Arbour Lodge Independent Hospital

Quality Report

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

Ratings

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

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

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

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

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

Summary of findings

Overall summary

The CQC is placing the service into special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made, and there remains a rating of inadequate overall or for any key question, we will take action in line with our enforcement procedures. At this point, we would begin the process of preventing the provider from operating the service. This will lead to cancelling the providers' registration at this service, or varying the terms of their registration within six months if they do not improve. The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

We rated Arbour Lodge independent hospital as inadequate because:

- Patients were at high risk of avoidable harm due to poor safety performance. There was limited measuring and monitoring of practice to ensure safe care.
- The hospital was not safely staffed. The level of staffing was not sufficient to ensure that observations were undertaken safely and that there were enough staff to care for patients safely.
- We witnessed unsafe moving and handling practice during this inspection which put patients at risk of harm.
- There was unsafe medicines management practice. Medicines were being given which were not legally authorised or safely monitored. Medicine stocks did not tally, medicine administration boxes were unsigned and administration times had been altered by hand. Qualified nurses did not ensure the medicines keys were safely managed.
- The hospital was not adhering to the Mental Health Act requirements. One patient had been being given medicine for three months which was not authorised. A copy of the treatment certificate had been altered by hand. Mental Health Act policies were not revised and up to date with the current code of practice.
- Patients' care and treatment did not reflect current evidence based guidance, standards and practice. Staff were not sufficiently skilled or knowledgeable regarding good practice guidance to deliver effective care. There was little monitoring of outcomes of care and treatment. Plans for patients transition or discharge were largely absent.
- We had concerns that two patients were being deprived of their liberty without authorisations for this and without this having been recognised by the service.
- There was poor governance in relation to the oversight of issues arising at the hospital and communication between the hospital management and the senior group management. There was no evidence of an effective system to manage issues and risks at a local or organisational level. Managers were not aware of problems identified at this inspection and did not investigate thoroughly when things went wrong.

We raised our concerns about the quality of care being provided at the time of the inspection to managers. We also raised a safeguarding alert regarding the care of one patient. We are taking enforcement action and we will be working with the provider to ensure that improvements are made.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Wards for older people with mental health problems	Inadequate 	

Summary of findings

Contents

Inadequate

Arbour Lodge Independent Hospital

Services we looked at
Wards for older people with mental health problems

Summary of this inspection

Background to Arbour Lodge Independent Hospital

Arbour Lodge independent hospital is run by Barchester Healthcare Homes Limited. It is a hospital that provides 24 hour support seven days a week for up to 13 patients with early onset dementia and/or mental health problems. The main focus is providing support to people whose behaviour may challenge. The service is for men aged 50 years old and above. At the time of this inspection, there were 11 patients living at the hospital.

The regulated activities at Arbour Lodge independent hospital are assessment or medical treatment for persons detained under the Mental Health Act 1983; diagnostic and screening procedures, treatment of disease, disorder or injury, nursing care and personal care.

CQC has inspected the service on four previous inspections. When we last inspected, in August 2015, the service was rated as requires improvement overall, with individual ratings of inadequate for safe, requires improvement for the effective, responsive and well led domains and good for caring. Given this, a comprehensive inspection was planned to check progress across the domains.

Following the inspection in August 2015, we served three requirement notices. We reviewed the requirement notices at this inspection and found that the hospital had largely addressed them. However, we found new concerns at this inspection, for example, in terms of medication use, which had developed since the service was last comprehensively inspected.

There was no registered manager in post at the time of this inspection. The previous hospital director had transferred to another hospital in February 2016 and the clinical nurse lead was acting hospital director whilst the provider was recruiting to the role. A new manager was due to start in August 2016.

The controlled drugs accountable officer was still recorded as the previous hospital director.

Our inspection team

Team leader: Andrea Tipping.

The team that inspected the service comprised two inspectors and three specialists: a Mental Health Act reviewer, a pharmacist and a specialist nurse advisor with experience of working with older men with mental health problems and behaviour that can challenge.

Why we carried out this inspection

This was an unannounced inspection. We undertook a comprehensive inspection to follow up on progress relating to concerns raised at a previous inspection in 2015.

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?

Summary of this inspection

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

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 five patients who were using the service;
- undertook a short observational framework for inspection;
- spoke with the acting hospital director and acting clinical lead nurse;
- met the regulation manager;
- met the general practitioner;
- spoke with nine other staff members; including nurses, support workers, the mental health act administrator, the activity co-ordinator and training manager;
- looked at nine care and treatment records of patients;
- reviewed 22 supervision files and appraisal records;
- examined the duty rota and staff allocation records;
- examined 11 medicines administration records and prescriptions;
- 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

Patients we interviewed indicated that they were generally happy with the care they received and the attitude and responsiveness of staff. All patients interviewed said that they felt safe on the ward all the time and said that the range of activities made available to them had improved in recent months and that they particularly enjoyed the trips that the hospital had arranged. Patients were particularly complementary about the efforts of the activities co-ordinator in this regard.

Patients could not recall their being involved in care planning processes but did confirm that they knew who their named nurse was and acknowledged being offered regular one to one sessions with them.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Inadequate

We rated safe as inadequate because:

- Staffing levels were not sufficient to provide safe care.
- Staff were completing continuous observations for several hours at a time, in contravention of the hospital policy and national guidance.
- Medicines management practices were unsafe with stock discrepancies, medication not signed and poor audits completed. Staff did not manage the keys to the medicines cupboard safely.
- Rapid tranquillisation was being used but staff were not aware of the policy or monitoring guidelines for rapid tranquillisation. Staff undertaking rapid tranquillisation had not completed immediate life support training. Rapid tranquillisation was being used without appropriate legal authorisation.
- Staff used unsafe moving and handling techniques.
- Investigation reports were not sufficiently thorough to allow for learning from incidents.
- Staff did not understand the principles of the Duty of Candour.

However:

- The ward areas were clean and well maintained.
- Staff were up to date with most mandatory training.
- Staff regularly checked resuscitation equipment.
- Staff completed and updated clinical risk assessments.
- Staff were trained and knowledgeable in safeguarding and confident in reporting concerns.

Are services effective?

Inadequate

We rated effective as inadequate because:

- Care plans were not always reviewed regularly or updated when circumstances changed. Moving and handling needs were not captured in care plans or assessments for all patients who required them. One patient's care plan relating to falls had not been reviewed despite further frequent falls. Care plans were referenced with out of date guidance.
- There was no outcome monitoring.
- All Mental Health Act policies were out of date and had not been updated to reflect the 2015 revised code of practice.

