

# Cambian - Oaks 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

**Good**



Are services safe?

**Good**



Are services effective?

**Requires improvement**



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.

# Summary of findings

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

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

## Overall summary

We rated Oaks Hospital as good because:

- The hospital was clean with good furnishings and was well maintained throughout.
- Safe staffing levels were maintained at all times and 92% of staff members were up to date with mandatory training.
- All patients were risk assessed using a recognised rating tool. Levels of risk were discussed daily by the multi-disciplinary team and risk management plans adjusted where necessary.
- Staff had a good understanding of safeguarding and incident reporting procedures and we saw there was a thorough investigation procedure in place.
- There was a wide range of professionals within the multi-disciplinary team who worked well together to deliver a comprehensive package of rehabilitative care. We saw the needs of individual patients were discussed in ward rounds, handovers and morning meetings. Staff appeared to have a good understanding of the needs of the patients and we saw how the day was planned to accommodate activities. Patient care records were personalised and covered a wide range of needs, focusing on recovery.
- The patients had regular access to an independent advocacy service. The advocate worked closely with staff to raise any concerns on behalf of the patient.
- The hospital catered for a wide range of nutritional needs, offering a variety of menu options including dietary and religious needs. There was a wide range of facilities and to support care and treatment such as therapy rooms, gym, therapy kitchen, classrooms, football pitch, art room and a pool room.
- Carers spoke positively about the service, they told us the hospital was always clean, staff were polite and always made time to speak with them if required.

- There was a structure to governance procedures. Managers shared results from key performance indicators and discussed best practice.
- Staff, patients and relatives reported that the hospital management team was visible and approachable. There was a good team ethos and we observed good relations between staff at all levels.

However:

- There were some restrictions in place that were not being recorded and reviewed in accordance with the least restrictive practice principle within the Mental Health Act Code of Practice.
- All staff had received training in the Mental Health Act (MHA) however this had not been updated to describe in detail the changes to the code of practice which were introduced in April 2015.
- The provider had not completed adjusting policies and procedures to reflect changes to the MHA Code of Practice and policies were still under review.
- Covert medication was being administered for a physical health condition and this had not been subject to the necessary authority within the Mental Capacity Act.
- Bedrooms on ground level could be looked into by anyone walking by the outside, the provider had not taken steps to promote the privacy and dignity of those inside.
- The hospital did not have a system in place to ensure staff members were in receipt of regular supervision throughout the year.
- There was no formal system in place to ensure staff members at all levels were able to share the learning from incidents.

# Summary of findings

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### Summary of this inspection

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Good 

# Location name here

**Services we looked at**

; Long stay/rehabilitation mental health wards for working-age adults

# Summary of this inspection

## Background to Cambian - Oaks Hospital

Oaks Hospital is a 36 bed hospital for men with mental health needs and other associated conditions, specialising in psychiatric mental health rehabilitation. It provides a multi-disciplinary treatment programme designed to assist patients with their return to independent living. It provides services to patients who are detained under the Mental Health Act as well as informal patients and is situated in its own grounds close to the town centre of Barnsley.

The hospital had a registered manager and accountable officer in place at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is ran.

The hospital consists of two separate units:

The House – a 16 bed unit.

The Lodge – a 20 bed unit.

Oaks Hospital has been registered with the CQC since 17 August 2011. It is registered to carry out two regulated activities; (1) treatment of disease, disorder or injury and (2) assessment or medical treatment for persons detained under the Mental Health Act 1983.

The hospital has been inspected by the CQC on five previous occasions. The last inspection on 9 July 2013 found no breaches of regulation.

## Our inspection team

Team leader: Janet Dodsworth, Care Quality Commission

The team that inspected the service comprised two CQC inspectors, a CQC assistant inspector, a CQC Mental Health Act reviewer, a forensic psychologist, registered mental health nurse, occupational therapist and a pharmacist.

## Why we carried out this inspection

We inspected this service as part of our on going 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.
- We received written feedback about the service from two commissioners, the local safeguarding team and an independent advocate..
- We sought feedback from 21 staff members who attended four focus groups.
- We spoke with five carers by telephone.

# Summary of this inspection

During the inspection visit, the inspection team:

- Undertook a tour of the hospital and looked at the layout of the ward and cleanliness of the environment.
- Spoke with nine patients who were using the service;
- Spoke with the registered manager, consultant psychiatrist and the head of care.
- Spoke with 23 other staff members; senior staff nurses, registered nurses, occupational therapist, occupational therapy assistants, assistant psychologist, nutritional therapist, housekeepers, maintenance workers, support workers, administration workers, mental health act support and catering staff.
- Attended and observed two nursing hand-over meetings, a morning meeting and two patient activity sessions.
- Reviewed five staff personnel files.
- Collected feedback from four patients using comment cards;
- Looked at 12 care and treatment records of patients:
- Carried out a check of the medication management.
- Reviewed a range of policies, procedures and other documents relating to the running of the service.
- Conducted a full Mental Health Act monitoring visit.

## What people who use the service say

We spoke with five carers by telephone prior to the inspection. All carers spoke positively about the service, they told us the hospital was always clean, staff were polite and always made time to speak with them if required. Visiting was by appointment but the hospital was flexible and had accommodated visits at short notice. If they had any concerns they felt comfortable taking issues to the senior staff on duty or the hospital manager.

We spoke with nine patients who reported feeling safe on the ward. Some did express concern about the behaviour

of other patients which impacted on them feeling safe times. Patients described activities they took part in and were overall positive about this. Patient's comments about the food were overall positive.

We received four completed comment cards during the inspection. Comments were mixed, one patient felt it was a very good service and that the staff were excellent and the manager was brilliant, another patient said the staff communication was poor and management did not listen. One patient felt there were no rules, another patient did not feel it was a rehab service and was understaffed.

# 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?

We rated safe as good because:

- The hospital appeared to be clean with good furnishings and was well maintained throughout.
- Emergency drugs and emergency equipment were present and checked on a regular basis.
- Safe staffing levels were maintained at all times and 92% of staff members were up to date with mandatory training.
- All patients were risk assessed using a recognised rating tool. Levels of risk were discussed daily by the multi-disciplinary team and risk management plans adjusted where necessary.
- Staff had a good understanding of safeguarding and incident reporting procedures and we saw there was a thorough investigation procedure in place.
- The hospital had a policy for duty of candour which was dated July 2015.

