Jasmine Court Independent Hospital

Quality Report

Paternoster Hill
Waltham Abbey
EN9 3JY
Tel:01992 787202
Website: www.barchester.com

Date of inspection visit: 27 March 2018
Date of publication: 10/05/2018

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	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

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

Overall summary

We rated Jasmine Court Independent Hospital overall as 'good' because:

• Patients and carers told us staff were caring. We observed examples of this during our visit such as supporting patients at lunch to make choices about what to eat. Staff developed 'hospital passports' for patients, which gave staff information about the patient, including details of their cultural and family background; events, people and places from their lives; preferences, routines and their personality. Staff promoted sensory stimulation for patients and had developed corridors with themes such as animals, the beach, garden and travel with pictures and objects to help orientate them.

• Staff felt supported by their managers. They told us they were passionate about their work and were motivated. They reported having good morale and feeling valued. The provider had ensured that staff had received appropriate training for their role, including dementia awareness training. Staff received appraisals and supervision to ensure they were competent in their work. The provider had ensured adequate staffing to meet patients' needs. There were no incidents of nursing shifts being below the numbers established by the provider. There were no nursing staff vacancies.

• Staff completed risk assessments and care plans for patients including for risk of falls and choking. Staff monitored patients for any physical health problems. The provider had some clear and effective systems in place for assessing and monitoring the quality and risks for the service and took actions to address risks as identified. This included senior staff 'quality first visits' where they assessed the hospital against a range of standards and identified actions for any improvements.

However:

• The provider did not have a robust process in place for reviewing level one incident documentation to identify when further investigation or actions should take place. The provider had identified that the hospital needed to improve the use of positive behavioural support plans with patients. Managers had identified through audits that staff recording of capacity assessments and best interest decisions for patients still needed improvement.

• The provider had identified that their fire safety assessment needed updating to specifically capture the hospital risks. The provider's oversight of ligature risk assessment was not robust as during our inspection, staff identified that not all ligature points were captured in their assessment which they took immediate action to address.

• The provider did not give information on how they were considering the workforce race equality standards (WRES) with staff at this hospital.

Summary of findings

Contents

Good

Jasmine Court Independent Hospital

Services we looked at:
wards for older people with mental health problems

Summary of this inspection

Background to Jasmine Court Independent Hospital

Barchester Healthcare Homes Limited is the registered provider for Jasmine Court Independent Hospital, an independent mental health hospital providing 15 beds for men with dementia and challenging behaviour.

The Care Quality Commission registered this hospital in May 2011 to carry out the following regulated and activities:

• Treatment of disease, disorder or injury

• Assessment or medical treatment for persons detained under the Mental Health Act 1983

The hospital has a registered manager and a controlled drugs accountable officer.

The CQC have inspected this location eight times since registration in September 2010.

The last inspection was in March 2017. We did not identify any breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. However, we identified some actions that the provider 'should' take relating to documenting when patients were offered a copy of their care plan; ensuring staff had access to the Mental Capacity Act 2005 policy and ensuring that best interest decisions were documented in patients records. The provider had taken actions to address the first two issues raised. We have identified in our report below that the provider should take further action to fully ensure that best interest decisions were documented in patients' records.

Our inspection team

An inspector led our inspection team from the mental health hospitals directorate.

The team that inspected the service included two CQC inspectors and a specialist advisor with experience of working with older people with mental health needs.

Why we carried out this inspection

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

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

Before the inspection visit, we reviewed information that we held about the location and asked a range of other organisations for information.

During the inspection visit, the inspection team:

• visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;

• spoke with four patients who were using the service;

• spoke with five carers;

Summary of this inspection

• spoke with the registered manager and divisional director;

• spoke with 11 other staff members; including doctors, nurses, support workers and housekeeping staff;

• spoke with the central training and Mental Health Act lead staff working across other provider locations;

• received feedback from an independent advocate;

• attended and observed patients lunch; a morning management meeting and a multi-disciplinary review meeting;

• looked at six care and treatment records of patients;

• looked at 14 staff records, relating to supervision, appraisal, training and recruitment

• carried out a specific check of the medication management; and

• Looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Due to the nature of patient's mental health needs we were not able to speak to all of them to gain feedback about the service.

• We spoke with four patients. They told us staff were caring and that they felt safe

• One patient said they liked the food another said the food could be improved. One patient said they would like more activities.

• We spoke with five carers. They told us staff were caring and the service was good. Four carers said that staff kept them informed and involved them in their relative's care. They said staff had a good understanding of their relative's needs. One carer said that staff communication could be improved.

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?

Good

We rated safe as 'good' because:

• The ward was for male patients only and complied with Department of Health guidance on same-sex accommodation.

• The provider had systems in place to check that equipment was well maintained and the environment was clean.