Summary of this inspection

Treatment not authorised under the Mental Health Act had been given for a prolonged period. A copy of a treatment certificate had been altered by hand to indicate treatment was authorised when it was not.
- Two informal patients were subject to undue restrictions despite not being detained under the Mental Health Act or subject to deprivation of liberty authorisations.

However:

- Staff assessed patients' nutritional needs and weighed patients regularly.
- Staff monitored the use of high dose antipsychotic medication including documenting the monitoring clearly, for example, additional electrocardiograph results.
- Some staff had received training in dementia awareness and mental health awareness.
- All appraisals had been completed within the last 12 months.

Are services caring?

Good

We rated caring as good because:

- We saw positive, caring interactions during this inspection.
- Patients were positive about staff that looked after them.
- Patients had regular one to one sessions with their nurse.
- Community meetings were held regularly.

However:

- Patients could not recall being involved in care planning and there was no evidence of patient involvement in careplan records.

Are services responsive?

Requires improvement

We rated responsive as requires improvement because:

- There was no discharge planning. In some cases, it was unclear what the plan for admission and subsequent pathway for moving on from the service was.
- There was limited written information provided to patients at admission and this was in small print, making it difficult to read.
- There were limitations in terms of space including for storage and private rooms, with only one quiet room available.
- Complaints processes had improved although the policy was still not being followed in terms of timelines for actions to be completed.
- There were few features of a dementia friendly environment.

However:

Summary of this inspection

- Food was of good quality with choice available.
- Patients could make private phone calls.
- A large activity board was being used which had large symbols and writing to inform patients of the planned activities.
- An activities co-ordinator worked three days per week.

Are services well-led?

Inadequate

We rated well-led as inadequate because:

- Staff were not following policies, particularly in relation to observations and moving and handling.
- All independent hospital policies were out of date by nearly twelve months at the time of inspection, including those relating to the Mental Health Act.
- Staff did not complete audits and plans resulting from audits stated no further follow up/timescale for action recorded. Audits were not being completed to check T2 and T3 forms.
- There was no evidence of an effective system to manage issues and risks at a local or organisational level. Managers were not addressing the issue of staff numbers and observations. Investigation reports were not thoroughly completed.
- There was poor practice observed in relation to the safe management of medicines keys.
- There was insufficient oversight of the Mental Health Act, resulting in unauthorised treatment being given for a prolonged period.
- Incidents were incorrectly notified to CQC.

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.

We had concerns about the oversight of the Mental Health Act at this hospital.

We were concerned that staff had given treatment to one patient which was not authorised by a second opinion appointed doctor. This had been happening for a number of months. The certificate copy was not stored with the medication card but the copy in the patient's notes had been altered by hand.

Qualified nurses had received training in the Mental Health Act, as had some support workers. Knowledge of the act and its application was variable.

All Mental Health Act policies were out of date and had not been reviewed to ensure they reflected the 2015 revised code of practice.

We were told that the ward received a good service from the contracted independent mental health advocacy service and that all new patients, including those who lacked capacity, were referred to the advocate to explain their role.

We saw evidence of the regular attempt to explain to patients what their rights were whilst detained, although the recording of the content of these discussions was minimal. We also saw evidence of patients being supported by staff to prepare for tribunals or managers' hearings they were to attend.

We found forms authorising section 17 leave were in place for all patients and appropriately completed. However, the section of the form which indicated that a patient or relevant others had been given a copy of the form was not completed on any of the forms we examined.

The ward had a policy and procedure in relation to patients who were absent without leave, but we were given contradictory evidence as to the frequency of patients going absent without leave.

We were told that all documentation relating to newly admitted patients was scrutinised by the provider's Mental Health Act lead and saw evidence of completed checklists which confirmed this.

We found little evidence of formal discharge planning for patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff had attended training regarding the Mental Capacity Act and Deprivation of Liberty Safeguards. However, understanding of the principles was variable and several staff were unclear about the Deprivation of Liberty safeguards.

Two patients had deprivation of liberty authorisations in place.

Medical staff completed capacity assessments to determine whether patients had the capacity to consent to treatment they were receiving. However, the forms completed were not regularly updated when a significant change to treatment programmes had been made.

We determined that the two currently informal patients were subject to restrictions that could constitute a Deprivation of Liberty and that this had not been identified by staff.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate
Overall	Inadequate	Inadequate	Good	Requires improvement	Inadequate	Inadequate

Inadequate

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Inadequate

Safe and clean environment

The main ward area had a large lounge and dining area with two bedroom corridors which led off it. The nursing office and clinic were on one of these corridors. This layout did not allow observation of all ward areas easily. Staff mitigated this by using individual levels of observation.

There were ligature points on the ward; ligature points are places where patients intent on harming themselves could tie something to harm themselves. At the previous inspection it was noted that the hospital had an audit report of the risks and an action plan to mitigate them, dated 8 July 2015. Many support staff were not aware of the audit or plan at that time. At this inspection, there was awareness amongst staff about these risks and the audit had been discussed at handovers. However, the version in use in the handover folder was from 2014 and did not include the mitigation plan.

In the assisted bathroom, taps, the showerhead and bath hoist presented a ligature risk as did a wall cabinet and wooden display unit. The plan to mitigate the risk was for staff to supervise patients when using the facility and for the bathroom to be kept secure at all other times. At the previous inspection, this had been noted to be unlocked, however at this inspection the bathroom was locked unless in use, with a new key pad lock to ensure it could not be inadvertently left unlocked.

The clinic room was small and nurses could not discuss medicines privately or allow dispensing to the patient in the clinic. Staff dispensed medicines and these were then taken by the nurse to each patient individually. There was no room for an examination couch in the clinic and physical observations were undertaken in patients' bedrooms. Clinical equipment was stored in inappropriate areas, for example, weighing scales were stored in the staff toilet due to lack of space.

Resuscitation equipment was stored in the nursing office. Records confirmed good practice of staff checking fridge temperatures daily and resuscitation equipment was checked weekly.

The hospital was visibly clean and presented to a high standard. Furniture was clean and in good condition and equipment was well maintained. The kitchen area was open plan and used to make drinks and serve meals. This area was always clean and tidy during this inspection.

