Cambian Lodge

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

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

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

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

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

Summary of findings

Overall summary

We rated Cambian Lodge as good because:

- The provider assessed the risks presented by the environment such as blind spots and ligature points, and took appropriate action to reduce them.
- The unit had adequate staffing levels. Staff were up-to-date with most of their mandatory training and they received annual appraisals and regular supervision.
- Staff were committed to the least restrictive approaches to managing challenging behaviour such as de-escalation (calming down).
- Care records were comprehensive and contained up-to-date risk assessments, and robust care plans that covered patients' physical and mental health needs. Staff fully involved patients and their relatives in assessment and care planning. Records and discussions showed that staff assessed capacity on a decision-specific basis.
- The provider complied with the relevant national institute of health and care excellence (NICE) guidelines, and offered a range of therapies in line with the acquired brain injury pathway. The provider's model of care focused on recovery and rehabilitation, and incorporated a positive risk-taking approach.
- Most family members gave positive feedback about Cambian Lodge and mentioned improvements they saw in their relatives since their admission.
- All patients received a welcome pack of useful items on admission and had access to a fund to purchase items for their room.
- The chef cooked food each day taking into account the patients' specific needs and preferences, and patients could also cook for themselves.
- Staff actively sought opportunities for patients to participate in community-based activities of their choice.
- The provider had a robust incident reporting process that led to actions and lessons learned for the whole organisation.
- There was good morale among staff and they felt valued and supported by all the managers.

However:

- The compliance rate for Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards training was low (44%).
- The unit had not fully complied with their complaints procedure in the past.
- Not all care plans had dates on them. This meant it was difficult to see when staff wrote them and when they were due for review.
- Patient involvement was not always evident in care records.

Summary of findings

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Good

Cambian Lodge

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Summary of this inspection

Background to Cambian Lodge

Cambian Lodge is an independent mental health hospital run by Cambian Learning Disabilities Midlands Limited. Cambian Lodge has a registered manager, a nominated individual and a controlled drugs officer. Cambian Lodge provides the following regulated activities:

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

Cambian Lodge is a locked eight-bedded rehabilitation facility for men with acquired brain injury. Patients may be detained under the Mental Health Act.

A sister location, Cambian Grange is located nearby, within walking distance. Cambian Grange is also an eight-bedded unit for men with acquired brain injury. Both locations share the same registered manager and most of the multidisciplinary team. Cambian Lodge is much smaller than Cambian Grange so patients and staff at Cambian Lodge use the facilities at Cambian Grange.

Cambian Lodge registered with the CQC in December 2011 and had received two inspections and two Mental Health Act (MHA) monitoring visits. We carried out the most recent inspection on 11 June 2013. At that time, Cambian Lodge complied with the relevant essential standards.

Our inspection team

Team leader: Si Hussain

The team that inspected the service comprised two other CQC inspectors and a Mental Health Act reviewer.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, and conducted a Mental Health Act monitoring visit.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with the acting manager for the hospital
- spoke with 10 other staff members including the psychiatrist, the psychologist, the speech and language therapist, the occupational therapist, nurses, healthcare support workers, and the domestic and catering staff
- received feedback about the service from one commissioner
- spoke with an independent advocate
- attended and observed a handover meeting

Summary of this inspection

- attended and observed a patients' community meeting
- looked at care records for four patients
- looked at records relating to the Mental Capacity Act, Deprivations of Liberty Safeguards and the Mental Health Act
- looked at medication charts for eight patients
- carried out a specific check of the medication management in the hospital
- looked at the clinic room and emergency equipment
- reviewed three staff personnel files
- looked at a range of policies, procedures and other documents relating to the running of the service.

Following the inspection visit, we spoke with seven relatives of patients using the service.

What people who use the service say

Most relatives and patients gave positive feedback about Cambian Lodge.

We spoke with three patients. Some patients were far away from their home area and were keen to return to placements nearer home. However, one patient had made good links with the local community and wished to stay in the area. Patients spoke positively about the staff, the homely environment, and the food. Some patients reported frustration with the restrictions associated with detention in a locked unit.

We spoke with seven relatives. Most relatives praised the staff and the service provided. Some family members described how calm and settled their relative was since they came to the unit. The main concerns expressed by relatives were about the limited space at the unit, for example, visiting rooms; the time taken to discharge or transfer patients because of the limited availability of specialist step-down facilities; and difficulties experienced in contacting the unit and communicating with some of its staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The ward layout allowed staff to observe most of the communal areas in the unit. The provider took action to reduce the risks associated with blind spots.
- The provider completed a ligature (items that could be used for hanging) risk assessment in September 2015. This noted all possible ligature points, assessed the level of risk presented and identified mitigating actions.
- The unit had appropriate staffing levels. Staff received and were up-to-date with most of their mandatory training.
- Staff were committed to the least restrictive approach to managing challenging behaviour. All staff, including the housekeeper and kitchen staff, received training in managing violence and aggression.
- Patients' files contained comprehensive risk assessments covering all aspects of care and treatment. Staff and the multidisciplinary team reviewed risks regularly and updated the patients' risk assessments.
- The provider had good medicines management policies and practices including strict protocols for self-medication.
- Staff knew how to identify and report safeguarding incidents and kept full records of referrals to the local authority and any outcomes.
- The provider had a robust incident reporting process that led to actions and lessons learnt for the whole organisation.

However:

- The compliance rate for Mental Health Act, Mental Capacity Act and Deprivation of Liberty Safeguards training was low (44%).

Are services effective?

Good

We rated effective as good because:

- Care records were comprehensive and covered physical and mental health needs. Staff completed a full review of care and medication on admission.
- Patients had regular access to physical healthcare and staff supported patients with all their physical health care needs.
- Staff were suitably skilled and qualified for their roles. They received role-specific training, annual appraisals and regular supervision.

Summary of this inspection

- Multidisciplinary team meetings (MDT) took place weekly, were well coordinated, and had good attendance.
- The provider's model of care focused on recovery and rehabilitation and incorporated a positive and well-managed risk-taking approach.
- The provider followed the relevant national institute of health and care excellence (NICE) guidelines. It offered services in line with the acquired brain injury pathway and used recognised tools and measures such as the health of the nation outcome scales (HoNOS).

However:

- Some staff had limited awareness of the principle of capacity to consent under the Mental Capacity Act.
- Not all care plans had dates on them or there were a number of dates noted that made it hard to work out when staff had created or reviewed the plan.
- Staff did not always record patient involvement in care records.

Are services caring?

Good

We rated caring as good because:

- Most family members gave positive feedback about Cambian Lodge and mentioned improvements they saw in their relatives since their admission.
- Staff strongly encouraged and promoted patients' independent living skills.
- The psychologist offered one-to-one and family therapy to relatives, where appropriate.
- Staff fully involved patients and their relatives in assessment and care planning.
- All patients received an easy-read information pack about the unit's facilities and services.
- All patients received a welcome pack of useful items on admission and had access to a patient fund within the first three months.