• The provider had ensured adequate staffing to meet patients' needs. There were no reported incidents where nursing shifts were below the numbers established by the provider. There were no nursing staff vacancies.

• Staff had received appropriate mandatory training as identified by the provider.

• Staff completed risk assessments for patients including for risk of falls and choking.

• Staff had effective medicines management practice (transport, storage, dispensing, and medicines reconciliation).

• Managers in the organisation were monitoring incidents in the hospital at clinical governance meetings and reviewing if there were any themes.

However:

• The provider did not have a robust process in place for reviewing level one incidents to identify when further investigation or actions were required.

• The provider had identified that they needed a separate fire safety assessment to specifically capture the hospital risks. Their current fire risk assessment also included the neighbouring care home.

• The provider had identified that the hospital needed to improve the use of positive behavioural support plans with patients.

• The provider's oversight of ligature risk assessment was not robust as during our inspection, staff identified not all ligature points were captured in their assessment which they took immediate action to address.

Are services effective?

Good

We rated effective as 'good' because:

Summary of this inspection

• We reviewed six patients care and treatment records and found that staff had completed comprehensive assessments of patients' needs.

• The visiting GP completed a physical examination of patients and staff monitored patients for any physical health problems and nutritional needs.

• Staff used nationally recognised assessment tools to assess and record severity and outcomes such as the national early warning score a tool recording staff observation of patients physical health; the Malnutrition Universal Screening Tool and the Waterlow pressure sore risk assessment tool.

• Staff received necessary specialist training for their role, such as dementia awareness training. The provider had achieved 100% compliance for staff appraisal and supervision.

However:

• Managers had identified through audits that staff recording of patient capacity assessments and best interest decisions still needed improvement.

• The provider had not ensured that all agency staff profiles gave adequate information regarding staff training.

Are services caring?

Good

We rated caring as 'good' because:

• Patients and carers told us staff were caring. We observed examples of this during our visit.

• Staff developed 'hospital passport's for patients which gave staff information on who the patient is including details of their cultural and family background; events, people and places from their lives; preferences, routines and their personality.

• Carers told us staff involved them in their relative's care and kept them informed.

Are services responsive?

Good

We rated responsive as 'good' because:

• Staff told us there was no pressure to admit a patient to ensure beds were filled and the hospital had some vacant beds when we visited. This meant that patients had a bed on return from leave. The average length of stay for patients discharged from the hospital was 341 days, from January 2017 to January 2018. The provider had effective systems to discharge patients.

• The hospital had a range of rooms and equipment to support treatment and care such as activity areas and meeting rooms. Staff

Summary of this inspection

had developed corridors with themes such as animals, beach, garden and travel with pictures and objects to help orientate patients. Staff had a range of items to promote sensory stimulation for example sponges and clothing.

• The provider had a system to deal with any complaints and staff knew how to handle complaints appropriately.

However:

• Staff had not recorded in community meeting minutes all the actions they had taken in response to activities requested by patients.

Are services well-led?

Good

We rated well led as 'good' because:

• The provider had some governance systems in place for assessing and monitoring the quality and risks for the service.

• All staff gave positive feedback about the hospital's management. They told us the hospital director had an 'open door 'policy, was approachable and had made changes to the service. They reported good morale and said they were motivated in their work. They could give feedback on services and input into service development.

• The provider had developed a quarterly peer review system where senior staff visited locations to carry out 'quality first visits' to review the quality of service against a range of standards and identified actions for any improvements.

However:

• The provider did not have robust oversight over the hospital's ligature risk assessments as they did not capture all ligature points.

• The provider did not give information on how they were considering the workforce race equality standards (WRES) with staff at this hospital.

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.

- Two patients were subject to the Mental Health Act 1983/2007 when we visited.
- The provider had an identified Mental Health Act lead and administrator from their central department to visit and offer the hospital regular support. They were involved in the scrutiny of legal documentation before and after patients' admission.
- Staff knew how to contact the Mental Health Act administrators for support. They offered staff support to ensure the Act was followed, for example, in relation to renewal of detention, consent to treatment and appeals against detention. Legal advice on implementation of the Mental Health Act and its Code of Practice was available as required.
- Staff kept records of leave granted to patients. The provider had systems to inform patients, staff and carers (where applicable) of the conditions of leave granted, including risk and contingency/crisis measures.
- Ninety six percent of staff had training in the Mental Health Act. Staff had an understanding of the Mental Health Act, the Code of Practice and the guiding principles.
- The provider had systems to review patients' capacity to give consent to treatment and copies of consent to treatment forms were attached to medication charts where applicable.
- The provider had systems for staff to inform patients and nearest relatives of their legal rights under the Mental Health Act on admission and routinely thereafter. The provider had developed letters and leaflets to assist with giving this information following feedback from a carer.
- Detention paperwork was filled in correctly, up to date and stored appropriately.
- The provider held regular audits to ensure that the Mental Health Act was applied correctly and there was evidence of learning from these.
- Staff would contact the local approved mental health practitioner service if a Mental Health Act assessment was required.
- The provider had an identified independent mental health advocacy service for patients to contact.
- The ward was locked and staff had displayed signs stating that informal patients could leave the ward.

