Cambian - Oaks Hospital

Quality Report

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

Ratings

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

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

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

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 Oaks hospital as **good** overall because:

- Following our inspection in March 2016, we rated the services as good for safe, responsive, caring and well led. Since that inspection we have received no information that would cause us to re-inspect these key questions or change the ratings.
- During this most recent inspection we found the service had addressed the specific issues that had caused us to rate effective as requires improvement following the March 2016 inspection. However we identified further issues which caused us to maintain the rating of requires improvement for this key question.
- Patient records were not always complete and accurate in relation to patients health needs. There were discrepancies in information relating to patients physical health which could cause confusion and created a risk of patients receiving inappropriate care and treatment. There was not always evidence to account for omissions in patient records.
- Mental capacity assessment and best interest forms were not fully completed to show how decisions had been reached. Expired Mental Health Act treatment forms which had been superseded had not been removed from current patient records.
- One patient's care plan made no reference to a daily goal sheet they had in place that staff were expected to complete. In addition, the information within this differed to what was in the patient's care plan. Another care plan contained details of interventions the service did not provide but this error had not been identified by staff.
- Positive behavior support plans were not in use at the service however there were plans to introduce these.

However:

- Although there were discrepancies within different areas of patient records, from our discussions we found staff were knowledgeable and consistent about patients support needs.
- There was a strong multidisciplinary working relationship between staff at the service which we saw in practice. There were good relationships between staff and external stakeholders and agencies.
- Staff had access to additional specialist training and there were opportunities for professional development. Staff had regular supervision and felt supported in their roles. New staff undertook a structured induction program and a period of shadowing on commencement of their employment.
- Staff were knowledgeable about the Mental Capacity Act and the Mental Health Act and training was mandatory for these subjects. The service kept the use and application of these Acts under review.
- Staff participated in clinical audits to help assess and improve service delivery. Staff worked in accordance with best practice and used recognised outcome models to measure clinical effectiveness.

Summary of findings

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Summary of this inspection

Background to Cambian - Oaks Hospital

Cambian Oaks Hospital is a 36 bed hospital for men with mental health needs and other associated conditions, specialising in psychiatric mental health rehabilitation. It provides a service to patients who are detained under the provisions of the Mental Health Act and to informal patients who have voluntarily consented to receive treatment there.

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

The hospital consists of two separate units called the House and the Lodge. The House can accommodate 16 patients and at the time of our inspection there were 15 patients. Fourteen were detained under the provisions of the Mental Health Act and one was an informal patient. The lodge can accommodate 18 patients and at the time of our inspection, 18 patients were there, all of whom were detained under the provisions of the Mental Health Act.

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

The hospital has been inspected by the Care Quality Commission on seven previous occasions.

Our inspection team

The team that inspected the service consisted of one Care Quality Commission inspector. A Mental Health Act reviewer was present on the first day of the inspection undertaking a review of the Lodge which was reported separately to this inspection.

Why we carried out this inspection

We undertook this inspection to find out whether Cambian Oaks hospital had made improvements to their long stay/rehabilitation mental health services for working age adults since our last comprehensive inspection of the hospital in March 2016.

We last inspected the Cambian Oaks hospital in March 2016, where it was rated as good overall. We rated the service as good for 'safe', 'caring', 'responsive' and 'well led' and as requires improvement for 'effective'. At that inspection, we found two breaches of the following regulations:

Regulation 11: Need for consent

Regulation 17: Good governance

As a result, we told the trust it must take the following actions to improve long stay/rehabilitation mental health services for working age adults:

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

Summary of this inspection

The provider sent us an action plan setting out the steps they were taking to meet the legal requirements of the regulations.

At the March 2016 inspection, we also found some areas where we advised the hospital should take further action to make improvements. These did not constitute a breach of regulations. These were:

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

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, we reviewed information that we held about long stay/rehabilitation mental health services for working age adults. This information suggested that the ratings of good for safe, caring, responsive and well led, that we made following our March 2016 inspection, were still valid. Therefore, during this inspection, we focused on the whole key question of whether the service was effective. We did not review all of the recommendations we made following our March 2016 inspection as these will be followed up at the next comprehensive inspection.