There was anti-bacterial hand sanitizer in the reception area for visitors to use. Support workers wore short-sleeved uniform tops so they were bare below the elbow. Staff had minimal jewellery on and adhered to infection control principles. At the previous inspection, it was noted that actions from the infection control audits had not been completed within the timescale. This had been resolved at this inspection and actions and timescales were indicated and adhered to.

All staff had alarms and the inspection team was provided with them.

Safe staffing

Inadequate

Wards for older people with mental health problems

The hospital was not safely staffed. The level of staffing was not sufficient to ensure that observations were undertaken safely or that there were enough staff available to care for patients.

Staffing establishment was one qualified nurse and five support workers during the day. At night, the establishment was one qualified nurse and three support workers. Rotas reviewed for June 2016 confirmed that the hospital maintained these staffing levels. The staffing levels at night had been increased from two support workers to three when there had been an increase in levels of observation. Between Monday and Friday the acting manager and clinical nurse were available between 9am and 5pm. At the weekend, and at night, there was no cover for the registered nurses to take a break or leave the hospital.

In addition to regular contracted staff, the hospital had regular bank support workers who covered shifts. This enabled patients to have support from familiar staff.

During this inspection, we did not see qualified nurses in the main communal areas of the ward. Support workers were providing the majority of care and support to patients. This included high levels of patient observations and we were concerned that the allocation of observations meant that staff could spend up to four hours at times continually observing patients.

We were concerned that there were not enough staff to safely manage the observation levels at the time of inspection. The hospital policy stated that staff should not complete observations for more than two hours unless in exceptional circumstances. Staff were routinely allocated to four hour allocations of continuous observations. National Institute for Health and Care Excellence guidance also states that staff should undertake continuous observations for no longer than two hours. (Violence and aggression: short-term management in mental health, health and community settings, NG10, 2015).

We reviewed observation levels and noted that five patients were subject to one-to-one continuous observations when in communal areas, with two to be nursed on observations within arm's length. This meant in practice that even if the patient was in their bedroom, a member of staff would need to be allocated so that if they then came into the main ward they could be continuously observed. If all five patients were within the communal areas, this would leave only the qualified nurse able to assist six other patients.

In practice, support workers continued to interact with other patients and assist, for example, at mealtimes, whilst technically undertaking observations.

Qualified nurses were not allocated to observations and support workers were left to devise the allocations themselves.

Patients reported that leave was facilitated by staff and regular activities took place. Patients and staff told us that leave was sometimes cancelled due to staffing difficulties.

The consultant psychiatrist visited the hospital once a week to review the patients with on call cover provided by the mental health trust. The general practitioner also visited on a weekly basis. If medical attention for physical needs was required in an emergency, the emergency services would need to be used.

Staff had received and were up to date with most mandatory training. The exceptions to this were pressure and skin awareness training, where staff had not returned the accompanying workbook, the figure for this was 62% and for documentation training the completion rate was 57%.

At the previous inspection, we were concerned that basic life support was not a mandatory training course for support workers. The provider had ensured that all staff now receive this training, including bank staff and domestic staff. The training also included training on managing choking incidents. At the time of this inspection, there were two members of nursing staff booked to attend, both were new starters and the percentage trained for nursing staff was over 90%. Neither of the two untrained staff were allowed to escort patients in the community until completion.

At this inspection, there had been regular use of rapid tranquillisation, which had not been the case at the previous inspection. The current level of life support training for qualified nurses was basic life support. If restrictive interventions including restraint and rapid tranquillisation are being used staff should be trained to immediate life support level. Guidance from the National Institute for Health and Care Excellence states that "staff

trained in immediate life support and a doctor trained to use resuscitation equipment should be immediately available to attend an emergency if restrictive interventions might be used." (Violence and aggression: short-term management in mental health, health and community settings, NG10, 2015).There were no nursing staff trained in immediate life support and no medical support on site.

At this inspection, there were concerns about moving and handling, as inspection staff witnessed poor moving and handling practice including unsafe techniques being used on two occasions. This was one person being lifted under the arms from sitting to standing and another patient being transferred to a wheelchair by one member of staff where the patient could not balance and nearly fell. The patient who nearly fell had no moving and handling plan in place. The inspection team reported this immediately to the manager. The training package was checked and concerns discussed with the training manager who confirmed these techniques were not taught.

Assessing and managing risk to patients and staff

The hospital manager said they did not use prone restraint. However we were told by staff of incidents where prone restraint had been used to give intramuscular medication. We could not find this reported as such in the clinical records. Staff reported one incident to be for a prolonged period of around fifteen minutes and involved the administration of an intramuscular injection. The training that staff received did not include prone restraint or floor holds.

All staff had completed training in managing aggressive behaviour. However some staff were not aware that there was a policy outlining this use within the hospital or of any care plans relating to restraint.

We reviewed nine care records. At the previous inspection, there had been concerns that risk assessments were not present in files and not reviewed regularly. At this inspection, the records contained regularly reviewed risk assessments. The hospital used the older adults' Galatean risk and safety tool behavioural risk assessment.

Patients had access to bedrooms throughout the day. The hospital allowed visiting throughout the day and evenings. There was one blanket restriction with patients not allowed to keep lighters for safety reasons. However, staff carried lighters and patients were allowed to smoke in designated areas.

The hospital had an observation policy dated July 2013 that defined the levels of observation as recommended by National Institute for Health and Care Excellence clinical guidance 25. However, this guidance has been superseded by NG10 and the policy did not reflect current guidance. This had been noted at the previous inspection but the same policy was still in use, with a review date of August 2015.

At the previous inspection, we were concerned that observations were being documented retrospectively, that staff were not completing their allocated observations and that support staff were not aware of the observations policy. At this inspection, most staff were aware of the differing levels of observations and reasons why these were in place. The observations policy had a read and sign sheet and qualified nurses had regularly discussed this at handover. There was a record sheet with the observations folder and in the nursing office with an at a glance guide to observation levels for all patients.

There was no evidence on inspection of observations being documented retrospectively. However, we did review an incident, which had occurred in February 2016. Staff had nursed a patient on intermittent observations when the observations should have been continuous and within arm's reach. This was because staff had used the wrong chart. This had not been identified, despite a shift change and handover. The observation chart had been altered after a fall at 03.17 as the form had already been completed up to 03.30 indicating the patient was asleep and a further similar correction had occurred later on the same shift.

All staff had attended the safeguarding vulnerable adults training. Qualified staff understood the safeguarding process and how to make a referral. Support workers showed a good understanding of safeguarding and were able to share relevant examples. We saw evidence of safeguarding notifications and meeting minutes.

