Connolly House

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	Good
Are services safe?	Requires improvement
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.

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 Connolly House as good because:

- The provider assessed the risks presented by the environment such as blind spots and ligature points, and took appropriate action to reduce them.
- The provider complied with the Department of Health gender separation requirements by providing a female-only lounge, and separate bedroom areas and bathrooms for male and female patients.
- Care records were comprehensive and contained up-to-date assessments and care plans that covered physical and mental health needs.
- The provider did not use prone (face-down) restraint. Staff were committed to the least restrictive approaches to managing challenging behaviour such as de-escalation (calming down).
- Staff had good awareness of the principles of capacity to consent and assessed a patient's capacity on a decision-specific basis.
- Relatives gave positive feedback about Connolly House, particularly impressed by the skilled and knowledgeable staff.
- There was a strong person-centred culture within the service and staff knew the patients and their relatives well. We observed caring and respectful interactions between staff, patients and relatives.
- Patients had access to a wide range of facilities including a large, pleasant garden and a well-equipped activity centre.
- All patients and relatives received an easy-read information pack about the unit, which included advice on how to make complaints.
- Patient and their relatives complimented the food that the chef cooked each day, taking into account patients' specific needs and preferences.
- Managers and staff said the unit had high quality staff with the right values and approach to patient care. There was good morale among staff and they felt valued and supported by all the managers.
- The provider had a robust incident reporting process that led to actions and lessons learned for the whole organisation.
- The registered manager undertook regular unannounced checks to help identify and address any issues with the unit or with patient care.

However:

- The emergency equipment lacked an oxygen cylinder, removed by the provider. Staff relied on emergency services, which increased the risk of delays in responding urgently.
- We found a large number of out-of-date medical supplies such as dressings, bandages and urine-testing strips.
- Staff did not receive regular one-to-one supervision although they had access to other sources of support such as group supervision and handovers.
- Training rates for some mandatory training were low, for example, first aid and resuscitation (50%), and basic life support (64%).
- The provider was unable to show us documentary evidence of any medicines management audits, and there was no pharmacy input to medicines management practices at the unit.
- We observed a nurse signing all the patients' medication charts at the same time after finishing a medication round, instead of at the time of administration.
- The women's bathroom on the first floor of Connolly House was not clean, and some parts of it were in poor condition.
- Male patients had limited access to baths because the men's communal bathroom was under repair.

Summary of findings

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Wards for older people with mental health problems

Summary of this inspection

Background to Connolly House

Connolly House is an independent mental health hospital run by Astracare (UK) Limited. Connolly House has a registered manager, a nominated individual and a controlled drugs officer. Connolly House provides the following regulated activities:

- assessment or medical treatment for people detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

Connolly House is a 14-bedded facility for older people with a range of mental health conditions including dementia, severe depression, and schizophrenia. Patients may be detained under the Mental Health Act.

The bedrooms are provided across two floors, with three bedrooms on the ground floor and eleven bedrooms on the first floor. The first floor is divided into two corridors, one for male patients, and one for female patients. At the time of our inspection, the unit was full. There were nine male and five female patients placed at the unit. One of the female patients was an inpatient in the local general hospital.

Connolly House registered with the CQC in 14 October 2010, and has received four inspections. We carried out the most recent inspection on 29 January 2014, at which time, Connolly House complied with the relevant essential standards.

Our inspection team

Our inspection team was led by: Si Hussain, Inspector, CQC

The team that inspected the service comprised one CQC inspector and one Mental Health Act reviewer.

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 all areas of Connolly House, looked at the quality of the environment and observed how staff cared for patients
- spoke with two patients
- spoke with the registered manager of Connolly House
- spoke with seven other staff members including the psychiatrist, the nurse-in-charge, the activity coordinator, healthcare assistants and administrative staff
- spoke with three relatives
- attended and observed one handover
- looked at the care and treatment records for five patients

Summary of this inspection

- looked at records relating to the Mental Capacity Act (MCA), Deprivations of Liberty Safeguards (DoLS) and the Mental Health Act (MHA)
- carried out a specific check of the medication management at Connolly House
- checked medication charts for 13 patients
- looked at the clinic room and emergency equipment
- reviewed two staff personnel files
- carried out a short observational framework for inspection (SOFI) exercise
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Relatives gave positive feedback about Connolly House. The relatives we spoke with commented on the improvement in their relative's overall health and wellbeing since their admission. Relatives praised the staff describing them as caring, supportive and informative. Relatives said they could visit the unit at any time, and staff always made them welcome.

At the time of our inspection, we were unable to speak with all the patients because of the severity of their dementia. However, we conducted a short observational framework for inspection (SOFI) exercise, which involved close observation of staff and patient interactions for short periods. We observed interaction between staff and patients that was responsive, supportive, and appropriately discreet. We observed warmth and affection between the staff and patients. Staff offered patients reassurance and discussed the caring tasks they were about to do with the patients.

We spoke with two patients. They gave positive feedback about the unit, the staff and the care they received. In particular, they liked the food. However, one patient reported that bathing once a week was not enough.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement 

We rated safe as requires improvement because:

- We found a large number of out-of-date non-prescribed medical supplies, for example, dressings, bandages, and urine-testing strips. We found items with expiry dates of 2008, 2010, 2011 and 2014.
- The provider was unable to show us documentary evidence for any medicines management audits carried out quarterly or annually.
- There was no pharmacy oversight of the management of medicines practices at the unit although the provider had links with the local pharmacy.
- We observed a nurse signing all the patients' medication charts at the same time after finishing the medication round, rather than at the time of administration.
- Some of the communal areas of the first floor of Connolly House were not clean and were in poor condition. For example, the women's communal bathroom had torn hazard tape on the floor at the entrance, and exposed piping. The handrails along the first floor corridors were sticky. In the men's shower room, we saw a broken showerhead, and a shower rail repaired with black tape, which presented an infection control risk.
- Although staff ensured patients' needs were met, the staffing levels meant they felt under pressure and frequently depended on support from the registered manager and activities coordinator.
- The unit lacked an oxygen cylinder as part of its emergency equipment. Staff relied on emergency services, which gave a risk of delays.
- Training rates were low for some essential role-specific training such as first aid and resuscitation (50%), basic life support (64%) and pressure ulcer prevention (57%).

However:

- Although the age, design and layout presented challenges to providing a safe environment, for example, it had sloping floors, narrow corridors and a steep staircase, the provider assessed the risks and took appropriate action to reduce them.
- The provider complied with the Department of Health gender separation requirements, supported by a gender separation policy.

Summary of this inspection

- Staff were committed to the least restrictive approach to managing challenging behaviour, and most staff were trained in Ethical Care Control and Restraint techniques.
- Patients' files contained comprehensive risk assessments covering all aspects of care, for example, nutrition, falls, and personal care.
- The provider had a robust incident reporting process that led to actions and lessons learnt for the whole organisation.
- The provider had a detailed duty of candour policy that strongly advocated openness and transparency. Staff complied with this fully.