This inspection was unnannounced which meant the provider was not aware before our visit that we would be attending. During the inspection visit, the inspection team:

- visited both the House and the Lodge at the hospital and observed how staff were caring for patients
- spoke with two patients who were using the service
- spoke with the registered manager and head of care for the hospital
- spoke with eight other staff members; including nurses, occupational therapist, psychologist, support workers and administration staff
- received feedback about the service from two commissioners
- spoke with an independent mental health advocate
- attended and observed one patient's care review at a multidisciplinary meeting
- Looked at six patient's care and treatment records,
- Looked at two staff personnel files and staff training records
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

We offered all patients using the service at the time of our inspection the opportunity to speak with us and two chose to do so.

One patient expressed some concerns about their medication and we arranged, with their consent, for the manager to speak with them about their issues which they did. The patient also wanted to speak with their solicitor and advocate which the staff promptly facilitated for them. Another patient spoke positively about the service and the improvements they had made since their admission. They felt the treatment they had received had significantly helped with their mental health.

The manager provided us with feedback from a patient survey the service had undertaken in January 2017 with 19 respondents. The lowest scoring positive responses rates were 63% and 68% in relation to whether patients received sufficient information to understand their diagnosis and what they could expect from the service. The highest scoring responses at 100% positive were in relation to the suitability of the environment; availability of activities, contact with friends and family and involvement and attendance at care plan reviews and meetings.

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

At the last inspection in March 2016 we rated safe as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services effective?

Requires improvement

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

- Patient records were not always complete and accurate in relation to patients health needs. There were discrepancies in information relating to patients physical health which could cause confusion and created a risk of patients receiving inappropriate care and treatment. There was not always evidence to account for omissions in patient records.
- Mental capacity assessment and best interest forms were not fully completed to show how decisions had been reached. Expired Mental Health Act treatment forms which had been superseded had not been removed from current patient records.
- One patient's care plan made no reference to a daily goal sheet they had in place that staff were expected to complete. In addition, the information within this differed to what was in the patient's care plan. Another care plan contained details of interventions the service did not provide but this error had not been identified by staff.
- Positive behavior support plans were not in use at the service however there were plans to introduce these.

However:

- Although there were discrepancies within different areas of patient records, from our discussions we found staff were knowledgeable and consistent about patients support needs.
- There was a strong multidisciplinary working relationship between staff at the service which we saw in practice. There were good relationships between staff and external stakeholders and agencies.
- Staff had access to additional specialist training and there were opportunities for professional development. Staff had regular supervisions and felt supported in their roles. New staff undertook a structured induction program and a period of shadowing on commencement of their employment.

Summary of this inspection

- Staff were knowledgeable about the Mental Capacity Act and the Mental Health Act and training was mandatory for these subjects. The service kept the use and application of these Acts under review.
- Staff participated in clinical audits to help assess and improve service delivery. Staff worked in accordance with best practice and used recognised outcome models to measure clinical effectiveness.

Are services caring?

Good

At the last inspection in March 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services responsive?

Good

At the last inspection in March 2016 we rated responsive as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are services well-led?

Good

At the last inspection in March 2016 we rated well-led as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating

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.

The service had a Mental Health Act administrator who received and scrutinised Mental Health Act documentation. They collated Mental Health Act information in a patient register they had developed. This was used to monitor the application of the Act and ensure patients' detentions were in accordance with the law and reviewed as necessary. Staff could seek advice about the Act from the administrator and a copy of the Code of Practice was accessible to staff.

All staff were required to undertake mandatory training in the Mental Health Act. At the time of our inspection 86 out of 99 staff, which equated to 87%, had completed this training. The remaining staff had been booked on the next available course which was scheduled to take place in May 2017. Fifty eight out of 77 eligible staff, which equated to 75%, had completed additional updated Code of Practice training with the remainder booked in for upcoming sessions.

The responsible clinician assessed a patient's capacity to consent to treatment on, or soon after, admission and provided the relevant authorisation dependent on the patient's capacity and choice. As part of a separate mental health act review at the time of our inspection, the Mental Health Act reviewer found discrepancies relating to medications listed on the two out of five authorisation forms. These issues were rectified during our inspection when we brought them to the manager's attention.

The Mental Health Act administrator completed Mental Health Act audits twice a year and we saw evidence that where issues were identified, these were acted upon.