At the previous inspection, it was noted that risks were not discussed at handover meetings, nor were the observation levels of patients. When the inspection team questioned this at that time, the nurse reported sharing information with support workers on a "need to know" basis. This was largely resolved at this inspection, and most support workers were able to discuss risks associated with specific patients and their observation levels.

Inadequate

Wards for older people with mental health problems

At this inspection, there were serious concerns about medicines management. We reviewed all eleven medication charts.

One patient had been given intramuscular when required medication for several months, despite this not being authorised by the T3 in place. (A T3 form is a certificate completed by a second opinion appointed doctor if a patient detained under the Mental Health Act lacks capacity to consent or refuses to consent to medication). On four occasions, the patient had been given a different dose to that prescribed.

The patient had been prescribed a second intramuscular medication since April 2016 which was also not authorised under the T3 form. However, this had not been used.

The use of intramuscular medication in response to challenging behaviour is referred to as rapid tranquillisation. There was no evidence of physical monitoring taking place following rapid tranquillisation. National Institute for Health and Care Excellence guidance states that "after rapid tranquillisation, [staff should] monitor side effects and the service user's pulse, blood pressure, respiratory rate, temperature, level of hydration and level of consciousness at least every hour until there are no further concerns about their physical health status" (Violence and aggression: short-term management in mental health, health and community settings, NG10, 2015). We were told by one nurse that rapid tranquillisation was not used in this service, suggesting this was not recognised as such by staff.

Following this inspection, we were supplied with a copy of the rapid tranquillisation policy. Staff were not aware of this during inspection and were not following this. The policy was overdue for review and referenced out of date guidance.

The same patient had an altered medicines administration sheet whereby a lunchtime medication dose had been moved to night time. We could find no medical entries indicating this change had been made by a prescriber and the prescription still showed lunchtime administration.

The same patient had a T3 copy in his case file, which had been altered, the word regular had been written above an instruction for intermittent antipsychotic use. Staff were giving the patient an antipsychotic regularly. The alteration was not present on the original certificate, indicating it had not been made by the second opinion appointed doctor.

There were several administration boxes on a medicines administration chart, which were blank, including two doses of an anticoagulant.

Medicines audits were being completed but with no clear action plans and outcomes.

Stock medication for two patients did not tally, the medication being diazepam and clozapine.

One patient had allergies noted, including penicillin, on the information sheet with his administration chart but the chart itself had no allergies recorded. Not having allergies recorded can increase the risk of a medication being given to a person with allergies.

An injectable depot medication was overdue by four days when the sheets were checked by the pharmacist. The pharmacist noted that the administration box had been signed by a nurse when he looked again at the sheet later that day, despite the nurse earlier being adamant that the depot was not due until the forthcoming week. The patient notes indicate the depot had been given on the correct date.

Two patients were prescribed thickeners to reduce choking risk. We noted a tub of thickening fluid left on the counter in the open kitchen during the afternoon. Whilst it is important that fluid thickeners remain accessible, they should be stored appropriately to try and reduce the risk of these being mistakenly added to drinks or food.

Medicines were not stored safely. During our inspection, we observed that the medicine keys were handed to the Mental Health Act administrator to hold by the qualified nurse. When requested later by the CQC pharmacist, neither qualified nurse had the keys in their possession and they were in the ward office. The stock cupboard had two locks requiring two separate keys for unlocking. However, staff routinely left one key in the cupboard door. One of the qualified nurses took this key from the door during the inspection and later it could not be found as this had not been attached to the remaining keys. Emergency maintenance staff had to attend to change the locks.

It was difficult to identify how many patients were receiving medication covertly. There were three covert medication care plans with the medicines administration sheets.

Inadequate

Wards for older people with mental health problems

However, one staff member told us that there were five patients receiving medication covertly and a qualified nurse could not tell us the number despite being responsible for medicines administration on their shift.

There was no controlled drugs accountable officer at the time of inspection as this was still listed as being the registered manager who left the service in February 2016. This is an important role that identifies a responsible person to have oversight of the handling of controlled medicines.

Track record on safety

One serious incident had occurred in the last twelve months, where a detained patient collapsed and died as a result of choking. Hospital management had incorrectly notified this to CQC using the wrong location and type of notification and the inspection team were unaware of this despite it having happened several months before this inspection.

We reviewed the investigation report, which did not include what evidence had been collected, staff who were interviewed, notes and policies reviewed or any analysis undertaken. The action plan contained one action, although staff spoke of receiving additional training and being reminded to use alarms to summon assistance, neither of which appeared in the action plan. The only qualified nurse on duty was not in the hospital building at the time of the incident and this was not adequately explored.

Other incidents which had occurred since the last inspection included a medication error, two assaults on staff, a patient who left the hospital without authority and a fall. The investigation reports relating to these were not sufficiently detailed and gave no indication of how specific actions or plans had been decided.

Reporting incidents and learning from when things go wrong

Health and safety eLearning was a mandatory course, which 91% of nursing and support staff had completed.

All knew how to report an incident. Most staff interviewed reported having a debrief following incidents.

A review of team meeting minutes from January 2016, showed these had taken place each month with good attendance. Incidents were not specifically reviewed within the meetings but an incident file was introduced on the ward to share learning from incidents. Some staff told us that incidents and lessons learned were discussed in handovers whilst others said they did not receive this information.

Hospital managers completed investigations following serious incidents, but these generally consisted of a description of the incident and an action plan, with no detailed analysis of the incident. This led to action plans that were not fully reflective of aspects of the incident and were not measurable or time scaled. In one case, the action plan following a violent incident was marked not applicable as the patient had been transferred from the service. This means that the hospital had missed opportunity to learn from the incident to prevent it recurring.

Duty of candour

We found that staff were not aware of the duty of candour.

In a serious incident report, we noted that there was a page titled “duty of candour summary sheet”, however this did not relate to the duty of candour in the content and was being used as part of the records.

We did not find that the duty of candour was followed following serious incidents with no correspondence seen involving families in subsequent investigations.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Inadequate

Assessment of needs and planning of care

We reviewed nine care records. There were current care plans in all of the records. Nurses were undertaking regular reviews of care plans, taking place on a monthly basis in some files. We noted that for one patient who was informal his care plans had not been rewritten when his legal status had changed.