Are services effective?

Good

We rated effective as good because:

- Care records were comprehensive and covered physical and mental health needs.
- The provider undertook comprehensive assessments of patients prior to admission to help decide whether the unit could meet their needs. This took into account the patients' condition and frailty, and the limitations presented by the environment.
- Staff completed a full review of care and medication on admission. The provider applied a holistic approach to identifying any health issues in patients that could be causing their challenging behaviour, poor mood or aggression.
- The psychiatrist was committed to minimising the use of antipsychotic medication for people living with dementia, in line with national institute of health and care excellence (NICE) guidelines.
- Patients had regular access to physical healthcare, and a local GP attended the unit weekly.
- All staff had received appraisals.
- Multidisciplinary team meetings (MDT) took place weekly and were well coordinated.
- Staff received and were up-to-date on training on mental capacity and the Deprivation of Liberty Safeguards (DoLS).
- Staff had good awareness of the principle of capacity to consent, and records showed that staff assessed capacity on a decision-specific basis.

However:

- Staff did not receive regular one-to-one supervision although they had other sources of support such as two-monthly group supervision sessions, handovers and informal supervision.
- Files contained records of patients' therapeutic activities but staff did not record how these went.

Summary of this inspection

Are services caring?

Good

We rated caring as good because:

- Connolly House received four compliments thanking staff for their care and kindness.
- The short observational framework for inspection (SOFI) exercise showed positive and frequent interactions between staff and patients. We observed warmth and affection between the staff and patients, for example, staff offered patients reassurance and explained what was going to happen before giving any care.
- Staff communicated with patients at an appropriate level to their understanding, for example, they checked that patients understood choices and gave them time to respond.
- Family members gave positive feedback about Connolly House and mentioned improvements they saw in their relatives since their admission.
- Staff encouraged and promoted patients' independent living skills, for example, washing their own faces, and dressing.
- Staff involved patients and their relatives in assessment and care planning.
- All patients received an easy-read information pack about the unit's facilities and services.
- The provider held coffee mornings (relatives' forum) for relatives that senior managers attended occasionally. Relatives found these enjoyable and informative, and appreciated contact with the senior staff.
- Staff recognised it was important to develop trusting relationships with patients, understand their needs and preferences, assess their moods, and develop a rapport with them.
- Staff supported relatives recognising their needs and worries.
- We found that staff adopted and showed person-centred practice with a strong focus on patients' individual care needs.
- The planned admission process was thorough, informative and involved the patients and their relatives. Staff welcomed patients warmly and were sensitive to their feelings.

However:

- A family member was upset that her relative was subject to DoLS. The provider had not explained what it meant in a way that she understood.

Are services responsive?

Good

We rated responsive as good because:

Summary of this inspection

- All the patients were from the local area because the local clinical commissioning group (CCG) commissioned the service on behalf of three CCGs in Essex.
- Patients at Connolly House had access to a wide range of facilities including a female-only lounge, a pleasant garden, and a well-equipped activity centre. Patients and their relatives gave positive comments about the range of activities offered.
- Bedrooms were well furnished but the décor looked 'tired'. Patients could personalise their bedrooms.
- The chef cooked the food to order each day taking into account patients' specific needs and preferences. Patients and relatives commented positively on the quality of the food saying it was good.
- Patients and relatives had access to accessible information about the unit, making complaints, and advocacy services.
- Interpreters were available from the local NHS trust.
- All patients had noticeboards in their bedrooms, which held "my chart". This showed patients' likes and dislikes, for example, whether they preferred a bath or shower, or, tea or coffee.
- Patients were encouraged to follow their religion, and staff supported patients to attend church.
- Staff helped patients with limited capacity to make complaints by looking for signs of dissatisfaction and reporting them to the nurse-in-charge.

However:

- Connolly House patients had to go outside to access the day centre located in the modern section of the building.
- There was limited access to baths for male patients because the men's bathroom was under repair.

Are services well-led?

Good

We rated well led as good because:

- Staff knew the senior managers and frequently saw the registered manager on the ward, and the directors on the site.
- Staff were aware of the vision and values of the organisation, and welcomed the change from a task-oriented culture to a patient-focused culture.
- The provider had governance systems and processes that helped it provide safe and high quality care, for example, clinical governance meetings, incident reporting procedures, and an audit programme.

Summary of this inspection

- There was good morale among staff, and they felt valued and supported by all the managers. Staff described an 'open door' approach by management, and said they could raise problems and ask for advice and support at any time.
- The provider gave staff mandatory training and specialist training for their roles, and offered them opportunities for further professional development.
- Managers and staff felt the unit had high quality staff with the right values and approach towards patient care.
- The registered manager regularly undertook unannounced checks to help identify and address issues about the unit or patient care.

However:

- We found a large amount of non-prescribed medical supplies in the clinic room that were out-of-date.
- The provider completed audits of medicines charts but it was unable to provide any evidence of audits of medicines.
- Although the provider did regular checks of the unit, we found areas of poor cleanliness and repair on the first floor.

Detailed findings from this inspection

Mental Health Act responsibilities

At the time of our inspection, 77% of staff had received training in the Mental Health Act (MHA), and the provider had organised refresher training for January and May 2016.

The provider had revised its MHA policy and training to reflect the MHA Code of Practice issued in 2015.

Although there were no patients detained under the MHA at the time of our inspection, we reviewed historical records to help determine if the provider had addressed the issues identified at earlier MHA monitoring visits. We reviewed the detention records for two patients and found them to be accurate.

Mental Capacity Act and Deprivation of Liberty Safeguards

Staff were up-to-date on Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. Ninety-seven per cent of staff had completed training on MCA and all staff (100%) had completed training on DoLS.

In the past twelve months, the provider made DoLS applications for eleven patients. Five patients had applications for both urgent and standard authorisations, and six applications were for standard authorisations only. At the time of our inspection, the urgent authorisations were in place. The provider had received approval for four standard authorisations but seven remained outstanding. The provider informed us of delays at the local authority owing to a backlog of applications. The provider kept a log of communication with the local authority about the outstanding applications.

Staff adopted the best interests approach to safeguard patients, and we saw best interest assessments for six patients.

Staff had good awareness of the principle of capacity to consent, and assessed capacity on a decision-specific basis. Care files showed completed mental capacity assessments for medication, information sharing, food, freedom of movement and personal hygiene.