Mental Capacity Act and Deprivation of Liberty Safeguards

• The Deprivation of Liberty Safeguards can only be used if the patient will be deprived of their liberty in a care home or hospital. Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation.

• There were five patients subject to DoLS applications and the provider had made urgent authorisations for others.

• All staff had received Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training. Staff had a good understanding of the Mental Capacity Act. The provider had given them small cards to refer to with reminders on how to support patients with making decisions and assessing their capacity. The provider had a policy on the Mental Capacity Act including DoLS which staff were aware of and could refer to.

• Staff told us that for patients who might have impaired capacity, capacity to consent was assessed. This is done on a decision-specific basis with regards to significant decisions, and patients were given every possible assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

• We observed that patients' capacity was regularly reviewed at ward reviews.

Detailed findings from this inspection

• The provider had system in place to monitor adherence to the Mental Capacity Act. Managers had identified through audits and 'quality first visits' in February 2018 that staff recording of capacity assessments and best interest decisions for patients still needed improvement. They had identified actions with timeframes for completion. We had also identified this as an area the provider should improve at our last visit.

• We found examples where staff had completed 'Do not attempt cardiopulmonary resuscitation' documentation involving the patient and their relatives as relevant.

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Good

Safe and clean environment

• The provider had installed mirrors to where there were blind spots in corridors to enable staff to observe all parts of the ward.

• The provider had not identified all ligature points in their ligature risk assessment dated 3 November 2017. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. For example it did not include radiators, soap, towel and paper dispensers. Therefore there was a risk that staff would not know what action to take to reduce the risks. One room identified by staff as having ligature points also had a door handle that had been incorrectly fitted, which posed a risk. Staff took immediate action to address this during our visit and sent us an updated ligature assessment and details of actions taken to reduce risks. The ligature assessment referenced staff would individually risk assess patients and increase staff observation if a risk of self harm was identified. Staff had not identified any patients during our inspection as being a high risk of using an item to ligature or harm themselves, nor had there been any patient incidents reported involving use of a ligature risk. This indicated the patient group presented a lower risk in this area.

• The ward was for male patients only and complied with Department of Health guidance on same-sex accommodation.

• The provider had a fully equipped clinic room with equipment for physical healthcare checks.

• The provider had systems to audit staff's compliance with infection control principles including handwashing. We observed staff regularly washing their hands and using disinfectant gel. Staff had systems for daily and deep cleaning.

• Staff had ensured that equipment was well maintained, clean and maintenance stickers were visible and in date. Housekeeping and maintenance staff had infection control systems including checking bed mattresses and showers for legionella and for the control of substances hazardous to health.

• Staff had systems for regularly checking, reporting and reviewing environmental needs. All ward areas were clean, had good furnishings and were well-maintained. However, we saw two brown patches on the corridor ceiling. The hospital director reported this for action to be taken. The patients' fridge held sandwiches which did not detail the use by date. The freezer compartment had not been recently defrosted and held a large amount of frost

• The provider had systems for assessing and monitoring fire safety, including a certificate from Essex county fire and rescue service dated June 2017. However, a risk assessment document dated July 2017 was not fully completed. The provider's 'quality first visit' report in February 2018 had also identified the need for an annual risk assessment. The provider contracted external maintenance staff completed these. The current assessment also covered the neighbouring care home and the director had requested a separate assessment for them as a hospital. They were training their own staff fire marshals, and had requested their own fire 'grab bag' with

emergency checklists and radios. They had placed this on their risk register with a timeframe for completion by April 2018. Staff had not developed individual 'personal emergency evacuation plans' for patients but had a summary document detailing the support staff needed to give patients in an emergency. During our visit a fire alarm went off and staff responded to the issue which was on the care home site

• Staff had systems to check bath temperatures did not exceed 44 °Celsius, the maximum temperature identified by the health and safety executive as safe for people.

• Patients and staff had access to alarms to summon assistance if needed.

Safe staffing

• The provider had ensured adequate staffing to meet patients' needs. The provider had identified a need for 25 staff. This included six nurses and 15 nursing assistants. There were no staffing vacancies. Thirteen staff had left employment between January to December 2017. The hospital director stated this was due to changes in the service being provided and needing to ensure a suitable staff skill mix. They had recruited new staff to work with the current patients. Short term staff sickness for September 2017 to February 2018 was 3.2% (slightly below the national average of 4.2%) and long term sickness was 4.7% (slightly above).