Qualified nursing staff completed assessments, including pressure area assessments, falls assessments, choking assessments and completed malnutrition universal screening tools. Staff regularly weighed patients.

Inadequate

Wards for older people with mental health problems

There was no indication of pathways or discharge planning in the files we reviewed, for example, moving on sections in plans were blank.

One patient had a care plan for falls completed at admission. There was a summary sheet of reported falls since admission, which did not include all falls recorded in the clinical notes. Although there were signatures indicating the care plan had been reviewed, there had been no changes made to the plan despite a number of falls. There was no evidence of a comprehensive multidisciplinary review of falls despite our concerns that medication changes may have contributed and a reduction in observations at night having been made, when most falls seemed to occur during the night.

Moving and handling needs were not captured in care plans or assessments for all patients who required them.

Covert medication plans were completed for three patients and included guidance about food or fluids for concealing medication. The pharmacist had been involved in changing preparations to liquid preparations and guidance as to whether some preparations were suitable for crushing.

At the previous inspection, the inspection team raised concerns that one of the patients' plans detailed the use of injectable medication to control a physical health condition. Since the last inspection a best interest's meeting had been held and a comprehensive plan was now in place regarding this.

At the previous inspection, two patients were being prescribed combined antipsychotic medication above the British National Formulary maximum limit and there had been no high risk monitoring plans completed for this. At this inspection, one patient was prescribed combined medication above the maximum limit for antipsychotic medication and a comprehensive monitoring plan was in place for this, with evidence of increased frequency electrocardiograph results stored alongside the monitoring forms.

Care records included entries by nursing staff with information from or to the GP. Care record entries indicated that the GP completed annual physical examinations. The reports and actions from these were not available in the records, as these were held on the GP system. This meant that there was a risk that staff would know about physical health problems.

Nursing staff completed comprehensive physical health care plans.

Care records were all in paper format, with a ring binder file for each patient. Contents included admission, working in partnership, care pathways, respecting diversity, practicing ethically, identifying people's needs and strengths, control and restraint, promoting safety and positive risk taking, promoting recovery and patient centred care, developing the personal security plan and making a difference. There were photographs of patients within their files. Care records were stored in the nurse's office to which all clinical staff had access. Safeguarding alerts, Deprivation of Liberty applications and Mental Health Act paperwork were stored in separate files.

Best practice in treatment and care

We noted that whilst care plans were often referenced to guidance, the guidance referred to was out of date. For example, we noted care plans relating to behaviour that may challenge with reference to the National Institute for Health and Care Excellence guidance on short term management of violence and aggression from 2005. This was superseded by a version in 2015.Similarly, we noted care plans referencing older policy versions, including one care plan which referenced the 2008 observation policy.

In terms of prescribing best practice, we noted that one individual was prescribed a regular antipsychotic medication, despite a history of cerebrovascular events, a diagnosis of vascular dementia and an authorisation by a second opinion appointed doctor that only intermittent treatment with an antipsychotic medication was to be given. Guidance suggests that antipsychotic medication should be avoided for those with vascular dementia and that use should be discussed fully with the patient and/or carer and reviewed regularly. A risk factor for mortality associated with antipsychotic use includes additional use of benzodiazepines, which was the case here (medicines and healthcare products regulatory agency guidance).

Skilled staff to deliver care

An occupational therapist attended the hospital one day a week to provide group activities including art and craft. On three days per week there was an activities co-ordinator who organised one-to-one and group activities within the hospital and structured community activities. A music therapist visited the hospital one day a week offering group therapy and one to one sessions with patients.

There was no psychology input provided by the hospital. Psychology input had previously been arranged via the GP if needed. Information on the provider website referred to structured one-to-one psychology sessions led by the consultant psychiatrist as part of the daily therapeutic services but this had not been the case for a number of years.

The GP visited the hospital once weekly. The consultant psychiatrist visited the hospital one day a week to review patients.

Pharmacy support was provided by a local chemist. There was no input from a mental health pharmacist. The chemist received prescriptions from the GP and dispensed medication and administration records to the hospital. An annual audit was completed which centred on storage and facilities.

A speech and language therapist visited the service if patients were referred by the GP. A podiatrist regularly visited.

All staff received an induction at the start of employment, including four days of office-based learning including the mission and values, safeguarding, Mental Capacity Act, Deprivation of Liberty safeguards and moving and handling. ELearning was offered in topics of health and safety, food safety and food allergies. In addition, training was offered in management of violence and aggression.

At the previous inspection, it was noted that there was a lack of further specialist training. For example, the dementia quality standard produced by the National Institute for Health and Care Excellence states that staff caring for people with dementia should be appropriately trained in dementia care. Staff had not previously attended dementia awareness and communication skills training. At this inspection, we saw that some staff had recently attended training delivered by the consultant psychiatrist in dementia awareness, mental health awareness and diagnosis.

Staff reported receiving managerial supervision every six to eight weeks. We reviewed supervision files which confirmed regular supervision was happening for all staff. However, this was recorded in a very brief format, which did not allow for recording of what had been discussed in any detail or any performance issues.

At the previous inspection, staff had not had an appraisal of their work performance. At this inspection, all staff had completed an appraisal and performance review in the last 12 months.

At the previous inspection, support workers and qualified staff had separate team meetings. At this inspection, we were able to see that regular staff meetings were held which support workers and qualified nurses attended together.

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings took place weekly when the psychiatrist visited to review patients. Reviews were generally attended by the psychiatrist and a qualified nurse. Care programme approach meetings were held at intervals of approximately six months and were often attended by family and local care co-ordinators.

We saw that handovers now covered the care of the patients and were also used to handover risk related information and to discuss specific guidance, for example, the observation policy. All staff attended handovers before commencing work.

There was good liaison with the GP service.

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

Five of the six qualified nurses had completed mandatory Mental Health Act training in the last 12 months. Three support workers had received training in a session entitled Mental Health Act and diagnosis.

A Mental Health Act administrator was newly appointed and waiting to undertake specific training. They were supported by the regional Mental Health Act lead.

Staff understanding of the Mental Health Act varied with some staff unable to give any explanation of the Act or its relevance to their role.

All Mental Health Act policies were out of date and had not been updated to reflect the 2015 revised code of practice.

The Mental Health Act reviewer completed a Mental Health Act monitoring visit as part of this inspection. Paperwork relating to detention under the Mental Health Act was present and correct.

All documentation relating to newly admitted patients was scrutinised by the provider's Mental Health Act lead and

there was evidence of completed checklists which confirmed this. There was also evidence that reports for tribunals and managers' hearings were thorough and prepared in a timely manner.