Are services responsive?

Good

We rated responsive as good because:

- Bedrooms were ensuite, spacious and well furnished. Patients could personalise their bedrooms. The homely environment helped patients see it as their home and motivated them to keep it clean and tidy.

Summary of this inspection

- The unit had a dedicated chef who cooked the food each day taking into account the patients' specific needs and preferences. Patients could cook for themselves and received a budget to support this. Patients had access to drinks and snacks at all times of day and night.
- Patients had access to range of easy-read information about the unit and advocacy services. Staff also gave them easy-read descriptions of the different roles in the multidisciplinary team.
- Staff actively sought opportunities for patients to participate in community-based activities of their choice.

However:

- There was limited space for visits and meetings at the unit. The multi-purpose meeting room in the reception area was often in use.
- The unit had not fully complied with their complaints procedure in the past.
- There was no payphone for patients and not all patients had their own mobile phones.
- There was no examination couch in the clinic room.

Are services well-led?

Good

We rated well led as good because:

- The provider had effective systems and processes to monitor service delivery, quality and performance.
- Staff knew and agreed with the vision and values of the organisation that promoted high quality care and person-centred practice.
- Staff knew the senior managers and frequently saw the regional manager on the unit.
- There was good morale among staff and they felt valued and supported by all the managers. Staff said they could raise problems and ask for advice and support at any time.
- The provider gave staff mandatory training and specialist training for their roles, and offered them opportunities for further professional development.
- Cambian Lodge was a member of an independent organisation that supported the delivery of high quality care for people with acquired brain injury.

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.

At the time of our inspection, 44% of staff had received training in the Mental Health Act (MHA). The provider had booked the remaining staff onto sessions scheduled in May, June and July 2016.

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

All staff knew who the mental health act administrator was and could seek legal advice and support at any time.

The provider commissioned Advent Advocacy to provide independent mental health advocates (IMHA) for its patients.

We completed a Mental Health Act monitoring visit in the week before the inspection on 27 April 2016. At that time, seven patients were detained under the Mental Health Act. We found that detention and renewal paperwork was up-to-date and completed correctly. The responsible clinician had completed capacity to consent to treatment or refuse treatment assessments. The relevant treatment certificates (known as T2 and T3) were in place and attached to the patients' prescription charts.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection, 44% of staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The manager had booked the remaining staff onto sessions scheduled for May, June and July.

One patient was subject to the Deprivation of Liberty Safeguards (DoLS). The patient's file showed a clear record of an assessment of capacity to consent to medication.

During our inspection and during the MHA monitoring visit, we found that not all staff fully understood the concept of presumption of capacity. However, we found all staff applied the principles in practice because they knew their patients well and supported their autonomy and independence. Furthermore, records showed good examples of capacity assessments and best interests decisions for a range of issues.

The provider had a policy on MCA and DoLS that staff were aware of. Staff knew that the mental health act administrator provided advice on any issues related to the MCA and DoLS, and could contact her anytime.

The provider commissioned Advent Advocacy to provide independent mental capacity advocates (IMCA) its patients.

Good

Services for people with acquired brain injury

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

Are services for people with acquired brain injury safe?

Good

Safe and clean environment

- The ward layout allowed staff to observe most of the communal areas in the unit. There was always a staff member present in the communal area to help improve observation. There were blind spots on the first floor corridor and parts of the lounge area. Staff positioned themselves on the first floor when patients were present, subject to the risks they presented. There was a convex mirror in the staircase that helped staff see if anyone was on the first floor corridor.
- Entry and exit to the building was through a locked reception area (airlock). The unit had CCTV that looked out to the front of the building and the car park. The airlock had a sign in and out visitors and fire register.
- The provider completed a ligature risk assessment in September 2015. The assessment noted all possible ligature points, assessed the level of risk presented and identified mitigating actions. The ligature risk assessment was comprehensive and covered all areas of the unit including staff-only areas. Most of the fittings in the bedrooms were anti-ligature. Staff increased the frequency of observations for patients at risk of self-harm or suicide. There were ligature cutters placed on each floor and staff knew how to use them.
- The unit had a fully equipped clinic room. The unit had emergency equipment that included a defibrillator, an emergency bag, adrenalin and oxygen. Staff checked these regularly. In the event of an emergency, staff applied resuscitation and called emergency services.
- The unit had a fully equipped kitchen for kitchen staff only, and an occupational therapy kitchen for patients. The kitchens contained a fire blanket, a burns kit and a first aid kit. Staff checked these items regularly. The kitchen staff maintained good food storage and dating practices. Electrical appliances throughout the unit had received safety checks. Stickers were visible and showed the due date of the next test.
- The unit did not have a seclusion room.
- The unit had good furnishings, pleasant décor, and was well maintained. All areas of the unit were very clean and free from clutter. The dedicated housekeeper maintained a high standard of cleanliness. The housekeeper was responsible for the safe storage of cleaning materials that contained chemicals, ordering stock, and ensuring supplies of PPE (personal protective equipment) and spillage kits. The housekeeper was also responsible for ensuring all communal areas and locked areas such as the laundry and OT kitchen were kept clean. The staff or the housekeeper supervised and supported patients, where necessary. The patients had a separate cleaning trolley with specific products that staff logged and checked at each use. The housekeeper checked the standard of hygiene in patients' bedrooms and intervened, where necessary. We reviewed the daily cleaning records from 1 April to 4 May 2016 that consisted of detailed checklists for every part of the unit. The records were fully complete and up-to-date.

- Staff adhered to infection control principles. We saw antibacterial hand gel in the reception area, the kitchens, the communal bathrooms and the occupational therapy (OT) kitchen. The provider gave staff uniforms to further promote health and safety.
- The unit had access to a maintenance worker. Staff reported jobs onto a central system, which enabled tracking of progress.
- All staff had mobile personal alarms that they carried at all times. All bedrooms had fixed nurse call alarms for patients to call for help.