However:

- There were some restrictions in place regarding the use of cutlery and crockery that were not being recorded and reviewed in accordance with the least restrictive practice principle within the Mental Health Act Code of Practice.
- The fridge used to store medication at the House was left unlocked.

Good



### Are services effective?

We rated effective as **requires improvement** because:

- All staff had received training in the Mental Health Act (MHA) however this had not been updated to describe in detail the changes to the code of practice which were introduced in April 2015.
- The provider had not completed adjusting policies and procedures to reflect changes to the code of practice and policies were still under review.
- Nurses were administering covert medication for a physical health condition and this had not been subject to the necessary authority within the Mental Capacity Act.

However:

- Patient care records were personalised and covered a wide range of needs, focusing on recovery.

Requires improvement



# Summary of this inspection

- There was a wide range of professionals within the multi-disciplinary team who worked well together to deliver a comprehensive package of rehabilitative care.
- Handovers between shifts were thorough and each weekday there was a morning handover attended by representatives of all staff groups.

## Are services caring?

We rated caring as good because:

- The patients had regular access to and independent advocacy service. The advocate worked closely with staff to raise any concerns on behalf of the patient.
- We saw records that demonstrated the needs of individual patients were discussed in ward rounds, handovers and morning meetings. Staff appeared to have a good understanding of the needs of the patients and planned activities accordingly.
- We viewed care records that showed patients and relatives were involved in planning care options.
- Feedback from relatives was positive, they mostly felt the hospital was clean, comfortable and the care was good.
- We saw how changes had been made following the patient survey such as more self-catering, a health promotion group and extended working hours for therapy assistants.

However:

- Some patients told us staff did not always knock on bedroom doors and wait to be invited in.
- It was not recorded that patients had always been offered a copy of their care plan.

**Good**



## Are services responsive?

We rated responsive as good because:

- There had been seven patients discharged from the service to other placements or back to their home in the six months prior to the inspection. Staff planned discharge, the patient and relatives were involved and kept informed where appropriate.
- There was a wide range of facilities to support care and treatment such as therapy rooms, gym, therapy kitchen, classrooms, football pitch, art room and a pool room.
- Patients and carers knew how to complain and felt they could raise their concerns with any members of staff if they need to.
- The hospital catered for a wide range of nutritional needs, offering a variety of menu options including dietary and religious needs.

**Good**





# Summary of this inspection

- A priest visited the hospital weekly and all faiths had access to religious support where required.

However

- Bedrooms on ground level could be looked into by anyone walking by the outside, this did not promote the privacy and dignity of those inside.

## Are services well-led?

We rated well led as good because

- Staff had an awareness of the organisation's values and we saw examples of this in practice.
- There was a structure to governance procedures. Managers shared results from key performance indicators and discussed best practice.
- Access to mandatory training and further development options was encouraged with a good take up by staff.
- Staff, patients and relatives reported that the hospital management team was visible and approachable. There was a good team ethos and we observed good relations between staff at all levels.

However:

- There was no system in place to ensure staff members were in receipt of regular supervision throughout the year.
- There was no formal system in place to ensure staff members at all levels were able to share the learning from incidents.

**Good**



# 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.

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients and completed a mental health act monitoring visit on one ward.

All staff had received training in the MHA however this had not been updated to describe the changes to the code of practice which were introduced in April 2015. We also found that the provider had not adjusted policies and procedures to reflect these changes and a number of policies were under review.

The provider had a MHA administrator who completed audits and scrutinised documents. Documentation was easy to locate and clearly filed. Detention documentation appeared in order.

There was an independent mental health advocacy (IMHA) service available to all patients. Information about the advocacy service was displayed on both wards. The hospital had a system to refer patients who lacked capacity to this service. The IMHA service felt supported by staff and was given adequate notice to ensure attendance at meetings.

At the start of the inspection the poster which detailed information about how detained patients could complain to the care quality commission was found to be incorrect. This was rectified during the inspection.

## Mental Capacity Act and Deprivation of Liberty Safeguards

During the inspection, we looked at 12 inpatient care records across two wards, looked closely at compliance and understanding of the Mental Capacity Act 2005 (MCA).

All staff had completed MCA and Deprivation of Liberty Safeguarding (DoLS) training, as part of their mandatory training package.

There were no patients at the hospital with Deprivation of Liberty Safeguards (DOLs) in place, and no pending applications. There was only one informal patient in the hospital, the rest of the patients were detained using the Mental Health Act (1983).






The hospital provided care for individuals who often have difficulty in communicating their needs and wishes. Care

planning showed that staff had taken all practicable steps to support individuals to make decisions. The files we reviewed contained details of advocates and IMCA's used to support people with communicating their needs.

We looked at one patient record that showed covert medication (that is medication concealed from the patient) was being administered by nurses for both psychiatric and physical health needs. The decision to use this treatment regime was made at a previous placement in September 2015, and continued when the patient moved to this hospital. Staff had not held a best interests meeting prior to undertaking this covert medication regime. We asked the manager to rectify this as soon as possible. A best interest meeting was planned for the week after the inspection.

# Long stay/rehabilitation mental health wards for working age adults

Good 

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

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

Good 

### Safe and clean environment

The hospital was clean with good furnishings and was well maintained throughout. We spoke with five carers who told us the hospital is always clean when they visit. Cleaning records were completed daily by housekeeping staff. Support workers assisted patients to clean their own rooms where they are able and this was recorded on a daily activity sheet. Nursing checked and recorded the cleanliness of the wards on a daily basis.

The nursing office had a large viewing window that allowed staff to view down the corridors on the wards. There were up to date environmental risk assessments which contained details of potential risks within specific areas such as ligature risks (that is anything that could be used to attach a cord for the purpose of strangulation), kitchen activities and manual handling scenarios. We noted some blind spots throughout the building however where risks were identified there was a clear list of actions required to mitigate the risk. An example of this was the garden area which had a smoking shelter with potential ligature points so this has constant staff supervision when being used by patients. Cutters to remove potential ligatures were kept in the nurses office, the examination room and the emergency bag.

The hospital is a male only setting so there was no requirement to comply with mixed sex accommodation guidelines.

Both wards had a clinic room which was clean and well organised. Emergency drugs and emergency equipment were present and checked on a regular basis.

We viewed the quarterly infection control audit, completed December 2015. This showed a range of checks with actions where this was required which had been completed. A hand washing audit was completed December 2015 and following this hand washing posters had been placed above all sinks.

