Fountains

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?	Requires improvement
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 the Fountains as good, however:

- The patient bedrooms we checked were not all clean and tidy. Eleven of the 32 bedrooms had a combination of issues including dirty bedding, missing bed linen, dirty mattresses, old pillows and one bedroom had a significant leak from the bathroom area into the bedroom.
- There was a blanket restriction in place that had not been individually risk assessed.
- We found that although the National Institute for Health and Care Excellence guidance was being implemented in monitoring of physical health care needs, monitoring the use of antipsychotic medication and Clozapine monitoring there were no audits in place to check the implementation of this with individual patients.

We found;

- Systems were in place to monitor and manage patient risks. Assessments were carried out in a timely manner, regularly reviewed and reflected in care plans.
- Staff delivered person-centred therapeutic interventions to patients to support them to achieve improved independence and wellbeing. Staff interactions with patients demonstrated personalised, collaborative, recovery oriented care planning and involvement.
- Staff ensured patients were engaged with assessments, care plans and discharge arrangements.
- The service was proactive in promoting equality and diversity and meeting the specific needs' of vulnerable groups of patients.
- Staff had an understanding of the Mental Capacity Act 2005 and the Mental Health Act 1983. They assessed mental capacity and supported patients to make decisions where possible. Staff routinely referred patients for advocacy support if they lacked the capacity to do so themselves.
- Staff received mandatory training, specialised training, supervision and appraisals.
- Patients were protected and safeguarded from avoidable harm and incidents were appropriately reported to the local authority. Staff received specialised training, supervision and appraisals.
- Patients were positive about the care and treatment they received and staff behaviours were responsive, respectful and caring. Staff involved patients in the care and treatment they received.
- The service had physical health checks in place.
- There was a programme of ligature risk assessment in place along with policies to support the management of this risk.
- There was an open and transparent culture within the hospital. Staff were aware of the provider's incident reporting and complaints processes.
- Staff received debrief sessions after incidents and feedback when things had gone wrong and there was a multi-disciplinary approach to care and treatment.
- Patients were able to access a range of psychological therapies and activities.
- Patients were positive about the care they received. We observed staff treating patients in a respectful manner. Patients were involved in their own care, and attendance at multi-disciplinary ward rounds was facilitated.
- Outcome measures were in place to assess the effectiveness of treatment.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good 	See main body of the report.

Summary of findings

Contents

Good

Fountains

Services we looked at ;
Long stay/rehabilitation mental health wards for working-age adults.

Summary of this inspection

Background to Fountains

Fountains hospital is a 32-bed rehabilitation unit. It provides care and treatment to males aged 18 and over with a primary diagnosis of mental illness and a high dependency level. The service provides care to patients who need a slower pathway to engage with rehabilitation. This includes patients with challenging behaviour, forensic histories and substance misuse issues. The service accepts informal patients and those detained under the Mental Health Act. At the time of this inspection, there were 31 patients. 30 patients were detained under the Mental Health Act. The unit includes five self-contained flats used to help prepare patients to return to the community.

There is a registered manager and a controlled drugs accountable officer in place.

CAS Behavioural Health Limited is the registered provider for the Fountains.

The Care Quality Commission (CQC) registered the Fountains to carry out the following legally regulated services/activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury.

The most recent CQC inspection was in September 2015 when a comprehensive unannounced inspection was carried out (inspection report published 3 June 2016). The service was found to be good overall. The Mental Health Act reviewer from the Care Quality Commission last visited in July 2016 and no actions were required.

Our inspection team

The team that inspected the service comprised two Care Quality Commission inspectors and two specialist advisors. These were a pharmacist and a mental health nurse.

Why we carried out this inspection

We inspected this service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information that we held about the location, and sought feedback from patients.