• The provider had identified 1.5 nurses and three nursing assistants for the day shift and one nurse and two nursing assistants for the night shift. This was a ratio of one staff to three patients. The day shift was 07:30 to 19:30 hours and the night shift was 19:30 to 07:30 hours. Staff had one hour's break.

• The provider had not given any data on the use of bank staff (employed by the provider on an as and when basis) or agency staff. The hospital director said they had significantly reduced they use of agency staff cost from January through to December 2017. The provider stated there was a 97% decrease of agency from July to December 2017 compared to the first six months of the year. From January 2018 to the date of inspection the provider had reduced the use of agency staffing by 98% compared to the same period in 2017. The hospital director stated they did not 'block' book regular agency to cover a specific period but tried to schedule staff familiar with service.

• We checked a total of five weeks staffing rotas, selected randomly from January, February and March 2018. There were no incidents of nursing shifts being below the numbers established by the provider.

• Staff confirmed there was sufficient staffing for patients' needs. The hospital director was able to adjust staffing levels daily to take account of patient's need and staff to observe patients. Nursing staff were present in communal areas of the ward. There were enough staff for patients to have individual time with their named nurse. Escorted leave or ward activities were rarely cancelled because there were too few staff. There was enough staff to safely carry out physical interventions.

• The provider had a contract with a local NHS trust for two consultant psychiatrists to provide treatment for patients. They each visited once a week and provided an out of hours on call telephone service where staff could contact them for advice. The provider had a contract in place with a local GP service who visited once a week to respond to requests to see patients. Staff said this was sufficient for the service needs. There had been no need for a doctor to attend the ward quickly for an emergency.

• Staff had received and were up to date with appropriate mandatory training as identified by the provider. The average mandatory training rate for staff was 98% above the providers' target of 90%.

Assessing and managing risk to patients and staff

• The hospital did not have a seclusion room. Staff had not reported any seclusion or long-term segregation of patients in the last six months. Seclusion is the supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others. If regular seclusion was required for a patient, staff would request a transfer for the patient to another service.

• Ninety one percent of staff had completed restraint training. Staff told us physical restraint was used as a last report and their preference was to use verbal de-escalation and distraction techniques first. From January to December 2017, staff had reported 10 occasions when they had restrained patients, (for four patients). None of these were in prone position. Prone position restraint is when a patient is held in a face down position on a surface and is physically prevented from moving out of this position. We checked six patients' records and found a positive

behaviour support plan developed for one patient, which is recognised as national best practice. Divisional clinical governance meeting minutes March 2018 showed managers had identified they needed to give staff more information to implement these plans. The provider had also updated their 'restrictive interventions' policy to reflect this.

• We checked six patients' paper record files and all patients had an updated risk assessment. Staff used a nationally recognised clinical risk assessment tool developed by the Sainsbury centre for mental health. Two files did not hold the initial assessment completed by staff at the time of admission but staff informed us these were archived. Care plans held details of relapse and crisis plans.

• Staff had completed specific assessments to identify patients at risk of falling. Staff could access appropriate equipment if needed such as laser sensors to assist in reducing this risk. The provider had systems to investigate any fractures resulting from a patient fall in the service. All staff had completed falls training. Ninety seven percent of staff had completed training to reduce the risk of patients choking.

• Staff did not have blanket restrictions for patients other than restricting patients' access to lighters and razors to reduce the risk of accidental self harm.

• The provider had policies and procedures for staff observation (including minimising risk from ligature points) and searching patients. We checked a sample of four patient observation records which staff had thoroughly completed.

• Staff said they did not use rapid tranquilisation with patients and clinical governance meeting minutes confirmed staff had not reported any incidents. Staff had effective medicines management practice (transport, storage, dispensing, and medicines reconciliation). The provider had a process for staff to follow if a patient needed staff to covertly administer medication. The provider had an agreement with an external pharmacy that supplied medication though the GP surgery. The pharmacist completed six monthly audits. They offered new staff training on the use of medication and administration records and carried out weekly checks of medicines.

• All staff had completed safeguarding training and knew how to make a safeguarding alert. We saw examples of this. The provider had given staff small cards to carry detailing the categories for reporting abuse. The provider had procedures for arranging visits to the ward (including children).

Track record on safety

• There were no serious incidents from January to December 2017. However there had been a 'near miss' incident and another director in the organisation had completed a root cause analysis investigation. This related to a patient going absent without leave when an external contractor visited the site. There had been no harm. The investigation report was received the day before our visit and the hospital director was making arrangements to feedback any learning to staff. The hospital director had taken initial action to remind staff to follow the completed risk assessment for external contractors visiting the site. The provider had offered managers root cause analysis training for carrying out incident investigations.