Safe staffing

- The unit had a total establishment of 31 whole time equivalent (WTE) staff. This included 4.5 WTE qualified nurses and 16.5 WTE healthcare support workers. Day shifts ran from 8am to 8pm, and night shifts from 7.30pm to 8.30am.
- The minimum staffing level was one qualified nurse and three healthcare support workers for day and night shifts. The unit generally operated with higher staffing levels so that it could increase the number of staff to patient contacts. For example, there was at least one additional support worker on day and night shifts. The manager further adjusted staffing levels, as necessary, to meet patients' needs.
- From the 4 January 2016 to 7 February 2016, bank staff filled 19 shifts. The provider did not provide data on how many shifts were left unfilled. We did not find that unfilled shifts were an issue. The manager offered overtime to Cambian Lodge staff or used Cambian bank staff to cover gaps in shifts. The staff used were familiar with the unit and the patients.
- Cambian Lodge reported a zero vacancy and turnover rate for the year to December 2015. However, at the time of our inspection, the overall staff turnover rate was 36%. For qualified nurses only, the turnover rate was 75%. This was because there had been some changes to staffing in recent months including internal transfers. There had been four vacancies since January 2016, one nurse and three healthcare support workers. The manager had recruited staff to fill the vacancies. Staff often worked in Cambian Lodge and Cambian Grange, a sister unit within walking distance, but were allocated to one or the other. When staff transferred from Cambian Lodge to Cambian Grange, the provider recorded them as leavers and new starters. This affected the turnover rate.
- We reviewed notes from a human resources meeting held on 26 April 2016. The meeting discussed a range of staffing-related matters, for example, pregnancy risk assessments, maternity leave, grievances and disciplinaries, and reviewed sickness levels and staff turnover rates. The notes indicated that the absence rate for April 2016 was 3.6%.
- There was always a staff member present in the communal areas of the unit. This could be a qualified nurse or a healthcare support worker.
- Patients knew their keyworkers and had weekly one-to-one meetings with them. There were two keyworkers allocated for each patient, which helped form strong relationships and ensure consistency in the care provided. The unit rarely cancelled escorted leave and activities because there was too few staff. However, staff occasionally changed or postponed activities when the unit's car was in use.
- The staff, patients and most relatives we spoke with felt there were enough staff around to meet the needs of the patients. However, some relatives thought there were too few staff and patients left bored and inactive.
- The psychiatrist worked full-time across two units, Cambian Lodge and Cambian Grange, a nearby sister unit. He visited Cambian Lodge on two days each week but was available and accessible throughout the week. The psychiatrist provided 24-hour cover from Monday 9am until Friday 5pm. A regional Cambian on-call rota provided medical cover on evenings and weekends.
- Staff received and were up-to-date with the provider's core mandatory training. As of January 2016, 80% of staff had completed training on safeguarding adults and children, infection control, health and safety, responding to emergencies (fire safety and basic life support), food safety, information governance, and equality and diversity. For first aid training, the rate was 100%. In addition, the provider offered staff essential training for their roles. This included training on managing violence and aggression, acquired brain injury (ABI) active care, and Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). At the time of our inspection, 96% of staff had completed training on managing violence and aggression. These included the housekeeper and chef because their roles involved frequent interaction with the patients. Any staff with little patient contact received

'breakaway' training. The training rate was 83% for ABI active care and 44% for MHA, MCA and DoLS. The manager had booked staff onto MHA, MCA and DoLS training sessions scheduled for May, June and July 2016.

- We reviewed personnel files for three staff members. Files were comprehensive, in good order and up-to-date. They contained recruitment information, references, disclosure and barring service (DBS) checks, professional registration details, induction and mandatory training records, sickness absence and supervision and appraisal records.

Assessing and managing risk to patients and staff

- The provider had a no seclusion policy. It did not use seclusion or long-term segregation.
- In the six months to February 2016, the provider reported 15 incidents of restraint involving three different patients. None of these was in the prone (face-down) position. Staff used restraint as a last resort, after de-escalation techniques had failed. Staff preferred to adopt a preventative approach to conflict supported by their knowledge of, and relationships with the patients. For example, they identified and recognised warning signs and triggers presented by the patient and responded with appropriate techniques such as calming down and distraction. All staff had received managing violence and aggression or 'breakaway' training. Following an incident, staff recorded any use of PRN ('pro re nata' - as needed) medication to calm a patient as rapid tranquillisation and completed the required observations. This was in line with the national institute of health and care excellence (NICE) guidance and the MHA Code of Practice.
- Staff completed initial risk assessments for all new patients on admission. In the weeks following admission, staff completed comprehensive and multidisciplinary risk assessments for the new patients using the short-term assessment of risk and treatability (START) tool. The multidisciplinary team (MDT) rated risks red, amber, or green. Risks rated red lasted seven days and staff reviewed them daily at morning handover meetings. Staff completed a START form for minor incidents, or an incident form for more serious incidents, and updated the patient's risk assessment. The multidisciplinary team reviewed all incidents to reassess risk and identify any patterns of behaviour for the patient.
- The unit operated robust observation practices. The multidisciplinary team assessed the observation levels required for each patient based on the risks they presented. For example, staff supported a patient on a one-to-one basis during all mealtimes because of the risk of choking. Discreet routine observations took place every fifteen minutes. Staff did two-hourly blocks of observation but could be relieved earlier. Subject to risk, staff searched patients' bedrooms once a week in line with the provider's policy. Bedrooms had night-lights to help staff with routine observations at night. Staff opened the doors to check on patients.
- Staff received training in safeguarding and knew how to identify and report safeguarding incidents. Cambian Lodge had developed a good relationship with the local authority safeguarding team, and had a joint working protocol. We looked at the safeguarding log, which showed Cambian Lodge made seven safeguarding referrals to the local authority during 2015. Records showed that referrals were timely and tracked. A safeguarding file contained full details of each safeguarding incident including correspondence from the local authority. However, the safeguarding log showed that Cambian Lodge did not notify the CQC about any of the seven referrals made in 2015 although CQC records showed we received one safeguarding concern in January 2015, and none thereafter. The acting manager had rectified this from February 2016. For example, CQC records showed we had received three safeguarding referrals in April 2016.
- We reviewed the provider's medication management practices. Medicines were safely stored in a locked clinic room. The clinic room had a stable door, which helped restrict access and maintain safe practice. Staff checked fridge and room temperatures daily. There was a British National Formulary (BNF) guide in the clinic room. This is a guide on the selection and clinical use of medicines. The unit used a supply of stock medication that staff checked weekly. Staff checked benzodiazepine medicines daily. We reviewed the prescription charts for all eight patients. The charts were mostly accurate and up-to-date although we found two gaps for signatures. Staff reviewed PRN (pro re nata – as needed) medication at multidisciplinary team meetings, or sooner, if required. The clinic room held a controlled drugs cupboard but there were no controlled drugs on site at the time of our inspection.

Good

Services for people with acquired brain injury

- At the time of our inspection, four patients were on stage two self-medication programmes, as part of their rehabilitation plan. Staff followed the provider's self-medication protocols that supported the safe implementation of self-medication. Stage one involved an initial risk assessment and MDT discussion and agreement. The patient attended the clinic without prompts, read their prescription chart and dispensed their medication on at least four occasions. The nurse observed the patient and signed the chart. For stage two, staff ordered a daily pack from the pharmacy. The patient collected the pack from the clinic. The patient kept these in his room and staff undertook a random daily safety check. The nurse signed the chart when the patient took his medication, and noted if he needed any prompts. There were two further stages but at the time of our inspection, four patients had reached stage two and no patients were beyond it.
- There were safe procedures for visitors to the ward. Visitors could not enter the locked ward area. Visitors used a meeting room located in the reception area (airlock) that was visible from the staff office. In cases of visitors with children, staff were present in the airlock to prevent contact from other patients entering or leaving the unit. Patients could only use offices and rooms normally kept locked such as the psychologist's office for a private phone call, under supervision and subject to their risk levels.