During the inspection visit, the inspection team:

- visited the hospital, looked at the quality of the environment and observed how staff were caring for patients;
- spoke with 10 patients who were using the service and spoke briefly with five other patients during the walk round the hospital;

Summary of this inspection

- spoke with the interim manager and the director of operations who was also the responsible individual for the hospital;
- spoke with 12 other staff members; including doctors, nurses, support workers, occupational therapist, psychologists and the Mental Health Act lead;
- spoke with an independent advocate;
- attended and observed one staff hand-over meeting, two multi-disciplinary morning meetings and two patient review meetings;
- attended a clinical governance meeting;
- collected feedback from one patient using comment cards;
- looked at six care and treatment records of patients;
- looked at five staff personnel files;
- carried out a specific check of the medication management; and reviewed 31 medicines cards;
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with ten patients and received one comment card from a patient.

Patients told us that staff were respectful, caring, kind and understanding. They also told us staff were interested in their wellbeing and about staff being involved and being supportive of them.

They told us that they felt safe at the Fountains.

Most patients we spoke with said they were fully involved in the care. They received information about the hospital and information about their rights. Most said they were involved in decisions about their care and had been involved in discussions about their care plans. They also said they had access to an advocate.

Most patients we spoke with said they were involved in lots of activities and groups. There were enough staff and activities were rarely cancelled. Some patients did say they wanted more activities planned at the weekend.

Patients told us that there were many ways for them to ask questions or raise concerns, which included community meetings.

Whilst most patients were positive about their stay at the Fountains and being involved in discussions about their discharge, others raised concerns about moving on and delays.

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?

Requires improvement 

We rated safe as requires improvement because:

- The patient bedrooms we checked were not all clean and tidy. Eleven of the 32 bedrooms had a combination of issues including dirty bedding, missing bed linen, dirty mattresses, old pillows and one bedroom had a significant leak from the bathroom area into the bedroom.
- There was a blanket restriction in place that had not been individually risk assessed.

However:

- Staffing levels were appropriate to meet the needs of patients. The manager had adequate resources to employ regular bank staff who were known to patients and staff. As a result, section 17 leave and other activities were rarely cancelled.
- Risk assessments were completed for all patients and were regularly reviewed and updated.

Are services effective?

Good 

We rated effective as good because:

- Staff had received an annual appraisal of their work performance and regular managerial supervision. Staff had also received the mandatory training they required.
- Patients assessments of need, progress and care plans were reviewed regularly in multi-disciplinary meetings.
- Staff were appropriately skilled to deliver care and there was a range of staff disciplines that contributed to care and treatment.
- There was effective multidisciplinary and interagency teamwork.
- There was good access to psychological and occupational therapies.
- Outcome measures were used to review patient progress and the quality of care delivered.
- There were good systems and audits in place to administer medicines safely and they carried out physical health checks on patients. High doses of antipsychotic medication was being monitored and reviewed.
- Patient records were complete and accurate and care plans and risk assessments had been completed and reviewed regularly.

Summary of this inspection

- The Mental Health Act and Mental Capacity Act and associated codes of practice were adhered to.

However:

- We found that although the National Institute for Health and Care Excellence guidance was being implemented in monitoring of physical health care needs and monitoring the use of antipsychotic medication and clozapine monitoring but there were no audits in place to check the implementation of this with individual patients.
- Figures provided for managerial supervision for qualified nurses did not indicate that this type of supervision was clinical supervision.

Are services caring?

Good

We rated caring as good because:

- Patients were treated with dignity, compassion and respect.
- Patients reported staff attitudes were caring, approachable and available.
- Patients using the service were involved in their care and treatment.
- Patients had regular 1:1 sessions with key workers and were invited to attend their patient review meetings.
- Patient meetings were held weekly at the hospital and they had access to independent advocacy.
- A patient representative attended clinical governance and unit meetings.

Are services responsive?

Good

We rated responsive as good because:

- There was active discharge planning from the point of admission and staff supported patients in their transition.
- The hospital maintained contact with care coordinators and commissioners including those for out of area patients.
- Patients had access to a range of facilities. This included a clinic, a gym area, a music area, activity rooms, an information technology room and outdoor space.
- Patients were supported with their cultural, spiritual and religious needs and this was assessed on referral and admission to the hospital.
- There was good management of complaints and information was readily available for patients.
- Interpretation and translation services were provided at the hospital as well as access to easy read materials and tools.