The service had a system in place for planned Section 17 leave. Staff explained patient's rights under the Act to them on admission and at regular intervals. Patients had contact with and access to their advocates and solicitors. An independent mental health advocate attended the hospital on a regular basis. Staff alerted them about newly detained patients and they were able to attend care reviews and other meetings a patient may request their support with.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff were required to undertake mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of our inspection 86 out of 99 staff, which equated to 87%, had completed this training.

Staff had a sound practical knowledge of the Mental Capacity Act and were able to state whether any patients lacked capacity in certain areas which corresponded to the information in the patient records. Staff said the doctor would be the primary person to undertake a capacity assessment although this would be a joint undertaking with input from others.

However, we identified shortfalls in completion of Mental Capacity Act documentation. Two capacity assessments and best interest recording forms had areas where key information was omitted. This information included sections for family members' views and the justification for proposed care and treatment. The best interest forms had not been signed by the attendees and nothing was recorded about when the decision should be reviewed. This information was a requirement for completion of the form. The pertinent information relating to these decisions was captured elsewhere such as in care program approach meetings and notes in the patient's care records. These showed family members and relevant persons had been consulted and decisions were being regularly reviewed.

A the capacity assessments and best interest forms had not been fully completed as required, these documents in themselves did not provide an accurate record to evidence how the decision had been reached.

At our last inspection of March 2016 we identified that staff had not adhered to the principles of the Mental

Detailed findings from this inspection

Capacity Act in relation to administration of covert medication. At this inspection we found sufficient improvement had been made in relation to this and to help prevent recurrence.

Independent mental capacity advocates were accessible and available from the local advocacy service. Records evidenced their involvement to aid decision making for patients. Records of all current capacity assessments and best interest decisions relating to patients were kept on a spreadsheet which allowed staff to have oversight of how the Act was applied.

Capacity and consent was referred to in patients care records where applicable. For example, patients had signed to authorise consent to share, or not to share, information with other parties. Care plans stated where patient's had been assessed to lack capacity to make a decision in certain areas.

No patients at the hospital were subject to a Deprivation of Liberty Safeguard authorisation.

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

At the last inspection in March 2016 we rated safe as **good.**Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We looked at six patients' care and treatment records. Assessment information was present in all records which included a pre admission assessment, a nurse assessment and a doctor's assessment. Staff completed an initial eight week care plan which was amended and added to as they got to know the patient. This incorporated the patient's personal, psychosocial, mental health and rehabilitation needs. The records of one patient admitted in February 2017 included an initial care plan dated October 2016 but staff were unaware of when this plan originated. The care plan included objectives the service could not meet which the manager and head of care confirmed. The plan had been reviewed and signed by various members of the staff team but they had not identified the erroneous information. This was rectified by the second day of our inspection as it was discovered the information had been inadvertently included from the patient's previous placement.

One patient's care plan referred to a 'positive behaviour support plan'. This was not present in the patient's care records and was kept separately in the nurse's office. It did not contain the name of the patient and there was no evidence of the patient's involvement. The document did not fit the criteria of a positive behaviour support plan and instead contained several behavioural goals for the patient. At our second visit this document had been rewritten to include more information and renamed as a 'daily goal sheet'. The service did not use positive behaviour support plans to help assess and reduce behaviour which challenged. The provider was introducing the use of these once all staff had completed updated managing actual and potential aggression training.

Some staff had also compiled a 'behaviour management plan' to help another patient with specific health needs. Staff were aware of the document as they told us about it when discussing the patient and we saw the latest completed one. However, there was no reference to the behaviour management plan in the patient's care plan which meant it may not be clear when and how this should be used.

We saw evidence of care plans that were detailed and included involvement of the patients. All plans were regularly reviewed. Information about how staff should help manage the patient's behaviours was contained

within the care plans or risk information. A recent patient survey undertaken in January 2017 showed 84% of respondents felt they were aware of and informed about their care, treatment and support.

Staff assessed patients' physical needs as part of their admission and monitored this on an ongoing basis in accordance with individual need. Each patient had a physical health file which included a physical health care plan, documented physical observations, health appointments, and test results. Physical healthcare was incorporated into each patient's overall care plan. One patient said staff undertook regular health checks and they were able to access a GP and other healthcare specialists without problem.