Track record on safety

- The provider reported no serious incidents during the period September 2015 to February 2016.
- For the year to 30 April 2016, staff reported 44 incidents. Most of these involved verbal or physical aggression between patients or from patients to staff. Staff recorded incidents on START forms and on incident forms (IR1). We reviewed the incident log summary and seven completed IR1 forms. Information recorded included the date, time and location of the incident, the parties involved, a brief description, and the START severity scale score. The forms showed if staff had used managing violence and aggression techniques and if the incident resulted in a safeguarding referral. The multidisciplinary team analysed the incidents to identify any patterns of behaviour and took appropriate action. The manager reported all incident data to senior management who looked at it corporately to identify any themes and trends.

Reporting incidents and learning from when things go wrong

- The provider, Cambian Learning Disabilities Midlands Limited, had a range of policies and tools that supported timely incident reporting, investigation, and debriefing for staff and patients. Cambian Lodge staff recognised incidents and reported them appropriately using the START form or the incident reporting form (IR1).
- Staff were open and honest with patients and relatives when they made mistakes and told them how they would address them, for example, investigate and change practice.
- Staff and patients received debriefings following incidents. Staff received feedback and lessons learnt from investigations at multidisciplinary meetings, staff meetings, one-to-one sessions, peer group meetings and 'clinical fairs' (learning sessions).

Are services for people with acquired brain injury effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

- We reviewed the care records of four patients. Records were clear, well-presented and in good order, which made it easy for staff to access. They were comprehensive and contained a range of timely assessments and care plans associated with the patients' needs. Documents we saw included positive behaviour support guidelines, daily section 17 leave plans, a weekly activity sheet, a grab sheet and an admission checklist. Care plans were person-centred and recovery-oriented. We found that some care plans did not have dates on them or had multiple dates making it difficult to determine when they were created or reviewed. Care plans showed patient involvement but this was not always easy to see.
- The service applied a holistic approach to patient care supported by good access to a wide range of multidisciplinary professionals. Patients received specialist assessments, as required. These included speech and language therapy assessments for patients

with communication needs or risks associated with swallowing. Patients received occupational therapy (OT) assessments on a range of needs including dressing, kitchen skills, road safety, budgeting and social skills. These assessments resulted in care plans to meet the patients' individual needs.

- The unit's model of care had a strong focus on recovery, rehabilitation, and independence. The unit adopted a positive risk-taking approach balancing risk with opportunities for independence and self-responsibility. The unit embedded these principles in all aspects of care. For example, four patients managed their own medication on a daily basis. Patients were responsible for cleaning their bedrooms, making their breakfast and supper, and doing their laundry. Staff offered patients jobs such as cleaning the communal areas of the unit for therapeutic earnings. Some patients received structured periods of unescorted leave. Some patients were on the flexible 'shop and cook' programme. This meant staff gave them money to manage their own shopping and prepare their own meals on some days of the week.
- All patients were registered with a local GP. One of the registered nurses at Cambian Lodge acted as the designated physical health lead for the unit. This helped ensure patients' physical health needs received timely and appropriate attention.
- All patients had separate physical health care files that contained a range of physical health assessments and care plans. The records were clear, concise, fully completed, signed and dated. The records showed that patients received a physical health assessment on admission, routine check-ups, and ongoing monitoring of physical health problems. Each patient received monthly physical health and weight checks, and six-monthly blood tests and electrocardiogram (ECG) tests. Staff supported patients with specific physical health issues, for example, diabetes, vitamin D deficiency, dental issues, and epilepsy. We saw a separate detailed care file for a patient with epilepsy. Staff supported patients to make positive changes to their health and wellbeing, for example, dietary changes in response to weight issues and a smoking plan to help reduce smoking.
- Each patient had a 'hospital passport' that was easy to read and up-to-date. As well as the patients' mental and physical health needs, it mentioned their support needs, and likes and dislikes. Each file contained a 'grab sheet', which showed a summarised profile of the patient's needs and wishes. Each patient had a detailed 'my individual specific rehabilitation prescription', supported by simplified care plans in an easy-read format. These included important things that people should know about the patient such as how they communicate. Staff wrote them in the first person, for example, "it helps when you…." and "please see/read/use my…"
- Staff had easy access to the patients' records that were kept in lockable cupboards in the locked staff office. At the time of our inspection, all records were in paper format but the provider was in the process of implementing an electronic care records system. We found it difficult to establish the dates of some assessments and care plans because when printed, the documents showed several dates that were not easy to interpret, for example, the date of printing, and version date for the form. However, the manager informed us that dates were clearer and more obvious in the electronic system.

Best practice in treatment and care

- The provider followed relevant national institute of health and care excellence (NICE) guidance, for example, depression and anxiety, personality disorder, psychosis, high dose antipsychotics, prescribing, and aspects of the acute head injury guidelines. The provider offered a range of therapies recommended in the acquired brain injury pathway.
- Cambian Lodge used evidence-based approaches to assessment and care planning. For example, staff applied positive behaviour support approaches in care planning, and used START forms and the neuropsychological analysis of behaviour model to record and analyse challenging behaviour.
- Staff offered patients a range of therapeutic intervention to help support recovery. For example, the speech and language therapist (SALT) undertook specialist assessments for dysphagia (difficulty swallowing) and offered support identified in the acquired brain injury pathway. The SALT ran one-to-one sessions with patients to help them with speech skills and gain a better understanding of language and concepts. One patient wrote a book about his life, with help from staff. This showed his long journey to recovery and his plans for the future.

- The SALT also ran a weekly social skills group that five patients attended. Staff had identified a need for a reading and writing group, and there were plans to set this up.
- The psychologist offered a range of therapies that included cognitive behavioural therapy (CBT), eye movement desensitisation reprocessing (EMDR), compassion-focused therapy, schema therapy, and support for post-traumatic stress disorder (PTSD). The psychologist and a volunteer assistant offered patients support on behaviours such as substance misuse, offending, and stealing. They also ran a drugs and alcohol group.
- The psychologist achieved an 80-90% participation rate for her activities. The psychologist discussed the benefits of receiving psychological support with each patient and offered them support based on their specific needs. Patients generally preferred one-to-one sessions although family therapy and group sessions were also available. At the time of our inspection, six patients received one-to-one sessions with the psychologist. The psychologist occasionally offered individual sessions to relatives to help improve family relationships.
- The multidisciplinary team used a range of outcome measures to monitor progress and recovery that included the health of the nation outcome scale (HoNOS), the global assessment progress (GAP), the functional independent measure (FIM), the functional assessment measure (FAM), the communication checklist adult (CCA), the model of human occupation screening tool (MoHOST), and the daily living skills observation scale (DLOSOS). We reviewed the GAP, FIM and FAM scores, which showed improvement in patients by discharge.
- Staff participated in a range of clinical audits. For example, the psychiatrist participated in audits of certificates authorising treatment (known as T2 and T3). Staff completed weekly medicines reconciliation checks. The SALT undertook a 'communication-friendly' audit on a six-monthly basis.