Good

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement

Safe and clean environment

- The site contained an old two-storey house (a listed building), with an attached modern, single-storey extension, and a separate administrative building. The building housed two separate units, the hospital, Connolly House, and a nursing home (The Harvey Centre), both provided by Astracare (UK) Limited. Connolly House's bedrooms, lounge and dining room were situated in the old house, which was not fit for modern mental health services. The building presented limitations to the hospital environment and its facilities. For example, the first floor contained a steep staircase, narrow corridors, sloping floors, and tight corners. These created blind spots, presented a risk of falls to patients, and made it difficult to manoeuvre wheelchairs. However, the provider assessed and mitigated environmental and individual patient's risks. Prior to admission, staff assessed patients for their suitability to the environment as well as the service. Patients received falls risk assessments. There was a lift for access to the first floor, which could hold a wheelchair. Given the challenges the environment presented, and the frailty of some of the patients, the number of slips, trips and falls was relatively low. There were seven incidents recorded between April 2015 and February 2016. This was because patients' care plans clearly indicated the levels of support they required, and most patients did not access their bedrooms on the first floor without staff support. Staff observed patients closely and the corridors had CCTV, which staff monitored from the nursing station.
- The building had 24-hour cover, seven days a week, with access controlled by reception staff during office hours, and the nurse-in-charge at other times.
- As well as undertaking annual health and safety, and environmental audits, the provider completed annual ligature risk audits. The provider last completed an assessment of ligature risks in May 2015. The assessment used a standard risk assessment framework to identify ligature points in each room and area of the unit. The provider assessed these risks against the level of risk presented by individual patients to inform a risk management plan.
- The provider complied with the Department of Health gender separation requirements, supported by a gender separation policy. The first floor corridor of the unit had two separate sections, and access to the female patients' bedrooms and bathrooms was through a locked door with a keypad entry system. There was a female-only lounge available on the ground floor.
- The unit had two clinic rooms, one of which contained an examination couch. The clinic room held some emergency equipment, including a defibrillator, a first aid kit and a special spillage cleaning kit, however, the provider no longer held an oxygen cylinder. The manager explained that staff relied on emergency services. The provider stated that staff completed weekly checks on the equipment but was unable to locate the chart showing these checks. Following our inspection, the provider sent copies of charts showing

checks completed in the past two months. These indicated that staff checked and cleaned the hoist and slings, and the defibrillator weekly, and showed that the provider had recently changed the defibrillator battery.

- The unit did not have a seclusion room and did not practise seclusion or segregation.
- The unit kept a log that showed thorough and detailed reports of jobs and improvements required in and around the unit. These covered health and safety issues, maintenance, repairs and décor. Staff reported any issues they came across in the unit, for example, broken furniture. The provider employed a maintenance worker who covered Connolly House and the adjacent nursing home.
- The modern area of the unit, which contained a clinic room, visiting rooms and the day centre, and the ground floor of Connolly House were very clean and in good repair. However, some of the communal areas of the first floor of Connolly House were not clean and were in poor condition. For example, the women's communal bathroom contained grime, torn hazard tape on the floor at the entrance, unused fittings (for example, a large, old hand towel holder with 'teeth'), old, worn framed pictures and notices, exposed piping, vinyl flooring coming away where it joined the walls, a dirty bin surround, and dirty scales. The handrails along the first floor corridors were sticky. In the men's shower room, the glove dispenser for disposable latex gloves for staff use was empty, the showerhead was broken, and the shower rail repaired with black tape, which presented an infection control risk. The detailed cleaning charts indicated that cleaning staff cleaned all areas daily. We informed the managers of our findings, who agreed to discuss cleaning issues with the cleaning company at the earliest opportunity. Following our inspection, the provider sent us its planned and preventative maintenance log for March 2015 to February 2016 that showed it had dealt with some of the maintenance issues we had identified. For example, the provider had replaced the shower rail, and covered the exposed pipes in the communal female bathroom.
- Staff adhered to infection control principles such as handwashing, and all staff had received and were up-to-date with infection control training. We reviewed four infection control audits from August to December 2015. These showed that focused infection control checks took place, for example, the first floor environment, training rates for infection control, and personal protective equipment (PPE). The provider scored the checks against an audit tool and scored between 78% and 100%. The provider completed action plans to address identified issues, with dates for completion and the person responsible. However, even though responses to the issues raised were good, we noted that staff and the audits had not picked up some obvious issues such as poor cleanliness in the women's bathroom.
- The provider did not use bed rails as they can increase the risk of injury to patients. All bedrooms contained nurse call alarms, and some patients who were frail or had a high risk of falls had sensors installed in their beds and fall safe mats placed on the floor. The sensors alerted staff if a patient left their bed.
- Staff offered relatives mobile safety alarms when they went into the garden with a patient so they could call for help, if required.

Safe staffing

- Between October 2014 and September 2015, the service had a staffing establishment of 15 whole time equivalent (WTE) staff (excluding the registered manager and the activities coordinator). For the same period, the vacancy rate was 0.33% and the sickness rate was 7%.
- At the time of our inspection, there was one vacancy for a healthcare assistant and 1.5 WTE vacancies for registered mental nurses (RMN). The staffing complement comprised the following staff (WTE):
  - three qualified nurses (1.5 vacancies)
  - three senior healthcare assistants
  - eight healthcare assistants (one vacancy)
  - one bank/agency nurse (booked long-term to cover the vacancy)
  - one registered manager
  - one activity coordinator.
- In July 2015, bank or agency staff filled 13 out of 93 shifts (14%) to cover sickness, absences and vacancies, and nine shifts were left unfilled. In August 2015, bank or agency staff filled 19 out of 93 shifts (18%), and 10 shifts were left unfilled. In September 2015, bank or agency staff filled 22 out of 90 shifts (20%), and three shifts were left unfilled. We reviewed the staffing rota for December 2015. We found that agency staff were used to fill night shifts at least twice a week but it tended to be the same staff. The provider was reluctant to use staff not known to the patients, and so it had its own bank staff system drawn from the two units on the site. If it needed

external agency staff, the provider booked them for long periods. At the time of our inspection, a qualified nurse had been booked for a three-month period to cover a vacancy.