Reporting incidents and learning from when things go wrong

• All staff knew when to report an incident. We saw examples of this. However, one incident of alleged abuse by another patient was reported by staff as a 'level one' incident and had not been formally reviewed by managers to consider if further action should be taken. The hospital director told us that these were not automatically sent to them for reviewing. They had identified this as a risk for the hospital and they were taking action to review these. Divisional clinical governance meeting minutes March 2018 confirmed this. Minutes showed there was an increase in staff reporting 'level one' incidents across hospital sites.

• Staff received feedback from investigation of incidents both internal and external to the service via team meetings or at the morning management meeting. In some cases memos were sent out for more urgent communications. Staff received 'GM' [general manager] bulletins with feedback from learning within the organisation.

• Managers in the organisation were monitoring incidents in the hospital at clinical governance meetings and reviewing if there were any themes. Staff had reported 30 incidents between, December 2017 to February 2018. Fifty percent of these related to physical aggression by patients.

Good

Wards for older people with mental health problems

• The provider offered staff debriefs and support after incidents, for example after any incidents that may have required physical intervention over level two. We saw from incident forms that staff offered patients debriefs also.

• The provider had training for staff and systems to ensure 'duty of candour', that staff were open and transparent, explaining to patients and carers if and when things went wrong.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

• We reviewed six patients care and treatment records and found staff had completed comprehensive assessments of patients' needs. Records contained up to date, personalised, holistic, recovery-oriented care plans.

• The visiting GP completed a physical examination of patients and staff monitored patients for any physical health problems. Staff monitored patients' nutritional needs and they were weighed throughout their stay.

• Information needed for staff to deliver care was stored securely and available when they needed it and in an accessible paper form.

Best practice in treatment and care

• Staff followed National Institute for Health and Care Excellence (NICE) guidance when prescribing medication. Policies and procedures also referenced NICE guidance.

• Managers could request specialist staff support for patients physical and mental health needs, such as physiotherapy, dietetics, speech and language therapy and chiropody. The provider could access psychological therapies recommended by NICE from a local trust.

• Staff used nationally recognised assessment tools to assess and record severity and outcomes such as the national early warning score (NEWS) a tool recording staff observation of patients physical health; the Malnutrition Universal Screening Tool (MUST) and the Waterlow pressure sore risk assessment tool.

• Staff participated in clinical audit, for example, for infection control, medication stock checks and review of care records. The provider developed action plans to address any issues.

Skilled staff to deliver care

• In addition to nursing and medical staff, the provider had recruited a replacement occupational therapist to deliver care, as their previous one had left.

• Staff received an appropriate induction, which included using the care certificate standards as the benchmark for nursing assistants.

• Staff received necessary specialist training for their role. They had completed dementia awareness level one training to increase their knowledge and skills to care for patients. The hospital director had requested level two staff training for completion by 2019. Eight staff had completed specialist risk assessment training for patients with dementia in January 2018.

• The provider had achieved 100% compliance for staff appraisal and supervision. This was confirmed in the sample of six supervision and four appraisals records checked. Staff had access to regular team meetings.

• The provider had systems to ensure that poor staff performance was addressed promptly and effectively. The hospital director gave examples of this. The provider's training lead carried out observation of staff practice, which included checking on their adherence to infection control, safeguarding, fire safety, moving and handling, communication and person centred care practice.

• We checked a sample of three staff recruitment records and the provider had systems for checking staff were eligible to work in the UK and had suitable skills and experience for their role. The provider carried out professional registration and disclosure and barring service checks for staff. These checks ensured that staff were of good character and patients were not placed at risk.

• The provider had systems to check that the doctors had received revalidation.

• The provider had an induction process for agency staff. However, we checked a sample of agency staff profiles and one agency had provided limited information regarding

staff training. The hospital director stated they were currently not using this agency because they had not given sufficient assurance that staff were suitably skilled and experienced to work at the hospital.

Multi-disciplinary and inter-agency team work

• Regular and effective staff multi-disciplinary meetings took place.

• We observed a morning management meeting with representatives from nursing, housekeeping and other staff and confirmed effective handovers took place within the team

• Staff had working relationships with teams outside of the organisation such as with the patients' local authority or community mental health teams. They said there could be challenges with getting some external agency staff to attend review meetings.

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

• Two patients were detained under the Mental Health Act 1983/2007, when we visited.

• The provider had an identified Mental Health Act lead and administrator from their central department who regularly contacted and visited the hospital. They were involved in the scrutiny of legal documentation before and after patients' admission.

