Cambian The Grange

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

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

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Summary of this inspection

Background to Cambian The Grange

Cambian The Grange is part of The Cambian Group. The registered provider is Cambian Learning Disabilities Midlands Limited. Cambian The Grange, located in Sutton in Ashfield, provides eight rehabilitation beds for men with an acquired brain injury.

At the time of inspection there were eight male patients, all detained under the Mental Health Act.

The hospital has two floors, communal areas and offices on the ground floor, patient bedrooms and a nursing station on the first floor.

Cambian The Grange is registered with the Care Quality Commission to provide the following regulated activities:

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

Patients admitted to this hospital have a diagnosis of established or suspected acquired brain injury, alcohol-related brain injury, Korsakoff's Syndrome, Huntington's disease or early onset dementia with rehabilitation potential. Patients might be detained under the Mental Health Act, the Mental Capacity Act Deprivation of Liberty Safeguards, or admitted on an informal basis.

Patients might present with challenging behaviours, co-morbid psychiatric disorders including a forensic history or substance misuse, moderate to severe cognitive impairment, organic psychiatric disorder or organic personality change, dysphagia or other communication problems and abnormal movements or restricted mobility, but will not typically be wheelchair users.

Cambian The Grange was last inspected on 13 April 2016. The service was found to be in breach of Regulations 9 (person-centred care) and 17 (good governance) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The hospital responded to the breaches by completing an action plan, which addressed these breaches.

At Mental Health Act monitoring visit occurred on 20 November 2015. All actions from that visit had been addressed.

Our inspection team

Team leader: Judy Davies, CQC Inspector Mental Health Central West.

The team that inspected the service comprised two CQC inspectors.

Why we carried out this inspection

We carried out this unannounced focused inspection due to previous breaches in Regulations 9 and 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and as part of our inspection programme. The provider had not reviewed and updated Mental Health Act policies and procedures to reflect the revised Mental Health Act code of practice. 61 percent of staff completed training on the Mental Health Act. Care plans did not have specific goals, patients' views on what mattered to them and interventions on how staff should support patients. Staff did not participate in a wide range of clinical audits to monitor the effectiveness of the service provided.

At this inspection, we only followed up the breach of regulations identified in the inspection carried out on 13 April 2016.

Summary of this inspection

How we carried out this inspection

Before the inspection visit, we requested and received copies of staff training records, mental health policies and procedures.

During the inspection visit, the inspection team:

- visited the unit, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the acting managers for the unit
- spoke with five members of staff
- looked at eight patients' care and treatment records.

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 effective?

- Care plans were recovery focused, personalised, up-to-date and holistic.
- Staff gave patients a copy of their care plans that used pictures and easy read language.
- All staff received face-to-face training on the Mental Health Act code of practice and were aware of its requirements.
- All staff received face-to-face training on the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Mental Capacity Act and Deprivation of Liberty Safeguards policies and procedures were current and had a review date.
- Staff participated in clinical audits, which monitored the effectiveness of the service.
- The provider ensured staff had appropriate training specific to their role, for example, support workers attended training that provided further support in their role.

However:

- We saw in two patient's records a statement stating that the patient did not understand their rights under the Mental Health Act 1983; no reason was given why the patients did not understand their rights. Staff presented patients their rights under the Mental Health Act using pictures and easy read language.
- Two patients had not signed their care plans; staff did not document the reason for this.

Are services well-led?

- The provider had a governance process that managed the quality of the service.
- The provider had developed and used key performance indicators, which measured outcomes on the quality of care provided to patients.

Detailed findings from this inspection

Mental Health Act responsibilities

Training on the Mental Health Act code of practice was mandatory for staff in the service. At the time of this inspection, all staff had received training on this. Staff received face-to-face training in line with the updated code of practice and were aware of its requirements. Policies and procedures we saw were current and had a review date. The acting registered manager and other staff we spoke with were clear on the guiding principles underlying mental health legislation.

All patients at Cambian The Grange were detained under the Mental Health Act. We looked at eight patient prescription charts and saw all charts had consent to treatment authorisation forms attached. This meant staff would know under which legal authority they were administering medication. However, we saw in two patient's records, a statement stating the patient did not understand their rights under the Mental Health Act, no explanation was given by staff.

The Mental Health Act administrator audited all files every six months to make sure detention paperwork was correct and up to date. Section 17 authorisation documents were in place for all detained patients. These were up to date and recorded in a standard format. We saw in the patient records, staff had told patients about their rights. We spoke to three patients detained under the Mental Health Act. They told us that they understood how the Mental Health Act applied to them and they knew about their rights to appeal. All these patients consented to their medication. Patients told us they could and did access independent mental health advocacy services.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received training on the Mental Capacity Act. Mental Capacity Act policies and procedures were current and had a review date. Staff we spoke to were able to show their understanding of the Mental Capacity Act's basic principles. Staff wrote mental capacity decisions about care and treatment in patients' records. The multi-disciplinary team completed mental capacity assessment on a specific issue. Cambian The Grange reported no Deprivations of Liberty Safeguards applications between 13 April 2016 and 5 September 2016.