- The provider estimated the number and grade of staff based on the needs of their patient group. Day shifts typically comprised one qualified nurse, three healthcare assistants (HCA), the activity coordinator and the registered manager. At the time of our inspection, there was one additional healthcare assistant on day shifts for a patient who required one-to-one care. The night shift comprised one qualified nurse and one healthcare assistant. The rotas confirmed these staffing levels for each shift.
- Most staff expressed concerns about staffing levels saying they were not enough to meet patients' needs. One staff member said there were enough staff but there were occasions when the team had to reprioritise tasks. Another staff member commented that it could be difficult to manage with just three healthcare workers on a shift, which was the usual staffing level. Other healthcare assistants said they found it difficult to give one-to-one support to patients with only three HCAs. Staff reported getting help from the Harvey Centre staff for activities, or from family members when going out. Care files showed that a number of patients required two staff for some care tasks. In one case, records showed that the patient had required three staff to help him take a bath.
- Each shift had one nurse-in-charge who was responsible for dispensing medication, dealing with emergencies (designated responder role), writing notes, and managing staff. This meant there was not always a nurse in the communal areas. Furthermore, the design and layout of the building impeded observation and timely responsiveness.
- Staff mentioned that it was difficult to manage at night with one qualified nurse and one healthcare worker on each shift. One patient required the assistance of two staff for frequent toilet visits throughout the night, which left no staff available to other patients, if required.
- Relatives had mixed views about staffing levels. One relative did not think it was a concern, whereas another said it was an issue. However, staff, relatives and patients confirmed that activities were rarely cancelled because of staffing shortages.
- Generally, only the qualified nurse or activities coordinator could write in patients' notes. However, there was only one qualified staff member on each shift.
- We concluded that staffing levels were not always enough to meet the needs of the patients taking into account the frailty of some of the patients, the number of patients requiring assistance with personal care (including two-to-one and three-to-one staff to patient ratios for some tasks), and the design, layout and condition of the unit. However, staff ensured patients' needs were met but they felt under pressure and depended on support from the registered manager and activities coordinator.
- Qualified nurses led physical interventions such as restraint, however, staff rarely carried out any physical interventions other than low-level holds.
- A psychiatrist supported the unit for two days a week and provided twenty-four hour on-call cover, able to attend within the hour. The psychiatrist's organisation offered cover during sickness absence or annual leave. The unit relied on mainstream GP and emergency services for physical health needs.
- We reviewed two staff personnel files. Files were comprehensive, in good order and up-to-date. They contained recruitment information, references, disclosure and barring service (DBS) checks, professional registration details, induction and mandatory training records, sickness absence and supervision and appraisal records. The staff welfare audit, conducted in March 2015, showed good performance in a number of areas associated with safe staffing. At the time of inspection, 100% of staff had an up-to-date DBS check completed within the past three years and for newly recruited staff, prior to their start date.
- The provider's mandatory training comprised core mandatory training and essential role-specific training. We reviewed training records for February 2016 and found variable rates of compliance:
  - fire safety and evacuation, 100%
  - health and safety, 96%
  - safeguarding of adults at risk, 100%
  - infection control, 93%
  - moving and handling, 100%
  - basic food hygiene, 100%
  - person-centred care/privacy and dignity, 100%
  - challenging behaviour and de-escalation, 93%
  - ethical care control and restraint (ECCR), 90%

- medicines management and administration, 100%
- first aid, basic life support and resuscitation, 50%
- basic life support, 64%
- pressure ulcer prevention, 57%.

- Training rates were low for first aid and resuscitation (50%), basic life support (64%) and pressure ulcer prevention (57%). We found that five out of 14 staff eligible for the basic life support course had not completed it, or it was out-of-date. Eight staff were eligible for the first aid and resuscitation training but three staff had not completed it, and for two staff, it was out-of-date.
- There was a small library and training room in the administrative building where staff could complete online training, reading or research.

Assessing and managing risk to patients and staff

- The provider had a restraint policy, which advocated a preventative and least restrictive approach to the management of challenging behaviour. Connolly House reported two incidents of restraint on two service users in the six months up to 31 October 2015. None were in the prone (face-down) position.
- The provider did not use seclusion, long-term segregation, or rapid tranquillisation. It reported no incidents of seclusion or long-term segregation in the six months to 31 October 2015.
- We reviewed care records for five patients. Files contained comprehensive risk assessments that were reviewed and up-to-date covering, for example, nutrition, falls, and personal care.
- The provider assessed patients for their suitability to the unit prior to admission. As well as the patient's specific needs, this took into account the layout, design and age of the building. Qualified nursing staff completed risk assessments on admission of a new patient. They used a locally developed risk assessment tool, informed by recognised good practice tools and guidance.
- The provider had an observation policy that described the four levels of observation used at Connolly House, and the associated standards expected by staff. Patients received the level of observation and support required to meet their individual needs.
- Staff were committed to the least restrictive approach to managing challenging behaviour. Most staff were trained in Ethical Care Control and Restraint (ECCR) techniques, and a qualified nurse led any restraints. The provider did not use prone restraint, but it did occasionally use soft or safe holds. Staff found de-escalation (calming down) techniques sufficient to manage most of the risk patients presented. Staff used their knowledge of patients to manage their behaviour. They looked for warning signs and triggers, and intervened with distraction techniques. In particular, staff called other staff that had a good relationship with the patient to help calm them down.
- At the time of our inspection, the manager confirmed that there were no patients asking to leave, and no patients deemed at risk of absconsion. Staff understood that informal patients could leave at will subject to deprivation of liberty safeguards. One patient was receiving one-to-one care because of the risk of falls.
- Staff received training on safeguarding and knew how to recognise and report safeguarding concerns.
- We found medicines management practice was inconsistent. Storage practice was good with locked areas, controlled access to keys, and fridge and room temperatures regularly monitored. Staff kept the lockable medicines trolley in the clinic room. The nurse-in-charge held the keys to the clinic room and the medicines cabinets, and kept them locked. The medicines cupboards contained mostly individually prescribed medication and a small amount of stock medication, which the unit was running down. However, we found a large number of out-of-date non-prescribed medical supplies, for example, dressings, bandages, and urine-testing strips. These items had expiry dates of 2008, 2010, 2011 and 2014. The items were not in use at the time of our inspection. The provider informed us that it completed medicines management audits quarterly and annually but was unable to provide evidence of these audits.
- The provider stated it had access to a local pharmacist but there was no evidence of robust pharmacy oversight of medicines management practices.
- Medicines charts were clear, easy to read, and fully complete, although the provider kept the authorised signature sheet in the administrative office, away from the ward. This meant that the signatures of staff who dispensed medication could not be checked easily to ensure they had the appropriate authorisation.
- The registered manager completed audits of medication charts on a quarterly basis, which showed any gaps or errors in records, and put actions in place to address them.

Good

Wards for older people with mental health problems

- During our inspection visit, we observed the nurse signing all the patients' medication charts at the same time, after finishing the lunchtime medication round, rather than at the time of administration. This increased the risk of error such as wrongly recording whether a patient had received and taken their medication, and was not in line with the required standard procedures for recording when administering medication.
- A small number of patients received covert (hidden) medication in line with the provider's policy and procedures and the best interests framework. Staff used covert medication as a last resort and stopped it if they no longer saw signs of resistance from the patient.

Track record on safety

- The provider reported five serious incidents between September 2014 and October 2015. In two incidents, patients fell and sustained injuries. In one incident, a patient assaulted another person. There were two separate incidents of a staff member 'being rough' with a patient. The provider investigated and took appropriate action in all incidents.
- The age, design and layout of the building presented challenges to the provision of safe and effective care for frail or confused patients. However, the provider assessed the suitability of patients for the environment prior to admission, and escorted patients in areas presenting increased risks.