• Staff knew how to contact the Mental Health Act administrators. They offered staff support to ensure the Act was followed in relation to, for example, renewal of detention, consent to treatment and appeals against detention. Legal advice on implementation of the Mental Health Act and its Code of Practice was available as required.

• Staff kept records of leave granted to patients. The provider had systems to inform patients, staff and carers (where applicable) of the conditions of leave granted, including risk and contingency/crisis measures.

• Ninety six percent of staff had training in the Mental Health Act. Staff had an understanding of the Mental Health Act, the Code of Practice and the guiding principles.

• The provider had systems to review patients' capacity to give consent to treatment and copies of consent to treatment forms were attached to medication charts where applicable.

• The provider had systems for staff to inform patients and nearest relatives of their legal rights under the Mental Health Act 1983/2007 on admission and routinely thereafter. The provider had developed letters and leaflets to assist with giving this information following feedback from a carer.

• Staff ensured that detention paperwork was filled in correctly, up to date and stored appropriately. The provider held regular audits to ensure that the Mental Health Act 1983/2007 was applied correctly and there was evidence of learning from these.

• Staff contacted the local approved mental health practitioner service if a Mental Health Act assessment was required.

• The provider had an identified independent mental health advocacy service for patients to contact.

• The ward was locked and staff had displayed signs stating that informal patients could leave the ward.

Good practice in applying the MCA 2005

• Deprivation of Liberty Safeguards can only be used if the patient will be deprived of their liberty in a care home or hospital. Care homes or hospitals must ask a local authority if they can deprive a person of their liberty. This is called requesting a standard authorisation.

• There were five patients subject to DoLS applications and the provider had made urgent authorisations for others.

• All staff had received Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) training. Staff had a good understanding of the Mental Capacity Act 2005. The provider had given them small cards to refer to with reminders on how to support patients with making decisions and assessing their capacity. The provider had a policy on the Mental Capacity Act including DoLS which staff were aware of and could refer to.

• Staff told us that for patients who might have impaired capacity, capacity to consent was assessed. This is done on a decision-specific basis with regards to significant decisions, and patients were given every possible assistance to make a specific decision for themselves before they were assumed to lack the mental capacity to make it.

• We observed that staff reviewed patients' capacity at ward reviews.

Good

Wards for older people with mental health problems

• The provider had systems in place to monitor adherence to the Mental Capacity Act. Managers had identified through audits and 'quality first visits' in February 2018 that staff's recording of capacity assessments and best interest decisions for patients still needed improvement and had identified actions with timeframes for completion. We had also identified this as an area the provider should improve at our last visit. We found that capacity assessments were only completed for medication and for DoLS assessments. Staff had completed 'Do not attempt cardiopulmonary resuscitation' documentation involving the patient and their relatives as relevant.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

• Patients that were able to talk to us said staff were caring. We observed examples of caring and respectful interactions between staff and patients. For example, staff supported patients at lunchtime including showing a tray of food to help them decide what they wanted to eat. Staff had an understanding of patients' individual needs.

• Carers said staff were caring and the service was good.

• Staff had developed 'hospital passports' for patients, which gave staff information about the patient including details of their cultural and family background; events, people and places from their lives; preferences, routines and their personality. Two had limited information but we noted this was due to a lack of information from the patient or carers.

• The hospital director had employed more male staff (a ratio of one to three female staff) to be on duty and support patients now the service was for men only.

The involvement of people in the care they receive

• Staff offered patients and carers the opportunity to visit the hospital before admission.

• Staff recorded in care records how they had encouraged patients and carers involvement and participation in care planning and risk assessment.

• Staff displayed information on how patients or carers could contact advocacy services.

• Four carers told us staff involved them in their relative's care and kept them informed about changes. However, one carer said communication could be improved. The provider had identified carers involvement needed improvement. The provider took action to improve attendance by offering the meetings on weekends which saw an increase in attendance. They were encouraging the use of video conference calls to encourage communication with carers and increase feedback.

• Patients were not routinely invited to take part in interviews for new staff applying to work at the hospital but were invited to give interview questions.

• The provider had an annual survey for patients to give feedback on the service they received. This had not been completed since our last inspection less than a year ago. Additionally the provider had feedback forms and comments boxes for people to give their views. The hospital director had recently identified that feedback was not being captured for their hospital and instead was collated with the neighbouring care home. The manager had taken steps to ensure there were separate feedback systems.

• The hospital had received one review of the service for 2018 on the care.home.co.uk website giving a rating of eight out of ten and stating the overall standard was 'excellent'.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

• The provider received referrals for NHS funded patients. The mean average for assessing patients following a referral was three days. The average time for the patient to receive treatment, following an initial assessment was 23 days. The patient's date of admission could be affected as funded needed approval by external commissioners. Patients were mostly referred from the local area.