All staff carried personal alarms and all the inspection team were provide with alarms, keys and fobs to enable us to walk around the premises without close staff supervision. Rooms had alarms fitted and the hospital was divided into three zones which had a display panel to identify where an alarm had been activated.

### Safe staffing

The hospital manager was able to demonstrate that staffing levels were calculated in accordance with the Cambian Healthcare staffing tool and adjusted where necessary to ensure safety and meet the needs of the patient group.

Clinical staff not included in the nursing establishments were:

Consultant psychiatrist 1 whole time equivalent (WTE)

Clinical Psychologist 1WTE

Assistant Psychologist 1WTE

Senior Occupational Therapist 1WTE

# Long stay/rehabilitation mental health wards for working age adults

Good 

Occupational Therapist 1WTE

Therapy co-ordinators 3 WTE

Head of Care 1WTE

1 WTE staff grade- using locum ( temporary doctor)  
currently awaiting start date of staff grade.

The House Nursing establishment

Staffing establishment levels: qualified nurses Whole Time  
Equivalent (WTE): 7

Staffing establishment levels: nursing assistants (WTE): 14

Number of vacancies: qualified nurses (WTE) 0

Number of vacancies: nursing assistants (WTE): 3

The number of shifts filled by bank staff to cover sickness,  
absence or vacancies in 3 month period: 176 No agency  
usage.

The number of shifts that have not been filled by bank or  
agency staff where there is sickness, absence or vacancies  
in 3 month period: 20

The Lodge nursing establishment

Staffing establishment levels: qualified nurses (WTE): 8

Staffing establishment levels: nursing assistants (WTE): 14

Number of vacancies: qualified nurses (WTE) 0

Number of vacancies: nursing assistants (WTE): 2

The number of shifts filled by bank staff to cover sickness,  
absence or vacancies in 3 month period: 176. No agency  
usage.

The number of shifts that have not been filled by bank or  
agency staff where there is sickness, absence or vacancies  
in 3 month period: 22

The overall staff sickness rate over the last twelve months  
was 6.9%. Staff turnover in the same period was 19.5%. The  
hospital manager explained that this high figure was  
partially the result of a number of staff changing between  
full time employment and bank due to the shift pattern not  
suits them.

Cambian healthcare have their own staffing tool to support  
the number of staff required per shift. This involves a  
minimum safe staffing level and increases based on the  
level of occupancy, clinical risk and levels of close

observations. Minimum staffing levels for occupancy level  
of 24 patients was four registered nurses and six support  
workers per day shift and one registered nurse with eight  
support workers at night. We viewed four weeks off duty in  
2016 at random to see this in practice. We noticed on three  
occasions there were only three registered nurses on a day  
shift but support worker numbers had been increased to  
provide the right number of staff. We were told that the  
head of care or hospital manager are both registered  
nurses would be available to cover on the ward if required.  
We attended the morning meeting which takes place  
Monday to Friday each morning. Staffing levels were  
discussed for each ward. We were told that if there had  
been last minute staff absence from work this would be  
discussed and reviewed across both wards and changes  
made to ensure safety.

The shift pattern for nursing staff was 12 hour shifts, two  
weeks of days followed by two weeks of nights. We noticed  
that nursing establishments did not include additional staff  
to cover holiday, training and sickness. We were told this is  
covered by nursing staff on the bank. Staff members told us  
the shift pattern was challenging and was the reason some  
staff chose to leave the service. The hospital manager had  
considered a range of options but felt this shift pattern  
allowed for better continuity of patient care and retaining  
skills with key workers not spending long periods on night  
shifts.

The hospital had a bank of 29 nursing staff, some of whom  
had previously been permanent staff members. They also  
had access to a pool of staff through Cambian Healthcare  
regional bank. All bank staff completed mandatory training  
and updates. The hospital had not used any agency staff in  
the past year. We saw a high level of staff presence on the  
wards at all times. Staff told us they get chance to meet  
with patients for regular one to one time. This varied  
depending on patient need and might be daily or weekly.  
Care records and patient feedback demonstrated this to be  
the case.

Patient records showed that staff members were able to  
attend to the physical health needs of the patients or make  
referrals to the GP.

There was an on call rota for the hospital doctors. On week  
days the responsible clinician for the hospital was always  
available on call. There was a five weekly rota to cover  
weekends for Cambian doctors covering the North East of  
the country. In addition to this the Oaks and a

# Long stay/rehabilitation mental health wards for working age adults

Good 

neighbouring Cambian hospital had a two weekly rota to be used where attendance at the hospital might be required on a weekend when there was no other alternative option.

We viewed the scheduled activity recordings for the three month period November 2015 to January 2016. This showed that there had been no cancellations of activities due to staff shortages. If there was a cancellation by an external provider of last minute staff sickness, the timetable was adapted to ensure there are always five activities available each day.

The hospital had twelve mandatory training modules: dealing with concerns, active care, equality and diversity, first aid, food safety, infection control, information governance, health and safety, responding to emergencies, safeguarding, management of violence and aggression and break-way. This enables staff to have the necessary skills and competence to complete their role to the required standard. The overall average compliance with mandatory training was 92%, all training was above 75% compliance.

## Assessing and managing risk to patients and staff

Restraint had been used on seven occasions in the six month period prior to the inspection, three in the House and four in the Lodge. There were no incidents of prone restraint (this is where the patient is restrained face downwards). There was a seclusion policy, however there were no incidents of seclusion recorded and we were told the hospital does not use seclusion and does not have a seclusion room. We observed staff making time for patients and on one occasion when a patient became annoyed and raised their voice we saw staff respond and de-escalate the situation in a calm and effective manner.

The hospital used the short-term assessment of risk and treatability tool (START). This was an evidence-based tool that assessed future violent and risk behaviours in the short term and identified risk to self and others through structured professional judgements. Repeat assessments captured attitudes and behaviours over time to evaluate patient progress. Staff undertook eight weekly reviews of the START and we saw how other members of the MDT contributed to and signed the assessments. Staff also completed a daily risk assessment of each patient. This was a Cambian document that consisted of a checklist of key risk behaviours in areas of neglect, suicide, and violence. It had a brief risk management plan focussing on risk

reduction and identifying leave status. Each patient had a coloured rating of red, amber or green depending on her presentation and behaviour over the previous twenty-four hours. Staff shared the risk status of each patient with the rest of the team at the morning meeting.