Reporting incidents and learning from when things go wrong

- We saw copies of incident reporting forms, and found that the provider had a robust reporting process that resulted in actions and lessons learnt. We reviewed the incident log covering 2015/16, which held a collated summary of all incidents throughout the year. There had been 26 incidents to patients and staff up to 23 January 2016. These included seven falls, six 'found on floor', and nine incidents of patients hitting or scratching staff. The log showed incidents classed as near misses or serious incidents that were reported to the clinical commissioning group (CCG), in line with the government's serious incident framework.
- Staff informed family members of any incidents or periods of agitation their relatives experienced. One relative said that staff told her whenever they had to use 'holds' with her relative. Staff contacted another family member when her relative suffered a fall.
- The provider had a comprehensive duty of candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. We saw good examples of openness and transparency when something went wrong even though not all some staff and managers were familiar with the term 'duty of candour'.
- Staff were aware of the procedures for reporting incidents. Staff received debriefs following incidents, and discussions about prevention, for example, falls. The provider discussed incidents at clinical governance meetings, handovers and MDTs.

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 the care records for five patients. Records were comprehensive and covered physical and mental health needs. Records contained a range of assessments and care plans appropriate to the patients' needs, for example, waterlow pressure sore, depression, falls, dressing and undressing, suicide intention, skin/tissue, diet and nutrition, eating skills, continence, sleep, handling and lifting.
- Files contained records of patients' therapeutic activities but staff did not consistently record the outcome of planned activities. We found blank copies of the 'activity progress form' in patients' files, which made it difficult to assess a patient's mood, level of participation, and skills shown in activities over a period of time.
- The provider undertook comprehensive assessments of patients prior to admission to help decide whether the unit could meet their needs. This took into account the patient's physical condition and frailty, the service the provider could offer, and the limitations presented by the environment.
- Staff completed a full review of care and medication on admission. The provider applied a holistic approach to

identifying any health issues that could be causing challenging behaviour, poor mood or aggression. For example, in one case, a patient's medication caused severe constipation, which was contributing to the patient's poor mood. In another case, a patient was in severe pain caused by dental issues. The unit responded appropriately to these issues.

- The provider kept paper records and stored them securely in the nursing office. The records were filed in good order in line with the provider's procedure. A cover sheet showed the order of records and helped staff access specific assessments and care plans quickly. The nurse-in-charge or activity coordinator completed the daily records.

Best practice in treatment and care

- The provider adopted a model of care underpinned by good practice, for example, recovery-based, and dementia-friendly approaches.
- The provider focused strongly on the relationship between physical and mental health and wellbeing. By consulting relatives, and observing patients closely, especially those with limited verbal communication, staff identified triggers and warning signs causing them distress. Staff then identified any physical health needs that could be a factor, and planned care that would address these. The overall aim was to improve the patients' quality of life.
- The psychiatrist was committed to minimising the use of antipsychotic medication in patients living with dementia, in line with national institute of health and care excellence (NICE) guidelines. The psychiatrist reviewed all patients' medication thoroughly and assessed its impact on patients' overall health. Through this approach, the psychiatrist identified the cause of internal bleeding in one patient. Staff and relatives commented on the improved quality of patients' lives when they were no longer over-sedated, or when their side effects or physical symptoms reduced.
- Patients had regular access to physical healthcare. A local GP attended the unit weekly.
- Staff assessed patients' nutrition and hydration needs, and requested specialist assessments, such as speech and language therapy, where required.
- Although the provider had links with the local pharmacy and could request advice, the provider did not have regular pharmacy oversight in the unit and there was no evidence of a pharmacist visiting the ward.
- The service had a programme of audits to help monitor service delivery, identify any issues and inform service improvement. Audits completed in the six months to 15 October 2015 included infection control, ligature points, staff training, CPA, hand hygiene, care plans, and physical examinations. Managers put action plans in place to address any identified issues. However, there was no evidence of audits on medicines management practices other than completion of medication charts.

Skilled staff to deliver care

- The unit had access to a multidisciplinary team. This comprised permanent Connolly House staff supported by 'consulting' and 'visiting' professionals. Connolly House staff included a consultant psychiatrist, an activity coordinator, registered mental health nurses and healthcare assistants. The provider accessed other professionals such as a physiotherapist, a neurologist and a mental health law expert on a consultancy basis. Visiting professionals included a dietician, a chiropodist, an optician, care coordinators, independent mental health advocates (IMHA), independent mental capacity advocates (IMCA), social workers, and community nurses. The unit relied on mainstream NHS services for speech and language therapy and occupational therapy support, which required a referral from the GP. Speech and language therapy support took about two weeks, with telephone consultations available in the meantime. Occupational therapy support took longer to access. The unit lacked pharmacy input.
- As of October 2015, all staff (100%) had an up-to-date appraisal completed within the past year.
- The provider did not have up-to-date figures on supervision. The provider's audit of staff records completed in March 2015 showed that up-to-date supervision notes were absent for 69% of staff. One of the reasons identified was missing paperwork in staff files. The provider took action to address this, for example, introducing a target for submission of supervision notes to Human Resources.
- During our inspection, we found that staff received supervision but this was not consistent. The provider's policy stated that staff should receive one-to-one supervision at least quarterly. Although one member of staff member reported receiving one-to-one supervision every two to three months, another staff member described six-monthly supervision sessions. We reviewed files for two staff. One file showed that the staff

member had last received group supervision in January 2016, and one-to-one supervision in September 2015. The other file showed that the staff member had last received one-to-one supervision in July 2015. We saw a sample of supervision records from the provider that showed quarterly supervision for one nurse, but only one supervision session each for a healthcare assistant and a senior healthcare assistant in the past six months. However, the manager had recently commenced group supervision sessions, which occurred every two months. Staff also had the opportunity to raise issues and discuss any concerns on a day-to-day basis, through handovers, or informal approach to colleagues, supervisors or managers. Following the inspection, the provider submitted supervision timetables for administrative staff, non-clinical staff and clinical staff showing supervision scheduled throughout 2016/17, on a quarterly basis.

- The provider offered staff additional training to help them fulfil their roles. As of February 2016, the training rates for these were:
  - mental capacity, 97%
  - Deprivation of Liberty Safeguards (DoLS), 100%
  - risk assessment, 100%
  - care planning, 100%
  - complaints and grievances, and internal incident reporting, 27%
  - Mental Health Act, 77%
  - dementia, an understanding, 70%
  - mental health awareness, 57%
  - palliative and end of life care, 87%.
- Staff found the role-specific training helpful in their work, alongside their knowledge of the patients. Relatives spoke highly of the staff's skills, knowledge and experience, and said they could ask them anything.
- One staff member told us that in the past, the provider had encouraged him to achieve a national vocational qualification (NVQ) level three, and more recently, had helped him undertake a management apprenticeship.