Documentation relating to patients' physical health was conflicting as information in physical health folders did not always match patient's care plans. We looked at the physical health records for six patients. Three gave differing information about the frequency which staff should undertake observations. For example, one patient's physical health folder stated they should have monthly blood tests and be weighed weekly but their care plan stated six monthly blood tests and weight taken two weekly. Another patient's records stated they needed daily blood glucose monitoring. However, an entry in their daily notes from a specialist nurse stated monitoring was not required but this information had not been updated in the physical health records. Where there were gaps in the records of physical observations for patients, such as missing temperatures, blood pressure readings or weights, there was often no evidence to indicate why these had not been taken. The manager and head of care said this may be where patients had refused to have their observations taken however with no information recorded it was not possible to confirm this.

Although we found discrepancies in documentation, staff we spoke with were knowledgeable when talking about patients and their needs. Staff knew about patients' physical health conditions, care and treatment needs and were consistent when they talked about what support they required. However, our findings had identified that patient records did not always contain a complete and accurate account of patient's needs and their care and treatment. This was acknowledged by the manager. This meant there was a risk that patients may receive inappropriate treatment due to differing information for staff to refer to, although we did not any identify instances where this had occurred.

Each patient had three paper based files which included care plan information, physical health information and Mental Health Act information. These records were stored in lockable cabinets in secure rooms accessible only to staff. Care plans were also kept electronically so staff were able to access these online too. Staff told us they had no issues accessing and locating information.

Best practice in treatment and care

The service worked in accordance with best practice and guidance. Managers met to discuss updates and new guidance, for example from the National Institute of Health and Care Excellence, in regional clinical governance meetings and internal governance meetings within the service. Staff said such information and updates were cascaded down to them in team meetings where they could discuss them and was also shared via emails and memos.

Psychological therapy was available to patients. Different therapies included cognitive behavioural therapy and dialectical behaviour therapy which are recognised good practice treatments recommended by the National Institute of Health and Care Excellence. One patient was positive about how their psychology input had helped them make considerable improvements to their mental health. The psychologist had recently introduced case formulation sessions which are a process to help aid staff understanding in relation to complex patients. Staff were very positive about these sessions and said it helped them gain a better insight of the patient and learn and implement new techniques. The intention was to make case formulation an ongoing process.

Patients were registered with a local GP following admission. Records showed patients had access to various other healthcare services, for example dietitians, dentists, diabetes nurses and others, to help meet their individual needs. Staff had recently implemented a document called a health improvement plan which helped capture information to identify any nutritional or hydration needs.

Staff used outcome measurements to help monitor clinical effectiveness. Occupational therapists used standardised tools to assess a patient's abilities and identify areas of

need. These included use of a daily living skills observational scale to assess functional performance, use of the model of human occupation screening tool and other tailored assessments. The occupational therapists had recently undertaken some further training on the model of human occupation screening tool delivered by one of the tool's designers. Staff rescored assessments on a regular basis so any improvement or regression could be identified and addressed. Outcomes were shared regularly at a governance level and between other services.

Occupational therapy staff attended meetings with peers where they could discuss items such as new therapies and changes to the therapy program. Similar meetings took place with the psychology staff to ensure that current treatments were aligned with best practice and guidance.

The provider had recently introduced a quarterly audit tool which had been designed to simplify the audit process and replace existing monthly audits. The manager and head of care were supported by staff to complete these to ensure all staff were involved in the process. Audits covered a number of areas which included; health and safety, infection control, consent to treatment, medication and care files. We looked at the last two audits in 2017 and saw that where shortfalls were identified, action plans and timescales were in place to address these. The audits had not identified any issues with care records similar to the ones we found which suggested the process may not have been fully robust.

Skilled staff to deliver care

There was a range of skilled staff who worked at the service. The team included; a registered manager, head of care, mental health nurses, consultant psychiatrist, speciality doctor, occupational therapists and therapy assistants, psychologists and psychology assistants, team leaders, support workers, administration staff and housekeeping staff.

Head office, and the hospital administrator at local level, kept a record of staff registered with professional bodies and details of when their registration was due for renewal. This helped to ensure staff skill and practice was kept up to date.