We noticed some practices limiting patient's freedom in place on the wards. We saw how thermos type cups were provided for patient use rather than standard pot cups. The use of plastic type cups was to avoid heavy cups being thrown and used as weapons by some patients. We also saw how cutlery was checked and locked away after meals. During this time, patients were not restricted in any way in leaving the dining area. Cutlery was available in the therapy kitchens at all other times. Some patients had been risk assessed to have unrestricted access to the therapy kitchens by the use of a key which also gave them access to all equipment located within. Other patients had access to the therapy kitchen with staff supervision. Therefore access was by assessment and this was detailed in patient care plans as appropriate. This accounted for the different stages of recovery of each patient and complied with the Mental Health Act Code of Practice.

There was one informal patient on the ward at the time of our inspection (this is someone who is not detained under the Mental Health Act). The hospital had a locked door which meant this patient was not able to leave the ward at will. The patient had been offered a fob to enable him to leave the ward but he had declined. The provider had a locked door policy but it was unclear how the locked door was reviewed or the impact on patients recorded.

The Mental Health Act Code of Practice states that any restriction should be least restrictive and for the least amount of time. They should also be recorded and reviewed formerly on a regular basis. There was no formal process in place to ensure restrictive practice was reviewed. We have asked the provider to consider how the impact of restrictions will be monitored, recorded and how accountability and governance arrangements will review and support the reduction of restrictions in line with the Code of Practice.

There was a search policy in place and we reviewed recent search records and found that staff carried out searches in accordance with the policy

# Long stay/rehabilitation mental health wards for working age adults

Good 

The hospital had an observation policy and staff could explain this to us. At the time of our inspection there was one patient on one to one observations. We saw how staff reviewed all patients and adjusted levels of observation in the morning meeting.

Training records showed that 86% of staff had received training in safeguarding. Staff described what adult safeguarding is, and what types of abuse may occur. They described that the policy of the hospital is that all incidents are reported within one hour. They also described that all complaints are taken seriously when they concern staff and they are always fully investigated.

The local authority safeguarding team were asked for information in relation to the hospital, but advised that they do not collate information on a location basis, only by individual. However it is likely that they would be aware of any high profile cases or concerns at the hospital. The hospital reported seven safeguarding alerts were raised in the six months prior to the inspection, five of these related to the House and two to the Lodge. All of the alerts were investigated at a local level and reported through the local safeguarding authority. We viewed records that demonstrated a thorough investigation process was in place.

The Oaks Hospital had a service level agreement with Speeds pharmacy to supply patients' medication. Staff told us that the pharmacist was rarely on site but they were always accessible by phone for enquiries. They had a robust process in place for nursing staff to check medicines quantities, expiry dates and monthly ordering.

We found clinic rooms to be clean and orderly with all cupboards kept locked when not in use. Fridges used to store medication were within required temperatures and staff recorded this daily. We found the medication fridge on the House to be unlocked and we mentioned this to staff who locked it immediately. Staff collected and urgent medication orders for physical health needs locally but SPEEDs would be contacted for implications with any interaction with psychiatric medication. We viewed all prescription charts and found these mostly to be well completed. There was an error on one prescription chart where a medication was prescribed under the incorrect category as detailed on the T2. Another prescription chart had PRN (as required) medication prescribed but not listed on the T2, this had never been administered. Both issues were corrected during our inspection.

The medication policy was under review and this also covered the use of rapid tranquilisation. Rapid tranquilisation was rarely used and we saw evidence in patient records that the use of rapid tranquilisation was followed including the monitoring of physical observations following administration. We viewed records of three patients undertaking a self-medicating regime. This followed a staged process and was regularly assessed by nursing staff for compliance.

A policy was in place to ensure the safety of children visiting the ward.

## Track record on safety

At the time of inspection Cambian Oaks Hospital reported no Serious Incidents Requiring Investigation (SIRI) occurred for the past 12 months.

We saw an improvement in procedure had been implemented in the minutes from a staff meeting. During a fire alarm test it became apparent some staff members were unsure how to activate some of the fire alarms. This had prompted a review and update of fire training

## Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and completed a paper based incident report. This was loaded onto an electronic database by administration staff. Managers held a monthly meeting at the hospital to discuss incidents and safeguarding concerns. We saw minutes of the meetings which showed a how incidents had been discussed thoroughly. We saw how there had been changes made to practice for example a new outside area for patients who do not smoke as there was no smoke free area in the gardens.

We attended a morning meeting which was held Monday to Friday attended by key staff from both wards, senior managers, doctors, allied professionals, catering and maintenance staff. Issues from the previous day and night (or weekend) were discussed such as issues relating to incidents and safeguarding where appropriate.

There were several formats where learning from incidents was discussed and shared such as staff meetings, emails and handovers. There was no formal procedure in place to ensure all staff at all levels received details of lessons learnt.



# Long stay/rehabilitation mental health wards for working age adults

Good 

## Duty of Candour

The hospital had a policy for duty of candour which was dated July 2015. The policy gave a good description of duty of candour, how it impacted on roles and responsibilities and clear step by step instructions on the process to be followed. Staff had a good understanding of the requirements under duty of candour. They were able to describe how they discussed the outcome of complaints with patients and their families and the requirement to be open and transparent in communication. Patients told us how they could discuss issues with staff and the hospital manager was available to speak with patients. A new training module on duty of candour had been introduced and this was being included into active care training which is delivered to all staff on an annual basis. We saw the training schedule which showed that the next session is scheduled for April 2016.

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

Requires improvement 

## Assessment of needs and planning of care

Following referral and assessment, the hospital manager or head of care would attend the discharge meeting at the previous placement for each patient prior to transfer to the Oaks. This provided up to date information to help inform staff and prepare for a smooth transfer of care.

Following the admission of a patient, nursing staff completed a detailed assessment which including family history, previous admissions, medications, level of observations, eating and drinking, personal hygiene, physical health and the short-term assessment of risk and treatability (START). In addition all patients received a physical health examination on admission. This was followed up with monthly physical checks which included blood pressure, pulse and weight. There was also a more detailed report completed at three monthly intervals depending on physical health issues for the patient. . Patients' attended physical health care appointments at the local GP and general hospital where appropriate.

We viewed care and treatment records of 12 patients in detail. Records were personalised and covered a wide range of needs. There was evidence of a strong multi-disciplinary (MDT) approach with input from a wide range of professions. All records were up to date and included the patients' views. Care plans showed a focus on recovery with short term goals identified with progress towards achieving these goals recorded and updated. Records from MDT meetings showed longer term goals where patients had been able to identify where they would like to move onto after discharge.