Skilled staff to deliver care

- The full range of mental health disciplines provided input to the unit. The multidisciplinary team comprised a psychiatrist, a psychologist, a speech and language therapist, an occupational therapist, nursing staff and healthcare support workers. In addition, the unit had access to maintenance staff, a Mental Health Act administrator, a housekeeper and catering staff. The unit received pharmacy support from a local pharmacy. A pharmacist visited the unit monthly and a pharmacy technician visited weekly to undertake medicines reconciliation checks.
- Staff were experienced and qualified for their roles. Many staff were long-serving at the unit. The qualified nursing staff included specialist registered nurses in mental health and learning disabilities. All new staff received a mandatory induction and the provider had adopted the Care Certificate for all new care staff. The Care Certificate identifies a set of standards for care workers to adhere to, and includes education and training. All staff had access to role-specific training. For example, staff had completed training on dysphagia, epilepsy, intermediate life support training, sensory awareness and phlebotomy.
- The provider offered staff a wide range of training and development opportunities. Staff commented positively that the provider was "always offering courses." For example, the provider had agreed to support the psychologist in studying for a diploma in neuropsychology and the OT had started a course in brain injury with a specialist charity. One nurse had applied for phlebotomy and ECG training, the psychiatrist had applied for a course in neuropsychiatry, and the team leader had attended a team-leading course. The provider had supported the housekeeper to achieve her aspirations by supporting her to complete a national vocational qualification (NVQ) in business and administration. As well as undertaking housekeeping duties, she helped the reception desk and did administrative duties for Cambian Lodge and its sister site, Cambian Grange.
- As of February 2016, all staff had received appraisals. As of April 2016, 100% of staff were up-to-date with supervision, which they received on a four to six-weekly basis. Nurses attended monthly meetings for qualified nurses and the support workers had access to support workers' support group. The registered manager met the operations director on a weekly basis, had access to regular meetings with other registered managers for services run by Cambian, and received regular clinical supervision.
- Specialist disciplines had the opportunity to keep up-to-date with practice and had access to peer support. The SALT attended quarterly peer meetings,

and the psychologist had good contact with the provider's head of psychology and neuropsychologist. The psychiatrist had access to monthly peer group meetings, regular clinical lead supervision and received an annual appraisal from the medical director. The OT received clinical supervision from a senior OT on a six-weekly basis and local management supervision from the unit manager.

- The manager held a supervision matrix that showed full compliance with supervision for all staff. We looked at supervision records for three staff. These showed that supervision sessions took place at regular intervals. The supervisor took notes and both parties signed them. We saw records that showed supervision had taken place in response to a change in a worker's personal circumstances.
- Staff had access to weekly learning sessions (clinical fairs) run by different professionals, for example, the SALT, OT, and psychologist. On Fridays, staff had access to reflective supervision sessions led by different professionals. The manager encouraged all staff to attend and provided cover in the unit, if required. The leads recorded attendance and sought feedback and suggestions from staff for future sessions. We reviewed notes from the sessions that showed topics covered included epilepsy, behavioural therapy, dysphagia and roles in the multidisciplinary team. The MDT occasionally used the sessions to hold case conferences.
- The provider had clear policies and protocols for addressing poor staff performance and behaviour. The manager dealt with any issues promptly and effectively.

Multidisciplinary and inter-agency team work

- The hospital had a highly effective and well-coordinated multidisciplinary team. The MDT met weekly. All patients received routine MDT reviews on a monthly basis. The MDT was available for urgent reviews at any time and regularly responded to other requests such as requests for changes to section 17 leave as required. The advocate attended the unit on the same day as the MDT meeting and attended the meeting with the patient, if they requested it.
- Staff held handovers twice daily, in the morning and in the evening between shifts. The handovers that took place in the morning had multidisciplinary input on most days, for example, the psychiatrist or OT attended as well as nursing staff.
- The unit had good working relationships and regular contact with commissioners and care coordinators for each of their patients.
- Cambian Lodge had good links with the local safeguarding team, the health centre, the local college, support groups, for example, alcoholics anonymous, and local charities. Cambian worked with these agencies to help patients improve their health and increase their independent living skills.

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

- At the time of our inspection, only 44% of staff were up-to-date with MHA training. The manager had booked the remaining staff onto sessions scheduled for May, June and July.
- We completed a Mental Health Act monitoring visit in the week before the inspection. At that time, seven patients were detained under the Mental Health Act. We found that detention and renewal paperwork was up-to-date and completed correctly. The provider had useful guidance notes and checklists for checking MHA documents, which helped ensure accuracy and detect missing information. Notes showed that the mental health act administrator had followed up instances where approved mental health practitioner (AMPH) reports were missing.
- The responsible clinician had completed capacity to consent to treatment or refuse treatment assessments. The relevant treatment certificates (known as T2 and T3) were in place, attached to the patients' prescription charts. Notes showed that the psychiatrist informed the patient of the outcome of a second opinion approved doctor (SOAD) visit.
- Patients received information about their rights on admission and every three months. The information was available in pictorial format.
- The provider had a number of practices that helped ensure the safety and wellbeing of patients. For example, staff noted what patients were wearing when they went on leave. This helped is patients became absent without leave and needed to be found by staff or the police.
- However, we found some gaps in practice. There was no evidence of leave forms given to relatives. The new

Good

Services for people with acquired brain injury

responsible clinician (in post two weeks) had completed new assessments of capacity to consent to medication for all patients but they needed further detail. The provider addressed this immediately.
- All staff knew who the mental health act administrator was and could seek legal advice and support at any time.
- The provider commissioned Advent Advocacy to provide independent mental health advocates (IMHA) for its patients.