All staff undertook a period of induction on commencement of their employment. We looked at the personnel files of two recently employed staff who were a nurse and support worker. Both contained an induction workbook which was aligned to the competencies set out in the care certificate. The care certificate was launched in March 2015 and although not a statutory requirement, it consists of an identified set of standards that health and social care workers adhere to in their daily working life. There was evidence of progression towards the competencies as some were signed off as completed by senior staff. The nurse's personnel file had a preceptorship induction pack which showed additional competencies they had attained in this role. New staff also undertook a period of shadowing where they worked alongside their peers to gain an understanding of their role.

Since our last inspection the head of care had designed a spreadsheet to gain better oversight of staff supervisions as we identified that monitoring was not robust. Staff received annual appraisals and supervisions every four to six weeks. They said they found these supportive and helpful in gauging their own performance. Staff could discuss any issues informally with their senior without having to wait for formal supervision. We saw evidence of regular supervisions in the personnel files along with file notes used between formal supervisions to record pertinent information. Group supervisions were held on a weekly basis and staff were free to access these as they felt necessary. The compliance rate for staff supervision and appraisal was 92%.

Staff performance issues were addressed appropriately. The manager told us that this could include additional training or increased supervision dependent upon the issue. The provider had systems in place to address other aspects of poor performance by alternative means, such as through disciplinary procedures if necessary.

Staff were appreciative of the range of additional training they were able to access. They told us about, and training records showed a variety of developmental training on offer. This included courses in suicide and risk, phlebotomy workshops, electrocardiograms, anti-harassment and bullying and dual diagnosis amongst other subjects. We saw evidence of a number of these courses available until December 2017 with various staff booked on to them. There were opportunities for staff personal development and managers encouraged this. Some staff told us about specialist topics they had studied, or had the option to study, in more depth that were of interest to them and beneficial to their role. For example, distance learning courses in dementia awareness and diabetes

management. A training needs analysis had been completed which identified further training which would be useful for different staff groups. Although staff were positive about the training, some felt it would be beneficial to have more face to face training as opposed to electronic learning due to the lack of interaction with this method

Multi-disciplinary and inter-agency team work

Multidisciplinary meetings were held each week whereby each patient's care was reviewed on a four weekly cycle. With consent from one patient, we attended their care review within one of these meetings. Where patients chose not to attend, they had the option of seeing the consultant at a later time or they could pass on their views to a staff member or advocate to put forward on their behalf. At the meeting we attended, the team was made up of the professionals involved in the patient's care and included the responsible clinician, speciality doctor, psychologist, occupational therapist, nurse and the hospital manager. Staff told us this was usual practice and in addition other individuals may attend such as other professionals, family members and advocates. During the meeting each professional gave an overview of their recent interactions with the patient, fully involving the patient in the discussion. There was talk about the patient's holistic needs including physical and mental health, medication, rehabilitation progress and goals for the next four weeks. On conclusion of the meeting, the team and the patient agreed a set of actions to work towards.

The multidisciplinary team held a morning meeting each day which included representation from all staff areas. We attended a morning meeting attended by seven staff and found this to be very comprehensive and included input from all present. The team discussed a wide range of issues including current patient information including risks, physical health, discharge and medication and any environmental concerns. Staff read out requests that had been written by patients and agreed actions from these. The meeting helped to ensure staff were aware of any patient issues and were kept up to date with current information relevant to all areas of the service. Records were kept of the meetings so that staff could refer back to these.

At the time of our inspection, the consultant psychiatrist was leaving their employment at the service and a new consultant had commenced and was undergoing a handover period. In the multidisciplinary meeting we attended, the current consultant introduced the new consultant to the patient and explained that they would be taking over responsibility for their treatment. The new consultant was also meeting informally with patients during this handover period. This helped to ensure there were processes in place to maintain continuity of care for patients. Staff told us they received detailed handovers at each shift change so that they were fully aware of the needs of the patients.

Staff spoke positively about the multidisciplinary team and felt this was an asset of the service. Team leaders and support workers had been involved in some multidisciplinary meetings which was informative as it helped them understand why certain decisions were made and gave them an insight into the different professionals input. One staff member said a recent 'multidisciplinary team open day' was held for staff and patients to meet the different disciplines and promote greater understanding about different roles. They said feedback had been positive about this.