Patient records were paper based and all files were stored securely in a lockable cabinet but were easily accessible to all staff on duty.

Best practice in treatment and care

We saw adherence to national institute for health and care excellence (NICE) guidelines when prescribing medication within the medication management policy and also in practice.

We saw how a wide range of outcome measures and therapies being used throughout patient records. Cambian active care model was used to deliver a mental health rehabilitation service at the Oaks. The model offered up to 200 outcome measures which were integrated into care plans as appropriate and reviewed and updated using a MDT approach. We saw a number of outcome measures in place such as short-term assessment of risk and treatability (START), HCR-20 on-going risk assessment, health of the nation outcome scales (HONOS) and the model of human occupation screening tool (MOHOST). Progress towards agreed goals was discussed by staff and patients in regular MDT meetings. We also saw the use of therapies which included cognitive behavioural therapy (CBT), dialectical behavioural therapy (DBT) and psycho social interventions (PSI). This might involve staff working with patients in a graded way to self-medicate, access leave from hospital, manage their finances, manage aggression and work towards self-catering. All of the above are therapies recommended within NICE guidance for patients with a variety of mental health conditions such as anxiety and depression. Outcome data was produced by the assistant psychologist and occupational therapists each month, and the data from all hospital sites was shared nationally within Cambian every quarter.

# Long stay/rehabilitation mental health wards for working age adults

Good 

Staff completed clinical audits such as reconciliation of medication, hand hygiene, infection control and checking of emergency equipment. We saw how issues had been listed on action plans which had been completed.

## Skilled staff to deliver care

There was a wide range of professionals within the multi-disciplinary team (MDT) which included a consultant psychiatrist, a forensic psychologist, an assistant psychologist, two occupational therapists and three therapy co-ordinators, registered nurses and support workers. We noted there was no social worker in the team. We were told that the occupational therapists undertake a lot of the work towards discharge with regard to housing or placements. Other site staff included catering, maintenance, administration and housekeeping. All staff spoke of a united approach to patient care and we saw how site staff attended morning meeting so they had an overall awareness of issues throughout the hospital.

There was a thorough induction programme in place which met the requirements of the care certificate. We viewed six staff personnel files in detail which were comprehensive and included full documentation in most cases. Files also showed that staff had the appropriate training and qualifications to undertake their role. There was a probationary period and we saw how one staff member had been dismissed prior to completing this. It was clear that the manager followed disciplinary processes where applicable.

The hospital report that 92% of staff had received an annual appraisal in the previous 12 months. The provider also reported that staff supervision was undertaken by all staff. We viewed nine staff files which showed all staff had received supervision in 2016. However, we noted large gaps in two files of four months and six months during 2015 when staff had not received supervision. Cambian policy states that staff should receive regular formal documented supervision. There was no system in place to ensure supervision uptake was monitored over the year.

The hospital also arranged for sessional staff to deliver specialist activities and therapies. There were seven sessional therapists to deliver music therapy, art therapy, gym, massage, DJ sessions, a teacher and a dietician. Sessional staff were managed through the occupational

therapy department who interviewed staff, negotiated rates and signed a simple contract detailing the expectations from both parties. DBS checks were then undertaken by the administration staff who kept this on file.

## Multi-disciplinary and inter-agency team work

Multi-disciplinary team (MDT) meetings take place each week and staff discussed patients care in detail on a four weekly rotation. We did not attend a meeting but we asked to review the minutes from two meetings selected at random in January and February 2016. We saw there was a standard agenda to discuss all aspects of care such as medication, physical health, leave, risk status and discharge planning.

We attended two morning handover meetings on the wards which were attended by ward based staff at the start of their shift. We saw how staff discussed each patient including physical and mental health plus any changes in behaviour that might change the risk status. There was a discussion regarding activities for the day and allocating staff to duties on the ward.

There was also a meeting held Monday to Friday at 9.15am which was attended by key staff from both wards, senior managers, doctors, allied professionals, catering and maintenance staff. Issues from the previous day and night (or weekend) were discussed. None clinical staff then leave the meeting and patient care is discussed including a handover of each patient and discussion on risk and levels of observation as required. Changes were implemented and the necessary documentation completed. All handovers were documented in books.

All staff groups reported close relationships within the team. The hospital also worked closely with another Cambian hospital in the locality and staff accessed peer support and attended meetings across both sites. Feedback from commissioners was mainly positive. They felt the hospital was very responsive, informed them of any incidents in a timely manner, always invited them to reviews on patient care and were viewed as a positive placement for patients. The local safeguarding team reported good relationships with the hospital and advocacy services told us they worked closely with the organisation which was very supportive.

## Adherence to the MHA and the MHA Code of Practice



# Long stay/rehabilitation mental health wards for working age adults

Good 

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients and completed a mental health act monitoring visit on one ward.

Completed consent to treatment authorisation forms were located with prescription charts. Patients were treated under the authority of a T2 or T3 form. T2 authorisations are completed by the responsible clinician for patients who had capacity and agreed to take medication. A T3 is provided by a second opinion appointed doctors (SOAD) when a person who lacks the capacity to consent to medication remains on medication after the first three months of detention. It is also used when a person who has capacity does not agree to take medication after the first three months. We saw referrals to SOADs were made appropriately. There was no discrepancy between medications being administered and medications authorised by the SOAD. However, in two records we found medication prescribed was not detailed correctly within the T2 authorisation. This was rectified during our visit. The providers own audit system had failed to see these errors.

Staff informed patients of their rights verbally and in writing. Staff told us, that if required, this could be provided in easy read format. We saw how patients' were given information about their rights and staff documented their response and understanding.

The provider had a MHA administrator who completed audits and scrutinised documents. Documentation was easy to locate and clearly filed. Detention documentation appeared in order. A system was in place to ensure timescales were met in relation to renewals, tribunal referrals and requests for second opinion appointed doctors (SOAD).

There was an independent mental health advocacy (IMHA) service available to all patients. Information about the advocacy service was displayed on both wards. The hospital had a system to refer patients who lacked capacity to this service. The IMHA service felt supported by staff and was given adequate notice to ensure attendance at meetings.

At the start of the inspection the poster which detailed information about how detained patients could complain to the care quality commission was found to be incorrect. This was rectified during the inspection.