• The average bed occupancy for the hospital from September 2017 to January 2018 was 89%. There is no

identified national guidance for older people's wards average bed occupancy. However, this is above the average (85%) recommended for adult in-patient mental healthcare. The hospital had admitted 13 patients when we visited with plans to admit other patients and have full occupancy by April 2018. Staff told us there was no pressure to admit a patient to ensure beds were filled and the provider had two beds vacant when we visited. This meant that patients had a bed on return from leave.

• The hospital director stated that patients were moved or discharged at an appropriate time of day. Staff tried to ensure that a patient was admitted the day before their doctor's ward reviews to ensure 24 hours constant staff observation and assessment before review.

• The average length of stay for patients discharged from the hospital was 341 days, from January 2017 to January 2018.

• The provider had identified one delayed discharge from January 2017 to January 2018, for a patient awaiting an appropriate placement. Another patient was awaiting discharge to placement organised by the local authority. Staff said that patients were mainly discharged to a care home or another hospital and not to their own homes due to their complex needs.

• We saw examples where staff actively planned for patients discharge with other teams and external stakeholders.

The facilities promote recovery, comfort, dignity and confidentiality

• The hospital had a range of rooms and equipment to support treatment and care such as activity areas and meeting rooms. Patients had access to outside space in the central courtyard. Staff were making plans for a sensory garden working with a local college and relative involvement and also planned to enter the organisational 'Barchester in bloom' competition. The provider had provided air fresheners in bedrooms to give a fragrant smell and ozone filters to increase air flow in corridors.

• Patients were able to personalise bedrooms as they wanted. Bedrooms all had ensuite showers. Bedroom doors had vision panels which patients could close from inside, staff had put privacy film on windows to prevent others from seeing into patients bedrooms. Patients did not have keys to their rooms as all rooms were left unlocked. Staff said they were vigilant to ensure patients did not go into other's bedrooms and we observed staff in corridors offering support to patients. Patients had somewhere secure to store their possessions.

• Staff had identified areas on the ward where patients could meet visitors in private. Patients could have their own mobile phones or use the hospital one to make private calls.

• The hospital had a dining area large enough to allow patients to eat in comfort and to encourage social interaction, including the ability for staff to engage with and observe patients during meal times. Food was prepared in the central kitchen for the hospital and care home on site. One patient said the food was good. Another told us the food could be improved. Staff regularly sought patient's feedback at community meetings on this. Patients had access to hot and cold drinks and snacks in the lounge diner area. The hot water urn was not working the day we visited but staff had made other arrangements for patients.

• Staff had developed a daily activities programme, for example gardening, cinema and crafts. Community meeting minutes detailed that staff had asked patients what activities they wanted to do with some actions taken. The hospital director said a new occupational therapist was in post and following induction would review the programme.

Meeting the needs of all people who use the service

• The hospital and ward was on ground level and was accessible to patients and others using wheelchairs. The provider could get aids and adaptions to support patients with mobility difficulties, for example chairs to use in the shower. There was an assisted bath. Beds were adjustable in height and if required staff arranged for an air flow mattress to alleviate pressure and ensure comfort for patients. The provider had gained bright blue toilet seats to assist patients' to find the toilet. There were clear and simple signs for example on bathroom doors at a visible height that include symbols as well as words.

• Staff had developed corridors with themes such as for animals, beach, garden and travel with pictures and objects to help orientate patients. Additionally staff had placed pots on wall rails with a range of items to promote sensory stimulation and memory reminiscence for patients to hold such as Lego and sponges. Staff had placed work

Good

Wards for older people with mental health problems

coats in one corridor for patients to try on as part of reminiscence therapy. Patients had picture boards in their bedroom to assist them to identify key staff involved in their care.

• The provider had a range of accessible information leaflets with information on treatments, local services, patients' rights and how to complain. These were available in languages spoken by people who used the service and also there were pictorial easy read versions. Staff could contact interpreters and signers to assist with communicating with patients as required.

• The hospital manager gave examples where staff had offered patients food to meet religious and ethnic dietary requirements for example halal food. Staff assisted and supported patients with eating and swallowing difficulties, with their dietary needs (including soft or fortified meals) and ensured they had enough to eat and drink. A 'quality first visit' February 2018 arranged by the provider had identified that staff needed to increase the amount of soft meal options and a plan was in place to address this.

• All staff had completed equality and diversity training to identify how to best support patients with protected characteristics referred to in the Equality Act 2010. Staff said they would assess lesbian, gay bisexual or transgender patients to identify any support they needed. The hospital director had arranged for a patient to have a keyworker from the same cultural background. They gave examples of supporting patient with their spiritual needs for example arranging for them to attend church or go to a mosque.

• Staff were planning dementia awareness training for relatives in response to carer's feedback.