Good practice in applying the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS)

- At the time of our inspection, only 44% of staff were up-to-date with MCA and DoLS training. The manager had booked the remaining staff onto sessions scheduled for May, June and July 2016.
- One patient was subject to the Deprivation of Liberty Safeguards (DoLS). The patient's file showed a clear record of an assessment of capacity to consent to medication.
- Staff understood and complied with the definition of restraint in context of the MCA.
- During our inspection and during the MHA monitoring visit, we found that not all staff fully understood the concept of presumption of capacity. Some staff were aware of fluctuating capacity and assessed it on a decision-specific basis. Staff who were unsure sought advice from their colleagues or managers. However, we found all staff applied the principles in practice because they knew their patients well and supported their autonomy and independence. Furthermore, records showed good examples of capacity assessments and best interests decisions for a range of issues. For example, three patients had received capacity assessments associated with eating and drinking issues or managing their finances. One patient's file showed a best interest decision in relation to alcohol. Another file showed full MDT discussions that involved relatives and related to a patient with serious dental issues.
- The provider commissioned Advent Advocacy to provide independent mental capacity advocates (IMCA) its patients.
- The provider had a policy on MCA and DoLS that staff were aware of. Staff knew that the mental health act administrator provided advice on any issues related to the MCA and DoLS and that they could contact her anytime.

Are services for people with acquired brain injury caring?

Good

Kindness, dignity, respect and support

- During our inspection, we observed positive interactions between staff and patients. Staff spoke to patients as equals and treated them with respect. We saw that patients talked comfortably with staff and engaged in humorous banter. Staff respected patients' privacy and dignity, for example, they knocked on patients' bedrooms doors and waited for an answer before entering.
- Most patients described the staff as kind and supportive. One patient described the staff as 'great' while another described them as occasionally 'moody'. Patients were happy about the positive-risk taking approach the MDT adopted. For example, this meant that patients received unescorted leave, which made them feel trusted and responsible. Three patients we spoke with talked to us about their plans for the future.
- The patients' survey 2015 (which applied to both Cambian Lodge and Cambian Grange patients) showed that patients found staff polite and approachable, and patients felt staff treated them with respect.
- Most relatives described the staff as kind and supportive, for example, one relative said, "the staff have been brilliant. Another said, "without exception, staff have been absolutely lovely." Most family members felt involved in their relative's care. Staff invited them to meetings and kept them informed of their relative's progress. However, some relatives described experiences of poor communication with staff, which had left them upset.
- Several family members commented on the progress their relatives had made, for example, one relative said, "he has come on brilliant since he's been there," and another said that their relative had calmed down and their behaviour had improved.

- Relatives could visit the unit anytime. However, they could not enter the ward area or patients' bedrooms, which some relatives found difficult, especially as there were limited meeting facilities in Cambian Lodge.
- Staff knew the patients well. They had a good understanding of individual patients' needs. The advocate visited the unit weekly and raised issues or points for clarification with staff on behalf of patients and their relatives. He found that staff welcomed any questions and gave appropriate and timely responses.

The involvement of people in the care they receive

- Patients visited the unit before admission to become familiar with the environment, facilities and staff. All patients received a welcome pack on admission, which contained a dressing gown, a radio and toiletries. In the first three months of their admission, patients could also access a 'wow' fund of up to £300 to buy items for their room.
- The multidisciplinary team fully involved patients in assessments and care planning but records did not always show this clearly. For example, there were gaps for patients' signatures on some care plans. Patients received copies of their care plans, and some patients displayed these on their bedroom walls.
- Patients attended their MDT reviews and invited the advocate, if they needed support. Staff support to patients focused strongly on recovery and rehabilitation. Staff and patients took measured risks to promote independence and self-responsibility. For example, four patients managed their own medication on a daily basis and several patients received structured periods of unescorted leave. Some patients were on the flexible 'shop and cook' programme, for which they received a budget of £5 per day. Most patients cleaned their own bedrooms as part of their rehabilitation programme. Some patients helped clean the communal areas of the unit for therapeutic earnings.
- The provider invited patients and carers to complete surveys annually. We reviewed the patients' survey for 2015, which Cambian Lodge and Cambian Grange undertook together. Nine patients received surveys and eight patients completed them. The combined results showed that patients generally felt positive about the unit and their care. The provider had produced a summary and action plan to follow up on any issues identified in the surveys, and discussed them at staff and patients' meetings.
- Patients had access to weekly community meetings. Patients also had access to daily morning planning meetings to discuss the plans and activities for the day. We observed an informal morning meeting during our inspection visit. This took place in the lounge. A support worker facilitated the meeting. Four patients attended, later joined by another two patients. Patients discussed their plans for the day. We observed good interaction between the patients and staff. It was clear that patients were at ease.
- Patients had access to advocacy services provided by Advent Advocacy. The advocate attended Cambian Lodge weekly on Tuesdays. As the advocate was new to Cambian Lodge, he spent time in the lounge area to get to know the patients and encourage interaction. The advocate acknowledged that access to advocacy services outside the weekly drop-in sessions needed improvement. The service was looking at this.
- Staff encouraged patients to maintain contact with their families and facilitated long- distance home visits. In the 2015 patients' survey (for Cambian Lodge and Cambian Grange), patients reported that they maintained contact with their relatives and invited them to meetings. Staff invited relatives to multidisciplinary team meetings and care programme approach (CPA) meetings.
- Relatives did not always know what support was available to them and gave mixed views about carer support from Cambian Lodge. Some relatives had attended sessions with the psychologist, either on a one-to-one basis or as part of family therapy with the patient. Cambian Lodge had held relatives' forums in the past but they had poor attendance because some families lived some distance away from the unit, and some relatives found it hard to visit the unit at set times because of their own daily schedules. Cambian Lodge recognised the need to improve support to families and had plans to offer carer support differently. Cambian Lodge planned to offer relatives a one-to-one 30-minute telephone consultation with the psychiatrist or the psychologist on a weekly basis. We saw a draft copy of a leaflet promoting the new service.
- The provider did not use advance statements (patients' wishes about their treatment) but staff applied the principles in care planning.

Good

Services for people with acquired brain injury

Are services for people with acquired brain injury responsive to people's needs?
(for example, to feedback?)

Good

Access and discharge

- The provider reported bed occupancy rates of 92% for the period September 2015 to February 2016. At the time of our inspection, the bed occupancy rate was 100%. Patients placed at the unit came from across the country because there were few specialist units for patients with acquired brain injury.
- The provider had a thorough referral, assessment and admission process. This involved review, assessment and discussion of all referrals to assess the suitability of the service for the patients' needs. Discussions involved regional managers, registered managers, clinical staff and medical staff.
- The provider completed pre-admission assessments that involved staff from Cambian Lodge. The care team reviewed all the available information before a patient's admission. The psychiatrist always saw the patient on the day of their admission.
- The multidisciplinary care team focused on recovery and discharge. Patients and relatives we spoke with talked positively about their plans for the future. Cambian Lodge had discharged one patient in the past twelve months and five patients in the past two years. At the time of our inspection, there were no delayed discharges. However, discharge planning often took a long time because commissioners struggled to find appropriate step-down placements. There was regular liaison between staff, the commissioners, the patients and their relatives throughout the discharge planning stage.