We found there was a standardised process in place for authorising section 17 leave (that is agreed leave for patients' who are detained under the MHA) Section 17 leave forms were clearly written and risk assessments took place before leave was agreed and took place. During the inspection we found that old copies of section 17 leave forms were not struck out, this can lead to confusion if staff view the out of date form.

Access to the hospital was through a locked door. We found no evidence that the impact of the locked door had been considered for individual patients. There was one informal patient on the ward at the time of our inspection. He had been offered fob so he could leave the ward at will but he had declined as he did not want that level of responsibility. The ward had some restrictions which applied to all patients regardless of individual need. This included that patients had to use thermos beakers or plastic cups for drinks. Cutlery was counted in following meals and searches would take place if anything was missing. This did not fit in with the rehabilitation ethos or least restrictive principle within the Code of Practice.

## Good practice in applying the MCA

During the inspection, we looked at 12 inpatient care records across the hospital, looking closely at compliance and understanding of the Mental Capacity Act 2005 (MCA).

All staff had completed MCA and DOLS training, as part of their mandatory training package. We viewed their Deprivation of Liberty Safeguards policy, which refers to the MCA and the code of practice, which was updated in November 2015.

Staff at all levels had a good understanding of the MCA and were able to describe the principles of the Act. Staff members described the difficulties they have in a rehabilitation setting in supporting patients who may be making unwise decisions. They described how they support them in taking positive risks in a least restrictive manner.

Staff recorded patients' capacity to consent and to make specific decisions appropriately using the two-stage assessment of capacity. This is the most appropriate tool as stated in MCA guidance.

# Long stay/rehabilitation mental health wards for working age adults

Good 

There were no patients at the hospital with Deprivation of Liberty Safeguards (DoLS) in place, and no pending applications. There was only one informal patient in the hospital, the rest of the patients were detained using the Mental Health Act (1983).

The hospital provided care for individuals who often have difficulty in communicating their needs and wishes. Care planning showed that staff had taken all practicable steps to support individuals to make decisions. The files we reviewed contained details of advocates used to support people in communicating their needs.

One patient record we looked at concerned a patient being given covert medication for both psychiatric and physical health needs. The decision to use this treatment regime was made at a previous placement in September 2015, and continued when the patient moved to this hospital. Cambian Oaks had not held a best interests meeting prior to undertaking this covert medication regime. The patient was detained under the Mental Health Act, however this detention does not cover medication for physical health needs. The patient had also not been referred for an Independent Mental Capacity Advocate, despite this being serious medical treatment. When speaking to medical staff we established that the care plan stated the patient should always be asked to agree to taking medication before this was given covertly. However nursing staff told us that this was not the case and nurses gave medication covertly throughout the day without the knowledge of the patient. We asked the hospital manager to make changes to the care plan and arrange a best interest meeting immediately and this was arranged for the week after the inspection.

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

Good 

### Kindness, dignity, respect and support

We observed interactions between staff and patients throughout the inspection, during activities, on the ward and during one to one interactions. We saw staff treating patients with respect and communicating with them in a

professional way but using simple language that was easy to understand. We observed patients approaching staff to support them with varying needs and staff members were always responsive, friendly and appropriate.

Carers told us staff members were mostly very respectful when they spoke with patients. One carer did say that he had heard support workers on occasion speaking to patients in an inappropriate manner but this was rare.

On admission patients' received an information and orientation pack, together with a "wow" pack. This contained basic toiletries, an electric shaver, towels and a radio alarm clock.

We received four completed comment cards during the inspection. Comments were mixed, one patient felt it was a very good service and that the staff were excellent and the manager was brilliant, another patient said the staff communication was poor and management do not listen. Patients we spoke with also offered mixed feedback. They told us the occupational therapists were good and provided varied levels of activity. One patient told us the doctor would sit down and talk to them but another did not feel the doctor was very good. Some patients told us that staff did not always knock before entering their rooms or sometimes they did knock but do not wait for a reply before entering.

### The involvement of people in the care they receive

All patients received an initial assessment with the occupational therapist within the first two weeks of their stay/ This helped to identify their needs and how groups/ activities could be planned to support them. They had an individual timetable which changed during their stay as their needs changed.

We viewed 12 care records in detail which showed that care plans were personalised and patients were involved in their care options. We reviewed records from two multi-disciplinary team meetings, chosen at random and saw how patients and carers were always invited to attend. Where patients chose not to attend, their views were presented by the advocate or a written report completed by a member of the nursing staff and the patient. Staff told us that patients were offered a copy of their care plan and eight had signed to say they had received a copy. The other four copies were not signed and it was not clear if the patient had been offered a copy. Patient feedback regarding care plans was mixed and patients were not

# Long stay/rehabilitation mental health wards for working age adults

Good 

always sure if they had been offered a copy. They also received copies of leave plans and activity plans which seemed to cause some confusion about what they were being offered.

We received written feedback from the advocacy service telling us that 90% of the people currently being treated at the hospital have asserted their right to independent advocacy, 42% of such people use the service on a weekly basis. There is a good working relationship between staff and advocacy workers, staff members make time to meet with advocates whenever necessary. The mental Health Act team made sure advocacy were informed of meeting such as tribunals. The advocate told us that the manager actively welcomed challenging conversations and actively listened to issues and was open to suggestions. Furthermore, she promptly reported her responses back to the patient and the advocate in a person centred manner.

There was a patient community meeting held on Friday every week. We looked at minutes from meetings which showed a good level of patient involvement about suggested activities and improvements needed to the service. Some examples were suggestions for a monthly meal out, a takeaway night, gym membership, more cooking sessions and patients needed to keep the kitchen tidy. We saw how staff followed up on actions from previous meeting minutes for example there was a curry night in place and gym membership had been made available.

There was a planning meeting held on each ward with patients at the start of the day. We saw how patients planned activities and gave feedback on the previous day. One patient had the role of taking minutes of the meetings and received therapeutic earnings for this. Other opportunities to receive therapeutic earnings were available such as shopping for groups, bingo caller and gardening.

Patients were involved in community projects such as redecorating and refurbishing rooms at Wath old town hall. There were also links with other community organisations such as gym membership, an arts project and an arts café.