Forms authorising section 17 leave were in place for all patients and appropriately completed. However, the section of the form which indicated that a patient or relevant others had been given a copy of the form was not completed on any of the forms examined.

Ward staff told us they received a good service from the contracted independent mental health advocacy service and that all new patients, including those who lacked capacity, were referred to the advocate to explain their role. Managers told us that the advocate routinely attended ward rounds and reviews. A poster informing patients how to contact the advocate was displayed on the wall of the ward. We were told by the manager that clarification of the role of the advocate was covered in the Mental Health Act training that was mandatory for all staff. However when we spoke to staff we determined a lack of clarity about the specific role that the advocate has. The ward did not routinely monitor the use of the advocacy service.

In terms of consent to treatment, one patient had been being given intramuscular as and when required medication for several months, despite this not being authorised by the T3 certificate in place. The certificate only authorised oral as required medication. (A T3 form is a certificate completed by a second opinion appointed doctor if a patient detained under the Mental Health Act lacks capacity to consent or refuses to consent to medication). At times, he had been given a different dose to that prescribed.

The same patient had also been receiving regular antipsychotic treatment when the certificate only authorised this on an intermittent basis. The copy of the T3 certificate in the notes had also been altered by hand from "intermittent" to "regular".

Good practice in applying the Mental Capacity Act

Staff training records showed that all staff had completed mandatory Mental Capacity Act and Deprivation of Liberty safeguards training.

However, staff knowledge of these varied, with some staff unable to remember any details around Deprivation of Liberty safeguards.

A form was being used to determine whether patients had the capacity to consent to treatment they were receiving although we found little evidence that this form was completed when patients were first admitted to the ward, or when a significant change to treatment programmes had been made.

Two patients were currently covered by Deprivation of Liberty safeguards and all authorisations were in place.

We determined that the two currently informal patients were subject to restrictions that could constitute a deprivation of liberty. Neither was able to leave the building as the doors were locked. They did not have the key code to enable them to move in and out of the hospital freely. Staff told us that notices were available near the doors explaining how informal patients could leave. We were not sure that either patient understood this related to them or would know this was there. Staff told us that neither patient had asked to leave. When we asked what would happen if either patient asked to leave we were told there would be a discussion with members of the multidisciplinary team and that consideration would be given to using holding powers under the Mental Health Act. In effect, their care had not changed since they had ceased to be detained but they no longer had the safeguards that detention under the Mental Health Act or the Deprivation of Liberty safeguards would give.

The provider agreed when we fed back our concerns that they would refer both patients to the local authority team for assessment.

Are wards for older people with mental health problems caring?

Good

Kindness, dignity, respect and support

There was a calm, relaxed atmosphere throughout the hospital. Staff assisted patients with their meals and drinks and provided nurturing and encouraging interactions from staff to patients. All staff knew the names of patients and referred to patients in a warm, interested manner.

We observed positive interactions using the short observation framework for inspection. CQC inspectors use this tool to capture the experiences of people who use

Inadequate

Wards for older people with mental health problems

services who may not be able to express this for themselves. It was developed with the University of Bradford Dementia Group. During a half hour period, nineteen positive interactions with patients were observed. Support workers clearly knew patients well, addressed them in preferred ways and ensured that patients were comfortable, for example, initiating conversations and checking wellbeing, bringing a blanket as one patient indicated they were cold and helping with drinks and snacks.

Staff described examples of how they would ensure they treated patients in a dignified way if they required assistance. Support workers were able to describe personal care provided to patients were they were aware of patient's preferences, for example when bathing. Support workers showed good awareness of privacy and dignity principles.

Five patients spoke about their experiences of living at Arbour Lodge. Patients indicated that they were generally happy with the care they received and the attitude and responsiveness of staff. All patients interviewed said that they felt safe on the ward all the time and said that the range of activities made available to them had improved in recent months and that they particularly enjoyed the trips that were arranged. Patients were particularly complimentary about the efforts of the activities co-ordinator in this regard.

The activity co-ordinator had started "My life story" folders for each patient which they were involved in creating and updating. These captured significant events and likes and dislikes but also incorporated more recent information, including photographs from planned activities that patients had enjoyed.

The involvement of people in the care they receive

Patients could not recall their being involved in care planning processes but did confirm that they knew who their named nurse was and acknowledged being offered regular one to one sessions with them. We saw that regular one-to-one sessions took place with named nurses.

Relatives and carers attended care programme approach meetings and were involved in care planning and decisions. We saw that relatives were involved in best interests meetings and in one case in the planning for a do not resuscitate order.

Advocacy was available to patients and contact information was displayed on the notice board.

Community meetings were held regularly and these were used to plan activities and discuss changes. These were chaired by the activity co-ordinator. Issues raised were passed to nursing staff and managers by the activity co-ordinator facilitating the meeting.

Are wards for older people with mental health problems responsive to people's needs?
(for example, to feedback?)

Requires improvement

Access and discharge

Admission criteria was for men only, with a diagnosis of functional or organic mental illness and behaviour that challenges. Sources of admission were from psychiatric hospitals including secure psychiatric care. The hospital completed a pre-admission assessment and initial plan prior to admission. Current bed occupancy was 85%. Patients were admitted from north west England and funded via clinical commissioning groups' commissioning arrangements.

Staff were not planning for discharge in care plans. Moving on sections in assessments were often blank. The provider spoke of plans to incorporate discharge planning and pathways into the admission process and to working with commissioners to ensure pathways were clearly identified.

Care co-ordinators visited regularly and there was information in the records regarding them looking to identify follow on placements.

The facilities promote recovery, comfort, dignity and confidentiality

Arbour Lodge hospital had one main ward area. There were limitations in terms of storage with equipment having to be stored in inappropriate places, for example, sit in weighing scales were stored in the staff toilet.

Inadequate

Wards for older people with mental health problems

The clinic room was small with only one person able to fit in the room. Medication was dispensed by the nurse who then took the medication to the patient. Physical health checks were carried out in patients' bedrooms due to lack of space in the clinic.

Activities took place in the main communal lounge, which also had an open plan dining area and kitchen area. However, we observed if there were activities taking place that were noisy, patients who found loud noises difficult would go to their bedrooms. There were three patients who spent the majority of the inspection time in their bedroom.