Staff told us about, and we saw examples of, joint working between professionals to aid patient's treatment. For example, we saw a specific care plan that had been developed jointly between a patient, a psychologist and an occupational therapist. Different disciplines told us about peer meetings that took place at a provider level which allowed them to meet their counterparts at other services and form positive working relationships.

Staff also had effective relationships with a number of external agencies. These included voluntary agencies, commissioners, local colleges and businesses. We asked for feedback from some stakeholders involved with commissioning with the service. The feedback we received was positive with regards to the communication and joint working with the service.

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

A Mental Health Act reviewer visited the hospital as part of this inspection. They reviewed detention documents for the detained patients and completed a Mental Health Act monitoring visit at the Lodge.

We spoke with the Mental Health Act administrator who was also the provider's lead in this role for the North East area. The administrator had completed a university course in mental health law and practice and was confident about

the process for receiving and scrutinising documents and seeking legal advice where necessary. They collated Mental Health Act information in a patient register they had developed. This register included key information such as; admission and section expiry dates, expiry dates of medication authorisations (known as T2 and T3 forms) tribunal dates, dates that legal rights were due to be explained to patients and other necessary information to help monitor application of the Act and ensure patients' detentions were proper.

The service had a system in place for planned section 17 leave. Documentation identified the restrictions placed on the patient and the level of escort required. Information included in the forms related to identified risks within patient's care plans. Patients were given a copy of their leave forms. Where patients failed to return from agreed leave, staff were knowledgeable and consistent about how they would deal with this in accordance with policy.

The Mental Health Act administrator supported staff with any queries they may have in relation to the Act; particularly in areas they may not be fully familiar with or use frequently. Staff we spoke with said they were able to seek advice and support and gave examples of doing so in the past. There was a copy of the Code of Practice accessible to staff and this could also be accessed online via the staff computers.

All staff, both clinical and non-clinical, were required to undertake mandatory training in the Mental Health Act. This was done in conjunction with Mental Capacity Act and Deprivation of Liberty safeguards training. At the time of our inspection 86 out of 99 staff, which equated to 87%, had completed this training. The remaining staff had been booked on the next available course which was scheduled to take place in May 2017.

At our last inspection of March 2016, we identified that not all staff had received training in the April 2015 updates to the Mental Health Act Code of Practice. Following that inspection, the registered manager had compiled a training package about the updates which she was delivering to all clinical staff. The content of the training reflected the key changes to the code of practice including new guidance on restrictive practices, interface between the Mental Health Act and Mental Capacity Act and the new guiding principles. Fifty eight out of 77 eligible staff, which equated to 75%, had completed this updated training with the remainder booked in for upcoming sessions as necessary.

The provider's policies had been reviewed and updated to reflect the 2015 Code of Practice updates. This helped ensure staff were working in accordance with current practice.

The responsible clinician assessed a patient's capacity to consent to treatment on, or soon after, admission and provided the relevant authorisation depending on the patient's capacity and choice. As part of the separate Mental Health Act review at the time of our inspection, the Mental Health Act reviewer looked at five patients medicine cards. They found discrepancies relating to medication on two of the authorisation forms. These issues were rectified by the responsible clinician during our inspection when we brought them to the manager's attention. We also found two patient's records still had previous medication authorisation forms in place although they had been superseded. As they had not been removed which was stated as a requirement, this could have led to confusion for staff.

The Mental Health Act administrator completed audits twice a year. We looked at the most recent Mental Health Act audit and saw evidence that where issues were identified, these were acted upon. The audit had highlighted some gaps in patients having their section 132 rights explained to them by staff. To address this, urgent memos had been sent to the nurses who had acted upon the information to ensure patients had their rights explained in accordance with timescales.

Staff explained patient's rights to them on admission and at regular intervals as was evident in care records. Patients told us about contact with advocates and solicitors and we heard staff supporting patients to make contact with their representatives, for example facilitating calls between a patient and their solicitor. The hospital had completed a patient survey in January 2017 and 89% of patients who participated were aware of the advocacy service. We spoke with an independent mental health advocate who attended the hospital on a regular basis. They said staff alerted them about newly detained patients and that they were able to attend care reviews, care program approach meetings and other meetings a patient may request their support with. They had no concerns with regard to their role and experience at the service.