Services for people with acquired brain injury

Effective

Well-led

Are services for people with acquired brain injury effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Staff assessed each patient's needs after admission. There was evidence in all care records we reviewed of a comprehensive assessment completed after admission. This assessment was holistic, covering needs such as social, financial, mental health and communication.
- Staff completed an assessment of physical health needs. In all care records we reviewed, all patients received a physical health examination on admission. There was evidence this assessment was ongoing and reviewed on a regular basis.
- All care records contained up to date personalised, holistic, recovery-oriented care plans. Each patient had a multi-disciplinary care plan written by the multi disciplinary team, patient, carers and other involved professionals. This plan contained themes such as key aims over the year, individual interdisciplinary plan, working strategy, 'who will help me', 'my decision', outcomes expected, goals met, and staff guidance. The care plan was reviewed on a monthly basis by the multi disciplinary team.
- Staff gave patients their multi disciplinary care plan in an easy read format. This document called 'My Care Plan' was a summary of the information and decisions agreed in the multi disciplinary care plan. Staff used easy read language and pictures to help the patient understand the information. A copy of this care plan was in the patients' records.
- All care plans we saw were recovery focussed, had specific goals, personalised and reflected the patient's needs found in the assessment. Patients we spoke to said they were supported to be involved in writing their care plan. We saw staff, patients and carers were involved in, signed and dated the care plan, staff would document if a patient refused to sign the care plan. However, we saw two care plans that patients did not sign and staff did not document why these patients did not sign their care plan.
- Staff and patients reviewed this care plan weekly. Staff wrote down patients' comments on the patients' one to one form. Patients we spoke to said they were given a copy of their care plan.
- All information needed to deliver care was stored securely. Cambian The Grange stored electronic and paper based documents and care records securely in locked cupboards. All computers used were password protected. All patient records we saw were organised, and available to staff where needed.

Best practice in treatment and care

- Staff followed National Institute for Health and Care Excellence guidance when prescribing medication. We saw information on patients' medication based on National Institute for Health and Care Excellence guidance included detailed information on monitoring needed for patients prescribed anti-psychotic medication.
- Staff used psychological therapies. Cambian The Grange had a full time psychologist, occupational therapist and nursing staff who used a range of therapies such as cognitive behavioural therapy, anxiety management and psychoeducation.
- Patients had good access to physical health care included access to specialists when needed. All the patient files we saw showed staff completed physical healthcare checks on admission and physical health care plans kept up to date. Staff monitored blood pressure and weight; GP had managed other physical health issues. Patients had access to specialist care; we saw letters written by staff referring patients to specialist teams for example, gastroenterology.
- Staff used recognised rating scales to assess and record severity and outcomes. For example, Health of the National Outcomes Scales was completed every three months. Staff completed other rating scales such as Functional Assessment Measure, which is a measure of disability in traumatic brain injured patients, Model of

Human Occupation Screening Tool which assess patients' pattern of occupation, communication/ interaction, process, motor skills, and environment and Global Assessment Progress, a numeric scale assessing the social, occupational and psychological functioning of an individual.

- Clinical staff participated actively in clinical audits. We looked at Cambian The Grange's Audit Schedule 2016 and saw staff were involved in a range of clinical audits. For example, a senior nursing staff completed a monthly medication audit and six monthly Deprivation of Liberty Safeguards audit. Information from audits was passed to the quality manager. Staff said they used information obtained from the audits to identify and deal with changes to improve patient care.

Skilled staff to deliver care

- Cambian The Grange had a full range of mental health disciplines and workers that provided input. The team included a neuropsychiatrist, psychologist, occupational therapist, speech and language therapist, qualified nurses and support workers.
- Staff had relevant qualifications and had several years' experience of working in a rehabilitation setting. We spoke to support workers who had several years work experience supporting adults with an acquired brain injury. A qualified nurse was always on duty with support workers.
- Staff received an appropriate induction. The acting registered manager said newly appointed and bank staff had a two-week period of induction before they were included in the staff numbers. Support workers were able to complete the Care Certificate.
- Staff were supervised, appraised and had access to monthly team meetings. Records showed all staff received an appraisal between April 2016 and September 2016. Staff said the manager provided regular clinical supervision every four weeks, compared to the supervision policy, which states clinical supervision should be given every six weeks. Staff attended team meetings every two months. The acting registered manager received management supervision every three months and clinical supervision from a manager from another unit.
- Staff received the necessary specialist training for their role. For example, the psychiatrist and psychologist accessed specialist training for neuropsychiatry. The psychiatrist held specialist training and support group for support workers called Valuing People – Supporting our Support Workers. This group provided additional support for support workers in their role.
- The acting registered manager addressed issues of poor staff performance. We looked at the most recent human resources review meeting minutes. Performance management, sickness levels, disciplinary conduct, staff turnover and grievances were discussed. These minutes showed staff performance issues were addressed in a timely manner.