Multidisciplinary and inter-agency team work

- The onsite multidisciplinary team (MDT) comprised a consultant psychiatrist, an activity coordinator, and registered mental health nurses. Healthcare assistants could attend MDT but this was often difficult in practice. The MDT invited other professionals, if required, for example, a speech and language therapist, a physiotherapist, a neurologist and a mental health law expert, a dietician, a chiropodist, an optician, care coordinators, social workers, and community nurses.
- MDTs took place weekly on Fridays, and reviewed each patient fortnightly. Care programme approach (CPA) meetings took place on a six-monthly basis and staff invited care coordinators, commissioners, relatives, and IMHA/IMCAs, as appropriate.
- We observed a handover, which included qualified and unqualified nursing staff, and the activity coordinator. All staff contributed to the discussion. Staff talked about how patients were that day covering their mood, behaviour, personal care and activities. The handover showed that staff had a good awareness of their patients' needs. Staff found handovers a good source of information, especially those who did not attend MDTs.
- The provider was in regular contact with the local clinical commissioning group (CCG) that commissioned the unit on behalf of a group of local CCGs. All patients had local care coordinators known to the provider.

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

- At the time of our inspection, 77% of staff had received training in the MHA, and the provider had organised refresher training for January and May 2016.
- The provider had revised its MHA policy and training to reflect the MHA Code of Practice issued in 2015.
- Connolly House had received two Mental Health Act (MHA) monitoring visits in the past. The first visit took place on 28 February 2014, and the second visit took place on 31 July 2015. These visits identified the following issues:
  - care records did not indicate whether patients had received assessments of their capacity to consent to, or refuse, treatment
  - DoLS applications had been made for 12 patients but none had urgent DoLS authorisations in place
  - there were some errors in the MHA documentation, for example, in one detention form, a section was left blank, and in another, the date was incorrect.
- The provider had submitted an action plan showing how it would address these issues. We reviewed these issues during our inspection and found the provider had addressed them.
- At the time of our inspection, no patients were detained under the Mental Health Act. The provider had started

discussions with commissioners about the future of the unit, that is, whether it should remain a hospital that admitted detained patients, or re-register as a nursing home.

Good practice in applying the Mental Capacity Act

- Records showed that 97% of staff had received training in mental capacity and 100% had received training in the Deprivation of Liberty Safeguards (DoLS).
- In the past 12 months, the provider had made DoLS application for eleven patients. Five applications were for both urgent and standard authorisations, and six applications were for standard authorisations only. At the time of our inspection, all the urgent authorisations and four standard authorisations were in place. The provider reported local authority delays in processing applications. The provider kept a log of communication with the local authority about the outstanding applications.
- Staff applied the best interests approach, where necessary. Care files for six patients contained best interest assessments.
- Staff had good awareness of the principle of capacity to consent. Records showed that staff assessed the capacity to consent on a decision-specific basis, for example, for one patient smoking was a decision he had the capacity to make.
- We reviewed care files for five patients. One file contained five completed mental capacity assessments for medication, information sharing, food, freedom of movement and personal hygiene.
- Care records showed that the psychiatrist undertook mental capacity assessments for medication.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

- An audit report for complaints and compliments, dated 12 March 2015, showed that Connolly House received four compliments from patients' relatives and one from previous staff members. Comments made by relatives included thanks to all staff for their wonderful care and kindness towards a patient; thanks to all staff for their care and attention towards a patient; thanks to staff for what they do for the patient; and a comment on how wonderful the care home and staff were. The compliment from two previous staff members thanked all staff for their kindness.
- Staff recognised that it was important to develop trusting relationships with patients, understand their needs and preferences, assess their moods, and develop a rapport. Staff also applied this approach to relatives recognising their needs and worries.
- During the inspection, we observed staff treating patients with dignity and respect. For example, a staff member adjusted a patient's clothing discreetly when it became tangled. Staff communicated with patients at an appropriate level to their understanding, checked that patients understood choices offered to them, for example, about activities, and gave them time to answer. We observed warmth and affection between staff and patients. Staff reassured patients and explained what was going to happen before any intervention took place. Staff were responsive, cheerful, compassionate and supportive. Staff lowered themselves to speak to seated patients. We saw that most patients looked content and showed good humour. Patients were well dressed and looked clean. At the time of our inspection, there were some patients experiencing distress. We saw staff approach them gently, speak to them softly, and comfort them by stroking hold their hands or arms. We observed patients smiling and laughing during interactions with staff. Staff responded promptly to patient requests.
- We conducted a SOFI exercise and saw positive interaction between staff and patients. Our findings showed frequent interactions between patients and staff, and among patients. During the SOFI exercise, we saw no poor staff interactions. Patients' moods were mostly neutral or positive, with the exception of one patient who appeared to be in pain. Staff noticed the patient, responded sensitively, and provided reassurance and comfort through touch. Most patients were engaged in tasks of some sort, whether drinking tea, watching television, or observing other patients.
- We found that staff adopted and showed person-centred practice with a strong focus on patients' individual care needs. Staff reported a change in approach at the unit, from task-oriented care to person-centred and a more human approach to care.

Good

Wards for older people with mental health problems

- We spoke to three relatives on the day of inspection. All commented on the high level of warmth and understanding shown by staff to their relatives. One relative said, "Staff always show kindness", and another said, "Staff can never do enough."
- Two relatives reported improvements in their relatives' overall wellbeing since moving to Connolly House.
- Two family members told us medical staff reviewed and changed their relatives' medication, which made the patients less drowsy.
- One relative described the care as "second to none", and another relative said there was good, adequate food, beds were changed and patients were always clean.
- One patient described the staff as "pretty good", "okay", and "nice." Patients used words such as 'kind' and 'nice' to describe staff.

The involvement of people in the care they receive

- The planned admission process was thorough, informative and involved the patients and their relatives. Relatives and patients said staff welcomed them warmly and were sensitive to their feelings.
- Patients had access to independent mental health advocacy (IMHA) services from Pohwer, and independent mental capacity advocacy (IMCA) services from Voice Ability.
- The provider held patients' meetings and relatives' meetings, and ran a patients' survey and a relatives' survey.
- Relatives explained that Connolly House staff invited them to attend care reviews and discussed any planned changes to their relative's care. Relatives said they found doctors and nurses easy to access, and available for any questions or concerns.
- Relatives stated staff kept them informed of any incident, even when, in their view, it was minor. Relatives welcomed this level of openness.
- Relatives enjoyed a coffee morning held in November 2015 and expressed a wish for these to continue. The provider had planned a further coffee morning for February 2016.
- Families recognised the efforts staff made to get to know their relatives. One relative said, "When my relative arrived I spent time with staff discussing their life including what jobs they did and likes and dislikes." Staff then displayed this information in bedrooms as an aid to the patient and staff.
- All patients received an information pack about the unit's facilities and services, which they kept in their bedroom. These were available in easy-read and pictorial formats.
- Staff asked relatives about the patient's food preferences where patients struggle to communicate.
- Staff involved patients and their relatives in care planning. Staff recorded if patients participated in their care planning, and care plans contained patients' signatures or the reasons why they were unable to sign.
- Relatives could support patients with personal tasks such as shaving, cutting toenails, and trimming hair.
- One patient described how staff helped him decide what activities to do each day. Staff told him what activities were available, helped him choose what to do, and he then decided whether to participate.
- Staff encouraged and promoted patients' independent living skills, for example, washing their own faces, and dressing.
- A family member was upset that her relative was subject to DoLS. The provider had not explained what it meant in a way that she understood.