Information was on display for patients informing them of advocacy services and also of their right to complain to the Care Quality Commission along with contact information.

There was one informal patient at the service who was free to leave the hospital when they chose. This was clearly recorded in their care plan and daily notes evidenced that the patient left at will without restriction.

Good practice in applying the MCA

The Mental Capacity Act 2005 is legislation designed to provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. All staff, both clinical and non-clinical, were required to undertake mandatory training in the Mental Capacity Act and Deprivation of Liberty safeguards. This was done in conjunction with Mental Health Act training. At the time of our inspection 86 out of 99 staff, which equated to 87%, had completed this training. The remaining staff had been booked on the next available course which was scheduled to take place in May 2017.

Staff we spoke with demonstrated a sound understanding of the Mental Capacity Act and were able to state where patients currently lacked capacity in certain areas. For example where a patient may need support to manage their finances. This corresponded to the information in the records for these patients. Staff told us about actions they would take if they suspected a person may lack capacity. This included consultation with relevant professionals and advocates where necessary. The doctor would be the primary person to undertake a capacity assessment although this would be a joint undertaking with input from others. Nursing staff were aware they were able to undertake such assessments if necessary in the circumstances. No patients at the hospital were subject to a Deprivation of Liberty Safeguard authorisation. Staff had understanding of these safeguards.

At our last inspection of March 2016, we identified that staff had not adhered to the principles of the Act in relation to administration of covert medication. Since then, the registered manager had involved an independent mental capacity advocate and held a further best interests meeting for the patient this related to and which we saw evidence of. The provider's policy for covert medication had been updated to reference the need for an independent mental capacity advocate where necessary. We saw a 'lessons learned' bulletin that had been circulated to staff highlighting the procedure to follow for covert medication. Staff supervisions had also incorporated discussions about capacity and covert medication. This helped to embed the required practice and procedures.

Independent mental capacity advocates were accessible and available from the local advocacy service. We saw evidence of another instance where staff had involved an independent mental capacity advocate as part of a best interests decision for a patient.

The service had devised a spreadsheet to keep a record of all current capacity assessments and best interests decisions relating to patients. This showed what the decision was that had prompted the assessment, whether a best interests meeting had taken place, the outcome and when this had last been reviewed. This allowed staff to have oversight of how the Act was applied with regards to patients as well a prompt for patients' capacity to be kept under regular review.

Capacity and consent was referred to in patients care records where applicable. For example, patients had signed to authorise consent to share, or not to share, information with other parties. Care plans stated where patients had been assessed to lack capacity to make a decision in certain areas and what support they needed in relation to this.

Although we found good reference to patient's capacity, we identified shortfalls in completion of documentation. We viewed two capacity assessments and best interest recording forms for one patient. We found areas where key information was omitted. For example, some questions which required an explanation to qualify the answer had been ticked only; such as the section to support a finding that the person had not been able to weigh up the information. Other missing information included sections for family members views and the justification for proposed care and treatment. These best interests forms had nothing recorded about when the decision should be reviewed and in what circumstances. This information was a requirement for completion of the form. Although these details were not present, we saw that pertinent information relating to these decisions was captured elsewhere such as in care program approach meetings and notes in the patient's care records. These showed family members and relevant persons had been consulted and that decisions were being regularly reviewed. However, as the capacity assessments

Long stay/rehabilitation mental health wards for working age adults

Good

and best interest forms had not been fully completed as required, these documents in themselves did not provide an accurate record to evidence how the decision had been reached.

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

Good

At the last inspection in March 2016 we rated caring as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs?

(for example, to feedback?)

Good

At the last inspection in March 2016 we rated responsive as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

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

Good

At the last inspection in March 2016 we rated well-led as **good.** Since that inspection we have received no information that would cause us to re-inspect this key question or change the rating.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all documentation in relation to each patient's care and treatment is accurate, complete and contains relevant information including any decisions or changes to care. This includes records of any assessments which may be undertaken. Where there are errors and omissions in information, the provider must have systems in place to identify and address these accordingly.

Action the provider SHOULD take to improve

- The provider should ensure that the service continues to work towards and embed the implementation of positive behaviour support plans for patients who may require these.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Staff did not always maintain an accurate, complete and contemporaneous record in respect of each patient, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17 (1) (c)