We received feedback from five relatives by phone. They told us that the hospital was good at keeping in touch with them. One relative told us how her son had visited her when she was ill in hospital on two occasions, supported by two staff members. Family members were invited to

meetings when patients were happy for them to attend. Visiting was by prior appointment however the hospital was flexible and had made provision for visits on the same day when necessary. Rooms used for visiting were away from the bedroom area. Visiting areas were clean and comfortable but one carer commented that they were quite bare. Family members were always made to feel welcome and offered refreshments during visits. If they had cause to make a complaint they felt able to discuss their concerns with staff at any time.

Carers / relatives were invited to take part in surveys on a regular basis. We received a copy from the last survey completed in 2016. There was no response to the postal request for feedback so staff completed a telephone review and eight carers completed the survey. The results showed that seven felt the location was clean, comfortable and well maintained. Three felt their relatives had access to health food options and could choose what to eat, the other five did not feel this question was relevant to them. Seven felt they were made to feel comfortable during visits and six felt they received enough information about the service.

There was a patient survey conducted each year. We viewed the survey from March 2015, of 36 patients, 25 responded. As a result of the survey the hospital made a number of changes which were highlighted within the report. Changes included; improvements to support more self-catering, health promotion group started, changes to the activity programme including extended working times of occupational therapy assistants and improvements in the complaints process.

Patients and relatives were not involved in the staff interview process.

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

Good 

## Access and discharge

There was a structured process from initial referral to admission to the service. Hospital staff were involved in the process from the initial referral stage.

# Long stay/rehabilitation mental health wards for working age adults

Good 

The average bed occupancy for the six months prior to the inspection was 88%. This level of occupancy ensures there is always a bed available when patients return from leave. The hospital had discharged seven patients in the same period, one to a psychiatric intensive care unit, one to low secure service, four to step down services, and one back to their home address. One patient was recorded as a delayed discharge. This patient was waiting for allocation to a community team. A delayed discharge is the term used to describe when a patient who is judged by the clinical team to be ready for discharge continues to occupy a bed in the service.

The discharge of patients was always planned and involved the patient and their relatives or anyone recognised as significant in their care. Staff supported patients' by using a graded approach to leave, firstly escorted leave then unescorted periods of leave prior to discharge. Commissioners viewed the discharge pathway as effective but one commented that sometimes they needed to move the discharge process forward. We viewed the minutes of multi-disciplinary team meetings and saw how discharge planning was always part of the agenda.

## **The facilities promote recovery, comfort, dignity and confidentiality**

There was a good range of facilities to support care and treatment. We viewed the timetable of activities which showed a wide variety of activities on offer with the support of the occupational therapy team Monday to Saturday. Sunday was less structured and allowed for a rest day. There was a gym which contained a selection of fitness equipment. Regimes were supported by a gym instructor who also has links with the local mental health football league. Patients were individually assessed to use the gym and were supplied with a key to access the gym independently. Some patients also attend the local gym in the community. There was an art room, DJ room, classrooms, pool table located in a communal area and a therapy kitchen on each ward. In the lounge area there was an x-box available and a picture board listing the therapy timetable and access to other activities.

Outside, the garden area had a poly tunnel for growing a variety of plants and a shed with gardening equipment. There was also a football pitch and the staff and patients took part in football tournaments with other Cambian hospitals. There was a smoking area with a shelter although one patient complained that this did not have

sufficient light, there was however light from the building. The hospital is looking at the lighting options to support this. There was also a dedicated non smoking area for those patients who did not smoke.

We noticed some of the bedrooms were on ground level and anyone walking by outside could see into the rooms, there was no protective film on the windows to promote the privacy and dignity of those inside. All windows had curtains which could be pulled to offer privacy. We mentioned this to the provider at the time and immediately steps were taken to remedy this.

The ward areas were spacious, light and airy. There was access to quiet space if required and sufficient rooms for staff to meet with patients for one to one interventions.

There was access to a pay phone on each ward and this was located in a small room where patients could have privacy. Patients were able to have their own mobile phones depending on a risk assessment.

Patients had open access to the therapy kitchen to make drinks and snacks. This was locked for short periods whilst the dishwasher was working due to cutlery being accounted for and available in the dishwasher. Some patient had been risk assessed for unrestricted access and others had access with staff supervision. The hospital had received a food hygiene rating of 5 (very good) by Barnsley Metropolitan Borough Council in January 2016.

We saw how patients had personalised their bedrooms and were able to choose a colour for a feature wall. All bedrooms had either a safe or a lockable cupboard to store possessions safely.

There was a large variety of activities on offer and the three therapy co-ordinators worked opposite shifts to offer support from 8am to 8pm Monday to Friday and one worked across the day on Saturdays.

## **Meeting the needs of all people who use the service**

The House was accessible to patients in a wheelchair, with a disabled access lift. There was also easy access to the garden area. Bedrooms had wet rooms within the en-suite facilities and corridors were wide to allow for wheelchair usage if required.

# Long stay/rehabilitation mental health wards for working age adults

Good 

There was a wide range of information leaflets available throughout the hospital. These were available in different formats for example easy read. Patients had access to interpreters if required.

Religious items were available for patients to use in the multi faith room, such as a prayer mat and holy books.

The catering was provided on site. The menu had a choice of food including a healthy option and a vegetarian option. The catering department described how they cater for a variety of needs including the provision of halal meats and vegan food for some patients. Patients were able to prepare their own meals in the therapy kitchen, some did this independently and some with the support of staff as part of their therapeutic plan.

## Listening to and learning from concerns and complaints

There were 27 complaints between March 2015 and March 2016. None of the complaints were formerly upheld, we could see from records that these were satisfied at a local level. No complaints were referred to the ombudsman. We viewed five complaints in detail and found that the hospital documented and investigated complaints thoroughly in accordance with Cambian policy. We noted that only one complaint of those reviewed clearly documented that the patient was happy with the outcome and resolution.

Patients and relatives told us that they knew how to make a complaint. We saw information on the wards which detailed how to make a complaint. Staff members understood how to handle complaints and were able to describe occasions when they had supported patients to make a complaint.

Staff described receiving feedback on the outcome of complaints and investigations through team meetings, handovers and in one to one supervision sessions. We saw evidence of this in meeting minutes, handover books and supervision records. There was no mechanism in place to ensure the learning had been shared by all staff.

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

Good 

### Vision and values

Cambian Healthcare have a vision to be the highest quality provider of specialist behavioural health services in the UK. It also had a list of four beliefs that would correspond to a list of corporate values; (1) everyone has a personal best, (2) everyone can find something to aim for, (3) everyone can achieve something special and (4) everyone should have the opportunity to strive for it. We found that staff members had an overall awareness of both the vision and values of the organisation. Staff uniform's had "everyone has a personal best" embroidered on the sleeve to display this value and serve as a reminder.

