual care plans are patient centred and reviewed regularly with patients.
- The provider must ensure that patients receive adequate daily fluids.
- The provider must ensure that staff receive training in the Mental Capacity Act.
- The provider must ensure suitable dining arrangement for patients.
- The provider must ensure that the ward environment promotes the comfort and dignity of patients.
- The provider must ensure that their complaints procedure is robust and effective and that outcomes of complaints were shared within the team.
- The provider must ensure they have an effective system in place to monitor and improve the quality of the service.
- The provider must ensure that the result of clinical audits are used to improve services for patients.

Action the provider SHOULD take to improve

- The provider should ensure that all staff are up to date with mandatory training.
- The provider should ensure that systems are in place for effective staff recruitment and retention.

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 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not have robust systems in place to ensure that care and treatment was provided in a safe way for service users.** • Bedroom and bathroom arrangements on Oakley Ward did not comply with Department of Health and Mental Health Act Code of Practice guidance on same sex accommodation.

This section is primarily information for the provider

Enforcement actions

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 Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Safe Care and Treatment** • The provider did not have robust systems in place to ensure that care and treatment was provided in a safe way for service users. • We found the provider did not ensure that risk assessments were fully completed. • Staff used seclusion and restrictive interventions but these were not recorded in line with the Code of Practice. • Medications were not stored, dispensed, or administered in line with legislation and guidance. • Emergency equipment was not available when needed and within a reasonable time without posing a risk to patients due to equipment being shared and keypads on doors between wards. • The provider did not assess the risk of the health and safety of patients in respects of their physical health care needs or doing what is reasonably practicable those to risks. • Premises were not safe to use due to bedroom doors being propped open in breach of health and safety and fire regulations and blind spots on the wards. • The provider did not promote comfort, privacy, or dignity of the patients due to the layout of one ward and unobscured glass in doors. Regulation 12 (1)(2)(a)(b)(d)(f) and (g)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	**Meeting Nutritional and Hydration Needs** The provider did not ensure that the hydration needs of the patients were met. Patients did not receive hydration levels that were adequate to sustain life and good health. Staff did not support all patients to eat and drink when required. • Eight fluid charts reviewed showed the amount of daily fluid intake ranged from 360mls to 1150mls. This was below the recommended daily amount. • Staff did not assist patients out of bed to get access to meals. Regulation 14 (1)(4)(a)(d)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Good Governance** The systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients who may be at risk which arise from the carrying on of the regulated activity, and systems to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services), are not operating effectively. • The providers systems and processes such as regular audits did asses the effectiveness. However, the provider was not able to give examples of how these processes had led to improvement in the services. • The providers did not have systems and processes to enable them to identify and assess risks to the health, safety and/or welfare of people who use the service. • The provider did not maintain accurate, complete, and contemporaneous record in respect of each service user, including a record of the care and treatment provided which included incident reports. • The provider did not maintain up to date and accurate records of staff that were employed in the carrying on of the regulated activity.

This section is primarily information for the provider

Enforcement actions

- The provider did not effectively manage complaints or use feedback form patients to improve the quality of care that they were receiving.

Regulation 17 (1)(2)(a)(b)(c)(d)(e)