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

(for example, to feedback?)

Good

Access and discharge

- Connolly House had 14 beds. The local clinical commissioning group (North East Essex CCG) commissioned 13 beds on behalf of three Essex CCGs. The spare bed was available for private purchase but the local CCGs often commissioned it on a spot purchase basis.
- The average bed occupancy rate for the six months to end September 2015 was 89%. At the time of our inspection, the unit had thirteen patients and held a room for another patient who was in hospital, which gave a bed occupancy rate of 100%
- All patients were from the local area. Patients usually arrived from hospital but occasionally some came from their own home.

- The unit had an admission policy that set out the guiding principles and procedures for admission. The principles focused on welcoming and being sensitive to new patients and their needs. The procedures for staff included discreet observation for the first 24 hours, creating new records, and collating information about the patient.
- At the time of our inspection, there were no delayed discharges. Although Connolly House was discharge-oriented, due to the patients' needs, there were no patients discharged in the past six months.

The facilities promote recovery, comfort, dignity and confidentiality

- The building comprised old and modern sections, and housed two distinct services, provided by Astracare (UK) Limited. There was Connolly House, the hospital, and The Harvey Centre, a nursing home. The bedrooms and lounge areas for Connolly House patients was in the older part of the building, over two floors, which had narrow corridors, steep staircases and many corners. The day services and visiting facilities (for visiting professionals and relatives) were in the modern part of the building, which was spacious, and well-furnished. Because of the design and layout of the site, Connolly House patients had to go outside to access the day centre. The only indoor route was through The Harvey Centre (the nursing home), which staff and patients used occasionally.
- The whole unit was set in extensive, landscaped grounds that were accessible to all patients. It had an enclosed patio area and a 'crazy golf' facility. The garden contained a smoking shelter with a bench.
- Connolly House had a large lounge on the ground floor, which had three separate sections, one of which was designated a female-only lounge. The whole area was warm and comfortable. There was soft music playing in the background, which helped to create a relaxed atmosphere.
- The dining room was large and spacious. The chef displayed each day's menu on a whiteboard. In addition, the chef displayed the four-weekly menu cycle on the dining room noticeboard. Patients and relatives commented positively on the quality of the food saying it was good. One patient said the "food is plentiful" and "it's good." Connolly House received a food hygiene rating of five (very good) fromTendring District Councilon 19 September 2013.
- There were facilities for making hot drink and snacks throughout the unit and available to patients and relatives at all times. Most patients received staff support to make drinks because of their frailty.
- Bedrooms were well furnished but the décor looked 'tired'. Patients could personalise their bedrooms. One patient described his bedroom as comfortable and said "the room has everything I require for my life."
- There were three bedrooms on the ground floor for male patients only. On the first floor, there were seven bedrooms for male patients and four bedrooms for female patients in a separate female-only area. All bedrooms had an ensuite toilet and washbasin. Two women's bedrooms also had showers. There was a separate adapted bathroom in the female corridor, and an adapted shower room in the men's area.
- The unit had a large, well-equipped activity centre based in the modern part of the building. Patients and their relatives gave positive comments about the range of activities on offer.
- The provider employed a dedicated full-time activities coordinator who planned a range of social and therapeutic activities based on individual patients' needs and preferences. The activity coordinator attended MDTs and CPAs and gave feedback on patients' participation in activities. The activity coordinator and staff were keen to tailor activities to patients' changing interests and ensure they had therapeutic value for them. Staff looked for signs of satisfaction, pleasure, boredom and disinterest in patients to help evaluate activities and personal preferences. Staff had a strong commitment to motivating patients, and finding opportunities for making a connection and communication. Where patients did not engage in activities, staff found other ways to communicate with them, for example, sitting with the patient when they were smoking.
- The unit had a minibus, which it shared with the adjacent nursing home. We saw an activity planner in pictorial format displayed on the lounge noticeboard. This showed a wide range of activities planned for that week. These included cards, tenpin bowling (onsite), bingo, wine tasting, light exercise, quiz, and one-to-one time allocated for any other activities individuals may wish to do. The activity coordinator recognised that patients may change their minds about what activities they wanted to do, and so incorporated alternatives into the planner.

- Other activities offered included pool, arts and crafts, ball games, knitting, music, pub visits, walking, church, shopping, and singing. Staff also arranged themed events, for example, Christmas and Halloween parties, and bonfire celebrations. Outdoor activities included visits to air shows, village trips, visits to the local duck pond, a fish lake, and an open garden. Staff invited relatives to join these activities. Patients from the adjoining nursing home shared some of the activities.
- The unit offered specific dementia-friendly activities such as reminiscence using photos, pictures and music from the past to spark memories and encourage conversation. The provider planned to introduce memory boxes. Staff had started collating patients' histories from their families.
- We observed a wine-tasting session, which was pleasant. The activity coordinator arranged the chairs to create a lounge-like setting in the activity room, turned down the lighting, played soft music and offered patients wine and snacks. The patients looked very comfortable and sat chatting and joking with each other.
- Staff ran activities at the weekend such as board games, looking at books and pictures, and outings in the summer.