The veranda off the dining area was accessible for patients to smoke or use for fresh air. There was an additional internal courtyard with seating and plants, which was accessible to all patients.

The quiet lounge accommodated up to four people and was used for visitors. There was no designated room for children to visit and an office off the main ward had sometimes been used.

Patients requiring quiet time would often spend time in their rooms. All rooms were en suite and furnished appropriately.

Food was of a high quality with choices available. Feedback from the patient community meetings regarding the food has been shared with the chef and improvements were noted. Staff served food in the welcoming dining area, which had tablecloths and condiments. We observed drinks being made for patients. Patients were not encouraged or enabled to make their own drinks.

Patients could make phone calls in private with the cordless phone, which they could take to a quiet area. Patients could have their own mobile phones although at this inspection no patient had one.

Bedrooms were personalised with patients' belongings. Patients could have keys to their rooms. Lockers were available for patients to lock their belongings in however staff had to access them for patients.

Information displayed on the notice boards included poster for the advocacy service, whistleblowing, CQC, complaints information, activities planner for the week, occupational therapy and music therapy dates for sessions.

The hospital had recently acquired a large activity board, which had large print days of the week and interchangeable tags with activities in words and pictures so patients could see what was happening that day.

Resources in the communal lounge for patients to occupy themselves included DVDs, CDs, books and board games. Music sessions occurred once a week for a full day. We observed patients enjoying the sessions, they were engaged and seemed relaxed. There was a planned day trip to Manchester airport and lunch during this inspection which a number of patients participated in. We saw recent photos from a canal barge day trip displayed on the ward. Community meeting minutes referred to recent trips to the local carnival, science museum and regular walks and meals out. Movie evenings and barbeques had been organised and were popular.

The activity co-ordinator worked three days per week with flexibility to work in the evening and at weekends to facilitate certain activities. They were able to organise one-to-one and group activities. They were keen to encourage activity and improve motivation for some of the quieter, less articulate patients and had been able to introduce activities like dog walking which had proved popular.

Meeting the needs of all people who use the service

Accessible and easy read information regarding medication was filed in the communal lounge for patients to access.

Information provided to patients was in English, which was appropriate to the client group at the time of inspection. A translation service could be accessed if needed.

Photographs of all staff were displayed at the entrance to the hospital with the name and role of the member of staff.

Some of the information displayed on notice boards had quite small font and may be difficult for some people to read.

Symbols were used on the bathroom doors and the flooring was plain which is helpful for people living with dementia. However, there were no other features of a dementia-friendly environment.

Inadequate

Wards for older people with mental health problems

The brochure given to potential patients had small print and was not accessible to people with a visual impairment or a cognitive impairment. Patients were not provided with any written information at the time of admission to assist with orientation to the hospital.

Food could be prepared to meet the needs of people with dietary requirements. There were regular meetings with the chef regarding menu choices. Staff used a thickener for patient's drinks whose health needs required this.

When required patents had been supported to go to church. Spiritual support could be accessed for patients if required.

Listening to and learning from concerns and complaints

Complaints practice was the subject of a requirement notice at the previous inspection.

Issues identified were that there was no log of complaints within the hospital and staff were not recording concerns received or following their complaints policy.

Complaints were now being logged and dealt with via a handwritten book and webforms which allowed data to be stored and accessed for the service.

Complaints were still not being addressed within the timelines of the policy. One complaint had an acknowledgement letter stored but no investigation was evidenced nor an outcome sent to the complainant.

A suggestions box had been recently placed within the ward area and any suggestions made were to be regularly reviewed by the manager.

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

Inadequate

Vision and values

The values underpinning care at Arbour Lodge are displayed on the website. The approach is based on a belief in the individual's potential to recover. Its constantly evolving service supports individuals to achieve their goals through shared work, helping them fulfil their potential based on care planning, key worker relationships and a focussed therapeutic environment. An atmosphere of empowerment enables individuals to take control of their daily life and achieve their optimum level of independence. Staff support people by taking a person-centred approach, including the person at the heart of all that is going on within their own life.

Staff we spoke to were aware of the vision of the service in terms of being person centred and providing individualised care.

The hospital had no individual objectives or key performance indicators apart from a proposed expansion to offer more beds and improve the facilities. These plans were on hold pending the commencement of the new registered manager.

Good governance

Governance was the subject of a requirement notice at the previous inspection.

Issues identified previously were around ineffective monitoring systems in terms of staff not following policies, staff not being aware of or following the observation policy, policies being out of date, staff not following the ligature audit mitigation plans, actions and time scales related to the infection control audit, risks not being discussed at handover meetings and high dose antipsychotic monitoring.

We found that infection control audits were now fully completed with actions taken clearly evident. Handover meetings were now taking place with all staff so that staff were fully informed about risks and incidents. Care plans were previously not in place for patients with medication prescribed above the British national formulary limit or anti-psychotic medication that required additional monitoring. This had been addressed and there was comprehensive monitoring in place.

At the last inspection, staff were not aware of or following the observation policy. This has been largely addressed in terms of staff awareness of the policy although there were concerns in terms of staffing levels and number of patients requiring increased levels of observations.

Policies were out of date at the last inspection and this remained an issue. All the Barchester independent hospitals policies, including Mental Health Act policies, were due for review in August 2015. Mental Health Act

policies should have been reviewed and amended to ensure they reflected the Code of Practice in place from April 2015. There was also no rapid tranquillisation guidance within the medication policy.

Previously, staff were not following the actions of the ligature audit. At this inspection, the ligature audit was accessible to staff, but the action plans were not. The most recent audit available in the handover folder was from 2014 with a typed report indicating it had been reviewed with no changes in 2015.

There were further concerns in relation to governance identified at this inspection.

Care plan audits and medication audits were being completed with no further follow up/timescale for action recorded. On asking about specific incidents or findings, staff told us what action had been taken but this was not recorded. For example, in April 2016 the medicines audit highlighted a stock discrepancy of a bottle of medicine. There was no follow up recorded for this and it was not referred to in the next audit. We were verbally assured that this had been followed up and it had been determined that the bottle had been broken by one of the nurses. However this was not recorded anywhere.

We were concerned about oversight of observations, specifically in relation to the number of staff rostered for continuous observations and the confusing nature of many of these. Feedback at the end of inspection about these being zonal observations rather than individual observations did not correspond with how staff were being told to complete these. The fact that many levels of observations were varied depending on where the patient was added to an already confusing system. This was also evidenced by an incident which occurred as a result of observations being wrongly recorded and then not adequately handed over. As a result, a patient had fallen from bed whilst being nursed on intermittent observations when these should have been continuous observations.