The facilities promote recovery, comfort, dignity and confidentiality

- The unit had two floors. There was a reception and multi-purpose room on the ground floor outside the airlock. The reception was also the staff office and opened into the ward area of the unit. There was a kitchen, a dining room, a lounge and activity area, and a laundry in the communal area of the unit. The kitchen was for staff only. Staff locked the laundry for safety reasons. The office for the psychologist and speech and language therapist was located next door to the staff office and locked when not in use. The lounge and activity area opened out to the garden that had a smoking area.
- The unit had a lift that staff kept locked for safety reasons. The unit had an assisted bathroom that was in good condition and felt homely. All the ensuite bedrooms were on the first floor. Also located on the first floor was an occupational therapy (OT) kitchen. This was a locked facility for safety reasons but patients could access it day or night for snacks and drinks with staff supervision. The provider planned to make some safety modifications to the OT kitchen so that it could give patients their own key.
- The unit had a clinic room on the ground floor. It did not contain an examination couch but staff saw patients in their own bedrooms if they wished to lie down. If required and appropriate, staff and patients could use the fully equipped clinic room at Cambian Grange.
- There were three ensuite bedrooms on the ground floor and five on the first floor. One patient showed us his room. It had an ensuite bathroom and was very spacious. The patient described it positively as his 'bedsit'.
- The unit was very small but it was homely and adequate for eight patients. The main issue was the limited meeting facilities with just one meeting room outside the locked area. This meant that visitors could not always get access to a meeting room. This meant they had to conduct visits in the reception area or find somewhere offsite. At the time of our inspection, no visitors could enter the locked ward area. Some patients and relatives found this restrictive.
- There was no payphone for patients but they could have their own mobile phones. Patients without a mobile phone could use the ward phone. Patients could use the psychology office or OT kitchen for privacy, if they were available.
- The unit had dedicated chef and kitchen staff who cooked the meals fresh daily. In August 2015, Ashfield District Council awarded Cambian Lodge a food hygiene rating of five (very good). The 2015 patients' survey for

patients at Cambian Lodge and Cambian Grange showed that patients liked the food offered but asked for more choice and more access to their favourite foods.

- The kitchen staff displayed the seasonal four-weekly menu in the dining room. They offered hot meals at lunch and dinner times and a range of light snacks. The menu included fortnightly theme nights, for example, West Indian food, Chinese, Indian, or Italian. Patients received their evening meals between 4.30pm and 5pm but had access to supper at around 8pm. Healthy eating featured strongly in menu planning. The menu included a RAG (red, amber, green) rating to indicate how healthy the food was. The chef attended community meetings every month and asked for feedback on the meals.
- Staff encouraged patients to develop or improve their independent living skills. For example, although the kitchen staff provided lunch and an early evening meal, patients were responsible for breakfast and supper, supported by staff. Patients could also shop and cook for themselves, for which they received a budget of £5 per day.
- Patients had access to drinks and snack at all times of day and night although they had to ask staff for access to the kitchen for safety reasons. Staff ate meals with the patients, which further improved the relationships between staff and patients.
- Patients could pursue activities of their choice and the 2015 patients' survey for both Cambian Lodge and Cambian Grange showed that most patients enjoyed the activities offered.
- The service strongly promoted community inclusion and actively sought opportunities for patients to engage in community-based activities. Examples of activities patients liked included horse-riding, thai chi, attending the local disco, social club and pub, going to the cinema and park, and playing basketball, football and pool. Patients could attend college, undertake voluntary work or attend specific support groups, for example, alcoholics anonymous. One patient had paid work in a local café. A noticeboard displayed information about local events and cinema listings.
- Some patients worked at Cambian lodge and received therapeutic earnings. Cambian Lodge staff and patients could access some of the facilities at Cambian Grange, the sister unit nearby such as the meeting rooms, the garden and the activity room. Staff planned and held some activities jointly with Cambian Grange staff and patients, for example, basketball and gardening.
- Staff drew up specific care plans to help patients safely undertake activities that posed potential risks to them, for example, a patient with alcohol issues visiting the pub, and a patient engaging in betting. Most of the patients enjoyed playing scrabble but staff restricted this to three days a week. This was because patients liked to play it a lot, were competitive and got into arguments.
- The unit had a vehicle for supporting patients with activities, escorted leave, appointments and long-distance visits. Staff encouraged patients with unescorted leave to use public transport and access community facilities as much as possible. We found examples of patients using the train to visit their families.
- Patients said they were happy with the facilities in the unit. Patients could personalise their bedrooms. They held the keys to their rooms, subject to risk assessment and their personal preferences.

Meeting the needs of all people who use the service

- The unit was accessible to people requiring disabled access. For example, there was a ramp at the entrance, doors and corridors were wide, communal rooms were free from clutter and obstacles and there was an assisted bathroom on site.
- Patients who smoked had access to a smoking area in the garden. Two patients had smoking plans they had agreed to and signed.
- Staff supported patients' individual communication needs. The speech and language therapist assessed patients' individual communication needs and developed support plans. At the time of our inspection, none of the patients required specific interpreters. However, most patients benefited from easy-read information. The unit had developed a range of information leaflets in easy-read format and used easy-read and pictorial formats throughout the unit. For example, the lounge displayed the time, date and weather in large font with pictures. The four-weekly menu was in pictorial format. There was a range of

Good

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easy-read leaflets about the roles of the staff team. The provider had an easy-read complaints leaflet but it had not displayed it around the unit and staff were not sure if patients had copies.

- Staff completed dietary preference sheets for each patient on their admission and passed them to the kitchen staff. Kitchen staff took into account patients' food preferences and individual needs when planning and preparing food. These informed the menus and the preparation of the food. We saw laminated versions of dietary requirement sheets displayed in the kitchen for patients with swallowing difficulties. Staff ordered patients their individual choice of takeaway on Saturdays.
- Staff noted patients' religious needs in their files and supported patients who wished to attend church.