Meeting the needs of all people who use the service

- Male patients had access to a shower room but not to a bathroom. The men's bathroom was being refurbished but there had been delays due to problems with the weight of the new bath and the adaptations required. Records showed that three men preferred to have baths but were not able to on a regular basis. Occasionally, staff supported male patients to use the women's bathroom after ensuring privacy and dignity for both men and women. The female patients had access to a bathroom but their shower room was under repair. This had minimal impact on the female patients because two had ensuite shower rooms in their bedrooms, one patient was in hospital and the other preferred baths.
- Staff informed us that patients received baths weekly, which suggested a routine practice that was not person-centred. One patient complained this was not enough. However, care records showed that while some patients had baths or showers weekly, other patients had baths or showers more frequently, for example, two to three times a week, based on their wishes or needs. We found that all patients were clean, odour free and appropriately dressed. Staff ensured patients received care to maintain hygiene and cleanliness when required, especially if they experienced continence issues.
- Patients and relatives had access to accessible information about the unit, making complaints, and advocacy services. All patients had an easy-read information pack in their bedrooms.
- Interpreters were available from the local NHS trust. Staff gave an example of a patient whose language caused some confusion. By using interpreters, they found out that this was because the patient spoke five languages. The information gathered helped staff adopt a person-centred approach to communicating with the patient. Staff realised that the patient was bilingual, and an interpreter was not required.
- All patients had noticeboards in their bedrooms, which held "my chart". This showed some basic yet important information about patients, for example, personal preferences for a bath or shower, tea or coffee, and likes and dislikes.
- The chef cooked the food to order each day taking into account patients' specific needs and preferences. At the time of our inspection, there were no patients with specific eating needs. However, a new patient had not been eating because she had a fear of choking, and was severely underweight on admission. The chef prepared soft food for the patient, which she ate. The patient's care notes showed she had started to put on weight.
- Patients were encouraged to follow their religion. Staff supported patients to attend church. The provider had links with the local roman catholic priest who visited clients regularly. A private room was available for communion.

Listening to and learning from concerns and complaints

- The provider received three complaints in the year to 30 September 2015. One complaint was upheld and two were partially upheld. There were no complaints referred to the ombudsman. All three complaints related to patient care.
- Staff described an 'open door' approach by management, and said they could raise problems and ask for advice and support at any time.

Good

Wards for older people with mental health problems

- Staff were aware that patients with limited capacity may struggle to make complaints. As such, they looked for signs of dissatisfaction and reported them to the nurse-in-charge. Staff gave examples of two patients who had made complaints.
- An audit report about complaints indicated that the provider listened to all complaints and dealt with them in line with its policy and procedure. The provider reviewed complaints and outcomes to help identify service improvements, and gave feedback to staff.

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

Good

Vision and values

- The provider's (Astracare (UK) Limited) Strategic Business Plan 2015-16 described its vision and values for Connolly House, and indicated a strong focus on high quality and responsive service provision.
- The provider displayed its strategic direction in posters across the unit.
- Staff knew the senior managers and frequently saw the registered manager on the ward, and the directors on the site.
- Staff were aware of the vision and values of the organisation. They felt there had been a positive change in the past year from a task-oriented culture to a patient-focused culture.

Good governance

- The provider's organisational structure showed there were management leads allocated for key business functions for oversight and governance purposes. As well as day-to-day operations, the leads' responsibilities included regular reporting on performance, and risk management. The provider had a range of policies in place to help ensure good governance and support service delivery.
- The provider held monthly governance report meetings and two-monthly clinical governance meetings. We reviewed the clinical governance meeting minutes from May and July 2015. The meetings included discussions on patients' involvement and experience, clinical activities and effectiveness, risk management and incidents, HR staffing and staff management, education and training, information and technology management, health-related services and management and quality assurance.
- The registered manager regularly undertook unannounced 'walk about management' checks. In addition, managers did 'dignity challenges', focused on patients' dignity. These audits helped identify issues and risks in the environment and possible lapses in the care of patients. Managers were responsible for taking action to address any issues found. We reviewed an annual report (April 2014 to May 2015), which indicated that 52 audits had taken place in this period. Examples of issues identified included broken furniture, untidy areas, and patients' poor states of dress. However, given the frequency of these checks and audits we found areas of poor cleanliness and repair on the first floor.
- We saw that the provider completed audits of individual patients' medicines charts, but it was unable to provide any evidence of audits of medicines management practices. Although the prescribed medicines for patients were in order, we found a large amount of medical supplies in the clinic room that were out-of-date.
- Staff had received mandatory training, appraisals and supervision but arrangements and frequency for supervision varied among staff. Staff spent a large proportion of their time on direct and face-to-face care activities. Staff were skilled and experienced but staff, patients and relatives reported shortages of staff at times. Shifts usually had one qualified staff member and three healthcare assistants, which placed a lot of pressure on staff given the frailty of the patients, and the design and layout of the unit. Consequently, the registered manager and activity coordinator frequently helped with day-to-day care tasks.

Leadership, morale and staff engagement

- The provider had systems to monitor some staffing-related matters. In October 2015, the provider completed an audit on staff welfare. This included reviews of staff personnel files (for example, up-to-date supervision, appraisals and personal development, DBS checks, professional checks); staff welfare (for example, training and development), staffing levels and feedback from appraisals.
- The provider's equality and diversity report (March 2014 to August 2015) stated there had been no complaints or

grievances from staff of discrimination, bullying or harassment. Furthermore, the report gave examples of how the provider supported staff with specific needs, for example, it gave a staff member with a hearing difficulty additional time allowance for training; it gave speech recognition software and colour filters to a staff member with dyslexia.

- Most staff felt valued and supported by all the managers. One staff member described the staff team as good, and the management as approachable. Another staff member described an improvement in the culture of the organisation finding it more open, transparent and supportive than in the past. Managers and staff felt the unit had a good calibre of staff with the right values and approach towards patient care. Staff commented on the training available to support a person-centred focus and increase awareness on some conditions, for example, dementia and palliative care.
- Staff could give feedback on service developments at the team meetings.

Commitment to quality improvement and innovation

- The provider, Astracare (UK) Limited, achieved the "employer of excellence" award by meeting the Peninsula accredited standard. The Peninsula accredited standard is a framework for ensuring excellence and best practice in human resource management. The provider achieved the award for its commitment to staff welfare and good relationships with its employees.
- The provider, Astracare (UK) Limited, had attained "ISO 9001" certification. ISO 9001 is a certified quality management system for organisations who want to ensure they continually provide products and services that meet the needs of their customers.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure there are robust systems and processes for monitoring and auditing the management of medicines.
- The provider must ensure it has the correct emergency equipment (including an oxygen cylinder), in line with NICE guidance.
- The provider must ensure that staff receive training that is essential for carrying out the requirements of their role.

Action the provider SHOULD take to improve

- The provider should ensure staff follow the required standard procedures for recording when administering medication.
- The provider should ensure there is adequate pharmacy input to the ward to ensure safe management of medicines.
- The provider should ensure that staff receive regular supervision in their role.
- The provider should ensure that staffing levels meet the needs of people using the service at all times.
- The provider should ensure that all areas of the hospital are kept clean.
- The provider should ensure there are adequate facilities for patients to take baths.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider's systems and processes for identifying issues where quality and safety were being compromised failed to identify out-of-date medical supplies. This was a breach of regulation 17(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Emergency equipment lacked an oxygen cylinder. This was a breach of regulation 12(2)(f)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Not all staff received training that was essential for their role, for example, the provider had low training rates for first aid and resuscitation (50%), basic life support (64%) and pressure ulcer prevention (57%). This was a breach of regulation 18(2)(a)