We had concerns about the investigations undertaken following incidents, which did not thoroughly investigate or analyse incidents to lead to robust action plans. We saw three critical event reports where a thorough investigation had not taken place. There was no format for formal investigations and reports did not include methods of investigation, interviews, information used, policies referred to or overall analysis. Actions were not measurable.

We were concerned at this inspection to discover that none of the incidents reported in 2016 had been notified correctly to CQC. We only learnt on the first day of this inspection about the death of a detained patient in February 2016. Notifications had been made but with identifying details of another Barchester care location.

We reported that names and confidential information on the ward office whiteboard could be seen from the corridor via the window.

Leadership, morale and staff engagement

We were concerned that the hospital lacked leadership, both clinically and managerially. The clinical lead nurse had been acting up to hospital director for the last five months, with a qualified nurse acting up to cover the position of clinical lead nurse.

Although staff took action in response to concerns CQC had identified in August 2015, there was no effective process in place for the provider or the hospital to identify issues themselves. At the previous inspection, we had raised a number of concerns and served requirement notices to ensure action was taken. However, whilst action had been taken in relation to these concerns, there was no opportunity taken to check that the same concerns were not apparent in relation to similar processes. For example, the infection control audit had no identified timescales and actions were not followed up. Although this had been addressed, at this inspection, we found similar concerns with medicines and care plans audits.

We were concerned that serious errors in terms of medication and legal authorisation had not been identified before and that there was no system in place to audit consent to treatment paperwork.

We were also concerned that there was insufficient oversight from senior managers within the organisation into the hospital's governance and management, for example, in overseeing investigations into serious incidents. This also related to all of the policies for the provider's independent hospitals, which had the review date of 1 August 2015. Managers told us that an independent contractor would imminently be reviewing all

these policies and they would then require ratification and introducing in a staged manner. There was no sense of urgency evident with this, despite all policies being nearly twelve months out of date.

This was particularly concerning when considering that guidance on the short term management of violence (national institute for health and care excellence NG10) has been updated and policies do not reflect this, for example the observation and medicines policies. A revised Mental Health Act code of practice has been in place since 2015 but all Mental Health Act policies still refer to the out of date code of practice.

We were concerned that qualified nurses did not have a good understanding of how many patients were being administered medicines covertly. They also demonstrated no understanding of rapid tranquillisation, despite this having been used frequently in the preceding months. We were concerned that one serious incident highlighted that the only qualified nurse had left the hospital at the time of the incident and was using the photocopier in the adjoining nursing home. This had not been addressed in terms of reinforcing to staff the importance of them remaining within the hospital with actions instead relating to purchasing a photocopier. There were repeated issues highlighted during this inspection in relation to safe storage of medicines keys with keys given to unregistered staff and left in the ward office.

Although managerial supervision was taking place regularly, detailed records of these sessions were not being kept by managers. This meant that performance related issues which may have been raised could not be monitored. An outcome in one critical incident review was for staff to have performance related discussions in supervision but no records were available to confirm this had happened.

Support staff described good morale but spoke of working as part of a good team of their peers rather than more senior staff. They reported concerns that spending on average ten hours per day undertaking continuous observations was affecting their abilities to spend quality time with patients or engage some patients in activities or leave. There was still a sense that the main care work within the hospital was delivered by support workers with very little direction provided by nursing staff, who were largely absent from the main communal areas where much day to day care occurs.

A recent initiative had been an employee of the month scheme, where staff were commended on their performance and received a financial bonus.

Staff reported knowing how to use the whistleblowing process and felt able to raise concerns with their supervisors and managers.

Commitment to quality improvement and innovation

The provider does not participate in any national quality improvement programmes.

Outstanding practice and areas for improvement

Outstanding practice

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that a controlled drugs accountable officer is identified.
- The provider must ensure that there are sufficient staff on duty to undertake observations safely.
- The provider must ensure that complaints are reviewed in line with the provider's policy. c
- The provider must ensure that staff undertaking investigations have the competency and knowledge to do this.
- The provider must ensure staff understand and are aware of the Duty of Candour.
- The provider must ensure that all policies are reviewed and updated.
- The provider must ensure that completed audits identify areas for improvement and that realistic timescales are identified for these changes to be incorporated.
- The provider must ensure incidents identified in regulation 18 (Registration) Regulations 2009 are correctly notified to CQC.
- The provider must ensure there is oversight and monitoring the use of the Mental Health Act.
- The provider must ensure that all staff are trained in the Mental Health Act.
- The provider must ensure that all Mental Health Act policies reflect the revised code of practice.
- The provider must ensure the two informal patients have their care reviewed by the local authority to determine whether they require formal deprivation of liberty authorisations.
- The provider must ensure that only authorised medication is provider to patients.
- The provider must ensure that all medication errors are investigated and action take to prevent a reoccurrence.
- The provider must ensure that medicines management audits are completed thoroughly and actions are completed and documented.
- The provider must ensure that only approved professionals hold the medicines keys.
- The provider must ensure that when rapid tranquillisation is used the recipient is monitored in line with published best practice and there are sufficient trained staff available
- The provider must ensure that all staff are offered training in dementia.
- The provider must ensure discharge planning takes place and is clearly documented.
- The provider must ensure that care plans are reviewed when patients circumstances change.
- The provider must ensure that staff are following policies in relation to observations.
- The provider must ensure all staff only use moving and handling techniques that they have been trained to use and only for patients who have moving and handling assessments and care plans completed.

On the basis of this inspection, the Chief Inspector of Hospitals has recommended that the provider be placed into special measures.

Action the provider SHOULD take to improve

- The provider should ensure that patients and carers are involved in the care planning process.
- The provider should ensure staff are aware of current guidance and reference this within care plans.
- The provider should audit the environment of the ward in line with dementia friendly environmental guidance.
- The provider should review the information provided to patients regarding the service to ensure it is more accessible and meaningful.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 20 HSCA (RA) Regulations 2014 Duty of candour **How the regulation was not being met:** Staff had little understanding of the Duty of Candour and this was not being followed in relation to incidents that occurred. This was a breach of regulation 20 (1)(2)

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **We have issued a warning notice.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **We have issued a warning notice.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints **We have issued a warning notice.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **We have issued a warning notice.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

Treatment of disease, disorder or injury	**We have issued a warning notice.**