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

- Training on the Mental Health Act code of practice was mandatory for staff in the service. At the time of this inspection, all staff had received training on this. We read the training programme, which showed staff received face-to-face training in line with the updated Mental Health Act code of practice. Staff demonstrated their understanding of the code of practice and was aware of its requirements.
- Policies and procedures we saw were current and had a review date. For example, we looked at a selection of policies and procedures such as Governing Discharge of Powers – Hospital Managers, Renewal of Detention and Community Treatment Orders. These policies and procedures were up to date and due to be reviewed in May 2019.
- The acting registered manager and other staff we spoke with were clear on the guiding principles underlying mental health legislation.
- All patients at Cambian The Grange were detained under the Mental Health Act. We looked at eight patient prescription charts and saw all charts had consent to treatment authorisation form attached. However, we saw in two patient's records a statement stating that the patient did not understand their rights under the Mental Health Act; no reason was given why the patient did not understand their rights. Information on patients' rights were given to patients in a format they understood and re-presented to the patient on more than one occasion.
- The Mental Health Act administrator audited all patients' files every six months to make sure detention paperwork was correct and up to date. Section 17 authorisation documents were in place for all detained patients. These were up to date and recorded in a

standard format. We saw in the patient records, staff had told patients about their rights. We spoke to three patients detained under the Mental Health Act. They told us that they understood how the Mental Health Act applied to them and they knew about their rights to appeal. All these patients consented to their medication. Patients told us they could and did access independent mental health advocacy services.

Good practice in applying the Mental Capacity Act

- All staff had received training on the Mental Capacity Act. We read the training programme; training was delivered face to face and reflected the Mental Capacity Act code of practice and Deprivation of Liberty Safeguards
- Cambian The Grange reported no Deprivation of Liberty Safeguard applications between 13 April 2016 and 5 September 2016.
- Staff were able to refer to Mental Capacity Act and Deprivation of Liberty Safeguards policies. These policies were current and due to be reviewed in May 2019.
- Staff we spoke to were able to show their understanding of the basic principles of the Mental Capacity Act. They wrote in the patient's records the mental capacity to make decisions about their treatment and care. We saw mental capacity assessment on a specific issue completed by the multidisciplinary team. Best interest decision assessments were stored in patients' records. Documentation about this assessment and decision was clear and through.
- Staff supported patients to make decisions. For example, we saw examples of the speech and language therapist providing communication support, which helped patients to make choices and decisions. All patients had access to advocacy services; an advocate visited the unit weekly. Written information in easy read language about advocacy services was placed on communal notice boards.
- Staff understood and where appropriate worked within the Mental Capacity Act definition of restraint.
- Staff knew where to get advice regarding the Mental Capacity Act including Deprivation of Liberty Safeguards. They said they would speak to the Mental Health Act administrator for advice on the Mental Capacity Act. Staff said they would contact the Independent Mental Health Capacity Team for further advice.
- There were arrangements in place to monitor adherence to the Mental Capacity Act. The acting registered manager completed a Deprivation of Liberty Safeguards audit twice a year; staff sent the outcome of this audit to the quality manager.

Are services for people with acquired brain injury well-led?

Good governance

- Cambian The Grange had a governance process to manage quality and safety. The acting registered manager gave information obtained from this process to senior management to measure service performance. The acting registered manager completed monthly returns, which was sent to senior management.
- Staff received mandatory training. The acting registered manager had a clear system for monitoring compliance. Mandatory training compliance was discussed every three months in the human resource review meeting held with managers and human resources staff.
- Cambian The Grange had a Mental Health Act administrator who ensured staff had the support to apply the Mental Health Act to their role. Staff demonstrated a good understanding of the Mental Health Act.
- Cambian The Grange used key performance indicators to gauge the performance of the team. The acting registered manager provided data on performance to the quality assurance manager. Examples of collected data was care plans, care programme approach reviews, discharge and admissions and patient activity levels. All information was analysed at unit level to identify themes and trends. This information was used to improve the quality of the service provided. For example, the data relating to care plan goals at the time of this inspection 30% goals were achieved, 40% of goals were partially achieved, 20% of goals not achieved and 10% of goals not yet recorded..

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff document reasons for patients not signing their care plan.
- The provider should ensure staff document reasons why patients did not understand their rights under the Mental Health Act.