Listening to and learning from concerns and complaints

- Cambian Lodge reported five complaints in the twelve months to February 2016. Three complaints were not upheld. Two complaints about staff behaviour were partially upheld. No complaints reached the Parliamentary and Health Service Ombudsman.
- The provider, Cambian Learning Disabilities Midlands Limited had a detailed complaints procedure. However, we found that until recently, Cambian Lodge had not followed the procedure in full. We became aware of this before our inspection when we found no records of complaints made by a relative over the past two years. Staff sometimes dealt with complaints informally but did not always keep records.
- At the time of our inspection, the manager had started to address this issue. He had developed a spreadsheet to log informal complaints. We reviewed the informal complaints log. This showed eight informal complaints made during the two months to 3 May 2016. The log showed a brief description of the complaint, action taken, and whether the complaint was upheld. We saw examples of complaints that led to changes in practice, for example, staff introduced a new inventory sheet to help prevent mix-ups between patients' clothes. The informal complaints log noted complaints requiring formal action, which the manager dealt with separately, in line with the provider's policy.
- We also looked at the formal complaints logged on the provider's complaints system. We saw that staff had logged eight complaints since 3 February 2016. Staff had referred complaints to the relevant department such as Human Resources or Estates. They had shared appropriate complaints with other agencies such as clinical commissioning groups. The log showed the action taken and the outcome. It also noted the date staff sent the outcome letter to the complainant. We looked closely at one complaint record. This showed that the manager took appropriate and timely action. We saw two complaints that showed that staff followed the complaints procedure. We found that Cambian Lodge had started to deal with complaints in line with the provider's complaints procedure.
- The 2015 patients' survey (for both Cambian Lodge and Cambian Grange) indicated that patients knew how to make complaints. Relatives knew how to make complaints, and we saw examples of such complaints.
- The patients we spoke with said they knew how to complain and would feel confident to make a complaint. Some patients had made complaints in the past and reported that staff took them seriously and dealt with them appropriately.

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

Good

Vision and values

- Staff knew and agreed with the vision and values of the provider and of their own service. These were providing the highest quality of care to patients and enabling them to achieve their personal best.
- The team's objectives reflected those of the organisation. The unit had a strong focus on quality in service delivery and patient care. Staff were encouraged by the progress and recovery they saw in patients and felt motivated by the 'success stories'. They liked the perseverance the unit had with patients, which meant the service tried different approaches to help patients recover rather than give up.
- Staff felt valued by the provider, Cambian Learning Disabilities Midlands Limited. Staff found their own manager accessible and appreciated his open door policy and consistent approach. Staff knew the operational director, who visited the unit frequently.

Good governance

Good

Services for people with acquired brain injury

- The provider's systems and processes were effective in assessing and monitoring service delivery and the quality of care.
- Staff received timely supervision, appraisal and training. Staff training rates were good for most mandatory and role-specific training, however, only 44% of staff had received training on the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). The provider had booked all remaining staff onto sessions scheduled in May, June and July 2016.
- Shifts had enough staff, and usually more than the provider's minimum staffing level. Shifts had a range of skilled and experienced staff. Staff spent a large proportion of their time on direct care.
- The provider had a programme of audits that helped it assess practice and performance, and drive improvements. Staff participated in audits, as appropriate. Completed audits included those for premises, suicide, hand hygiene, person-centred delivery, service user involvement, staff personnel records, and Mental Health Act documentation. The provider submitted a schedule showing planned audits in 2016 for health and safety, infection control, suicide, medication, information governance, Mental Health Act and DoLS.
- The provider collated and analysed data to help gauge the performance of the unit, identify themes and trends and inform changes to practice. This included patient-level data used by the multidisciplinary team to assess risk and plan care; unit-level information used by the manager to make changes to practice and improve quality locally; and provider-level data reviewed by the corporate team to inform wider changes.
- Staff recognised and reported incidents and safeguarding concerns appropriately, in line with the provider's policies. Staff received debriefings following incidents and feedback from investigations, including any lessons learnt and changes implemented.
- Staff complied with MHA and MCA procedures and sought support, where necessary. However, not all staff fully understood the concept of presumption of capacity although they applied the principles in their practice.

Leadership, morale and staff engagement

- The provider undertook a staff survey annually. We reviewed the staff survey completed in 2015 that 15 staff responded to. The survey asked for staff's views on certain aspects of their roles such as team working, motivation and flexibility. The results were generally positive ranging from 53% to 93% for responses of 'good' or 'excellent'. The degree of responsibility experienced by staff in their roles scored very highly at 93%. This included staff feeling encouraged to take initiatives, having important tasks delegated to them, having the opportunity to learn and grow, and taking ownership of their work. The theme of rewards scored the lowest at 53%. This included getting recognition for performing well, being offered opportunities for individual growth, and receiving praise for good work. Staff's positive comments focused on making a difference to patients' lives and seeing them make progress. Areas for improvement included pay and opportunities for progression.
- There had been a recent change to the staff team at Cambian Lodge. The registered manager went on maternity leave in February 2016 and an interim manager covered the post. The previous responsible clinician had left and his replacement had been in post for a few weeks. Some staff had been concerned about the impact the changes might have had on staff morale. However, the staff team spoke positively about the new leadership and staff morale remained good. Staff described a well-functioning, supportive and stable team with good leadership. Staff expressed strong motivation and commitment to patient care.
- Staff felt well looked after and felt managers supported them personally and professionally. Staff received a range of training and development opportunities. Staff also received support for any long-term conditions, pregnancy, and family or personal issues. One staff member said it was "the best environment I've ever worked in."
- The provider encouraged staff to give feedback on services and suggest areas for improvement. Staff had access to a number of forums for sharing their views and any issues that included one-to-one supervision, peer groups, clinical fairs and reflective supervision sessions.
- Staff knew how to raise concerns and were familiar with the whistle blowing process. Staff felt confident in speaking up and felt managers listened to them. Staff were equally open with patients and relatives when something went wrong.

Commitment to quality improvement and innovation

Good

Services for people with acquired brain injury

- Cambian Lodge was a member of the independent neurorehabilitation provider alliance (INPA). INPA is a group of independent specialist health care providers who wish to ensure the delivery of excellent care in quality environments by trained and experienced staff. INPA completed an inspection in 2015. They found that the site was clean and fit for purpose, patients seemed content and were engaged in meaningful activity, staff were welcoming, and the unit had a good atmosphere.
- Cambian Lodge was a member of the UK rehabilitation outcomes collaborative (UKROC). This was a Department of Health-funded initiative to develop a national database for collating case data that would inform a payment by results tariff for acquired brain injury services.

Outstanding practice and areas for improvement

Outstanding practice

Healthy eating featured strongly in menu planning. The menu included a RAG (red, amber, green) rating to indicate how healthy the food was.

Patients received a welcome pack on admission. It contained toiletries, a bathrobe, and a radio. Patients also had access to a 'wow' fund of £300 in the first three months of their stay for any other items they wanted.

Patients had the opportunity to work at the unit as part of their rehabilitation, for which they received therapeutic earnings. Patients also had access to paid and voluntary work in the local community. For example, one patient worked in a café.

The care team offered relatives 30-minute telephone consultations with the psychiatrist or the psychologist on a weekly basis. This was in response to poor attendance at carers' forums because many relatives lived some distance away from the unit.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure staff are up-to-date with training on the Mental Health Act, the Mental Capacity Act and the Deprivation of Liberty Safeguards.
- The provider should ensure it follows correct policies and procedures for dealing with complaints.
- The provider should ensure that staff have a good knowledge and awareness of the Mental Capacity Act, best interests decisions, and the decision-specific application of capacity to consent.
- The provider should ensure care records reflect patient involvement, and best interest decisions.