Staff and patients reported that the hospital management team was visible and approachable, and the operations director visited the site on a regular basis. There was a good team ethos and we observed good relations between staff at all levels.

### Good governance

There was a robust system in place to ensure staff members were kept up to date with mandatory training and annual performance appraisal. Most staff had received supervision in 2016 although there was evidence of gaps in the delivery of supervision in the last year. There was no system to check on staff supervision month on month to identify trends when this was not being undertaken. This was rectified during the inspection with a month by month spreadsheet starting in 2016.

Staff turnover was 19% in the last 12 months. The hospital manager told us this is due to staff joining the bank to allow for more flexible working options rather than the scheduled shift pattern. Staff members participated in the clinical audit process and we saw how actions were clearly list and acted upon.



# Long stay/rehabilitation mental health wards for working age adults

Good 

The Cambian staffing ladder is used to ensure shifts are filled with the right number of staff and safe staffing levels were maintained. Staffing levels were discussed each day in the morning meeting and adjustment made where necessary.

The manager used key performance indicators to monitor the performance of the hospital. These were compiled from the electronic recording systems that staff populated with certain patient data. This included number of incidents and safeguarding's, patient outcome measures, activity levels, medication issues, restraints, levels of observation and patient leave. This produced a monthly data pack for benchmarking and analysing with other hospitals within the Cambian group.

Governance meetings at the Oaks were held on a quarterly basis however in March 2016 this changed to monthly meetings as it was felt the distance between meetings to monitor and review information was too long. The standing agenda items included a review of key performance indicators, patient involvement, research and development, audit and compliance, risk management, external reviews, HR/staffing, community involvement and operational. There was also a regional governance meeting attended by other local Cambian hospitals in the East Midlands region. The minutes of these meetings provided evidence of checking action points from previous meetings, analysing trends from audits, benchmarking between the services and of discussion of comparative data on key performance indicators (KPI's).

We saw the occupational therapists, psychologists, doctors and the hospital managers all had regional meetings to support continuing professional development, share best practice and review outcome measures.

We saw examples of how staff share learning from incidents and complaints through staff meetings, handovers and supervision. However there was no structure in place to ensure learning was shared by all staff members.

There was a Cambian national risk register used to collate risks from across all Cambian hospitals. The Oaks had implemented a local risk register in February 2016. This had six items listed with actions and review dates. Whilst we were on inspection the hospital manager added in the use

of blanket restrictions and issues with privacy and dignity where there was no facility to stop viewing into downstairs bedrooms. All items were listed for review on 17/4/2016 at the next governance meeting.

## Leadership, morale and staff engagement

Staff, patients and relatives reported that the senior managers were approachable and highly visible in the hospital. The last staff survey was completed in December 2014 and we were told this was due to be completed again. Eight areas were covered including communication, flexibility, team commitment, responsibility, rewards, clarity, self-worth and motivation. Most staff responded with either excellent or good in all areas with the exception of rewards where 45% rated this as poor or less than satisfactory. One of the issues from the last survey included difficulty working the shift pattern and some staff reported this to still be an issue

There were no registered nurse vacancies and five support worker vacancies at the time of inspection. Staff turnover was 19% in the last 12 months. The hospital manager told us this is due to staff joining the bank to allow for more flexible working options rather than the scheduled shift pattern.

All staff interviewed stated that they could raise issues without fear of bullying or intimidation and we found no reported incidents of bullying within teams. They knew the contacts for whistleblowing and stated that they would not feel bullied or intimidated within the hospital for making a whistleblowing alert.

Staff teams reported working well together but support workers did sometimes feel as though they were not involved in the decision making process. There was a weekly group supervision session open to all staff for discussing issues within the workplace. All staff reported good morale within the workplace and we observed good communication between all staff groups during the inspection.

Staff members were able to make applications for external learning by completing an application which was considered nationally by Cambian. Staff had attended conferences and training days as part of this process. Members of the nursing team were undertaking mentorship training.

## Commitment to quality improvement and innovation

## Long stay/rehabilitation mental health wards for working age adults

Good 

The Oaks hospital did not participate in accreditation for inpatient mental health services (AIMS) although were considering it for the future.

The psychology department had put forward a business case to increase the assistant psychologist from one to two to enable some participation in research.

# Outstanding practice and areas for improvement

## Outstanding practice

The occupational therapy team at the Oaks hospital arrange and host an annual football tournament primarily for teams from Cambian hospitals across the county (both male and female). In 2015 there were seven teams involved, one of which was made up of staff from Community Links Rotherham. The teams were made up of both staff and patients playing together. There were

also fund raising activities undertaken such as a tombola, raffle and quiz. This allowed all patients to get involved if they wanted to. All proceeds are donated to the local church. The trophy is awarded to the winners and retained for one year. The Oaks hospital won the trophy in 2015.

## Areas for improvement

### Action the provider **MUST** take to improve

- Policies and procedures must be updated to reflect the change in the Mental Health Act Code of practice which came into effect in April 2015. All staff must be trained in the revised code of practice.
- The provider must ensure that where a person lacks the mental capacity to make an informed decision, or give consent, staff must act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.

### Action the provider **SHOULD** take to improve

- The provider should ensure that any restrictive practice is formally documented and regularly reviewed. It should always be the least restrictive option and be proportionate and appropriate to the patient group.

- The provider should ensure that fridges used to store medication are always kept locked when not in use.
- The provider should ensure that all patients are offered a copy of their care plan and where this is refused, this should be clearly documented.
- Bedrooms on ground level should have appropriate screening applied to the windows to protect the privacy and dignity of patients.
- The provider should ensure that there is a system in place to monitor the regularity of staff supervision in accordance with their policy.
- The provider should ensure there is a formal system in place which clearly records all staff members receive information with regard to lessons learned from incidents.



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	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>All staff had not received training in the revised Mental Health Act Code of Practice.</p> <p>The provider had not completed adjusting policies and procedures to reflect changes to the code of practice and policies were still under review.</p> <p>This was a breach of Regulation 17 (2) (a)</p>
Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>Covert medication was being administered for a physical health condition and this had not been subject to the necessary authority within the Mental Capacity Act.</p> <p>This was a breach of Regulation 11 (1)</p>