Listening to and learning from concerns and complaints

• The provider had received two complaints, from January 2017 to the date of inspection. One complaint in January 2017, regarding the environment was partially upheld. There was one complaint for January 2018 relating to an external service used and an investigation was taking place No complaints were referred to Ombudsman. There were four compliments for the service from January 2017 to January 2018.

• Posters and leaflets were available for patients and others to know how to complain and receive feedback. The provider had a suggestion box and regular community meetings for patients and others to give feedback on the service. Staff displayed actions taken in response on their 'you said, we did' board. However, staff had not recorded in community meeting minutes all the actions they had taken in response to activities requested by patients.

• Staff knew how to handle complaints appropriately. They received feedback on the outcome of investigation of complaints and acted on any findings via team meetings.

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

Good

Vision and values

• Staff understood the organisation's visions and values which related to 'respect; integrity; passion; empowerment and responsibility'. The provider had also sent them information about these in their payslip as a reminder. The provider stated that staff were also given small cards with this information. Governance meeting minutes showed that managers regularly discussed these values with staff.

• Staff knew who the most senior managers in the organisation were. They told us the divisional director frequently visited the hospital and we observed them meeting with staff and patients. The provider stated that as a large organisation with over 220 sites actual visits by the chief executive officer and chief operating officer could be challenging. The Chief operating officer had visited the hospital in the last year.

Good governance

• The provider had clear and effective systems in place for assessing and monitoring the quality and risks for the service. These included divisional and hospital based team meetings such as the morning management meeting to share and gain feedback on key areas such as incident reporting and management, staffing, training and development. The provider sent weekly bulletins to the hospital for staff to share information and updates.

• The provider had key performance indicators and other indicators to gauge the performance of the hospital against others. The hospital director developed action plans where there were issues.

Good

Wards for older people with mental health problems

• The hospital director carried out checks of the service at nights and weekends. The training lead had monthly contact with the manager overseeing staff training compliance and training needs. This information was monitored at central and hospital governance meetings.

• However, the provider's oversight of the hospital's ligature risk assessment was not robust as we identified that some ligature points had not been identified.

• The hospital director had identified staff champions to lead on areas such as for health and safety and infection control. The hospital director was the named officer in the hospital with lead responsibility for the protection of vulnerable adults.

• The hospital director had sufficient authority and administrative support.

• Staff had the ability to submit items to the provider's risk register.

Leadership, morale and staff engagement

• The provider monitored staff sickness and took action to address any issues. Short term staff sickness for September 2017 to February 2018 was 3.2% (slightly below the national average of 4.2%) and long term sickness was 4.7% (slightly above). The hospital director said they were trying to get a more accurate assessment and improve staff self reporting of this as sometimes staff requested sickness leave instead of carers leave.

• All staff gave positive feedback about the hospital's management. They told us the hospital director had an 'open door 'policy, was approachable and had made changes to the service. They reported good morale and said they were motivated in their work. They could give feedback on services and input into service development.

• Staff knew how to use whistle-blowing process and said they were able to raise concerns without fear of victimisation.

• The provider did not provide the CQC with details of how the hospital was meeting workforce race equality standards (WRES) with staff, despite request. Independent healthcare organisations with NHS contracts are required to identify how they are engaging with WRES and develop action plans to address any data gaps or known differences in indicators between black and minority ethnic staff and white staff. The hospital director explained the staff group was culturally diverse, which staff confirmed.

• The provider had carried out a staff survey to gain feedback on their service. The provider had not published these results when we inspected.

Commitment to quality improvement and innovation

• Hospital staff did not participate in national quality improvement or peer accreditation programmes.

• The provider had developed a quarterly peer review system where senior staff visited locations to carry out 'quality first visits'. Staff reviewed the quality of service against a range of standards and identified actions for any improvements. The hospital received a visit in February 2018 and the hospital director had developed an action plan for issues identified.

• The provider gave 'employee of the month' awards to reward staff's good work or innovation. A housekeeping staff member had won this for the improvements they had made to the service and hygiene.

Outstanding practice and areas for improvement

Outstanding practice

• We observed staff supporting patients at lunchtime including showing patients a tray with different meals explaining what they were. Staff interacted in a very patient, kind, caring and supportive manner. We considered this was an example of best practice for supporting patients with cognitive difficulties to make decisions.

Areas for improvement

Action the provider SHOULD take to improve

• The provider should review their procedures for documenting capacity assessments of patients.

• The provider should review their ligature assessment process to ensure all ligature points are captured and there is effective management oversight.

• The provider should review their process for reviewing level one incidents documentation.

• The provider should review their fire safety assessment process for the hospital.

• The provider should consider the use of positive behavioural support plans with patients.

• The provider should develop their systems to address the workforce race equality standards.