Summary of this inspection

Are services well-led?

Good

We rated well-led as good because:

- The service was well led by the manager.
- There was a commitment towards continual improvement.
- The service was responsive to feedback from patients, staff and external agencies.
- The service had governance structures in place.
- Staff morale, job satisfaction and staff engagement was good.
- There was clear learning from incidents.
- The service had been proactive in capturing and responding to patients concerns and complaints and patients were involved in aspects of the service.
- Key performance indicators were used to gauge performance of the team.

However:

- Workforce race equality standards had not been adopted to work towards improving workforce race equality.

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 Mental Health Act reviewer last visited the Fountains unannounced in July 2016. No actions were required and it was reported there was good application of the Mental Health Act at that time.

All staff had received training in the Mental Health Act and code of practice. Staff we

spoke to showed a good understanding of the Mental Health Act and its application. A training programme had been devised for new starters. Support for staff was available through a Mental Health Act administrator on site. There were regional Mental Health Act leads that were available and they reported to the operations directors.

The Mental Health Act administrator submitted data to the quality leads that ensured checks were in place in relation to the application of the Mental Health Act. Regular audits and supervision of more junior staff were completed by the Mental Health Act administrator on site to ensure compliance with the Act and documentation standards. There were completed audits, which demonstrated their compliance with the Mental Health Act and code of practice. This included audit checks by the regional Mental Health Act administrator twice per year. In addition to that, the Mental Health Act administrator on site completed a monthly activity schedule recording details of holding powers used, Section 62 (urgent treatment authorisations) and second opinion appointed doctor requests. The Mental Health Act administrator had three ongoing schedules for renewal of detention, Section 132 patient rights and consent to treatment requirements. These were updated on a regular basis and highlighted when paperwork had been given to the Responsible Clinician; the nursing team then recorded when completed paperwork had been returned.

Patients had access to independent mental health advocates who visited the hospital regularly. The advocate confirmed they had regular contact from the Mental Health Act administrator They told us there was a good relationship with staff and that patients were

fully aware of the advocacy service and their role. The advocates attended the multi disciplinary meetings as well as the Mental Health Act tribunals and best interest meetings. Information about the independent mental health advocacy service was clearly displayed in the hospital patient areas. Staff were aware of how to refer patients to advocacy services. The service were able to provide another service should individuals not be happy with the service provided.

Risk assessments were completed before the patient went on leave and copies of the S17 leave forms were kept in the reception area to facilitate patients leave with original copies being kept in the patient files. Patients were offered a copy of their leave form.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received training in the Mental Capacity Act. The Fountains stated that there were no Deprivation of Liberty safeguards applications in the last six months, as at 1 July 2017.There was a policy and procedure in place in relation to the Deprivation of Liberty safeguards.

Staff we spoke with displayed a good understanding of the Act and the five statutory principles. They were applying the Act in practice. Capacity assessments were in place and completed on admission and where appropriate and reviewed regularly. Care records we reviewed contained assessments that were appropriate and decision specific. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interest and best interest meetings were in place.

The manager was aware of where to get advice regarding the Mental Capacity Act and the Deprivation of Liberty safeguards.

Detailed findings from this inspection

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Requires improvement	Good	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Requires improvement

Safe and clean environment

The patient bedrooms we checked were not all clean and tidy. Eleven of the 32 bedrooms had a combination of issues including dirty bedding, missing bed linen, dirty mattresses, old pillows and one bedroom had a significant leak from the bathroom area into the bedroom. This was brought to the attention of the interim manager who immediately took action to change the mattresses, replace bedding and pillows, and moved one patient into a spare room until the work had been completed to rectify the leak. All patient bedrooms were checked again with the interim manager on the second day of the inspection and the areas of concern above had been actioned with bedding, pillows and mattresses replaced. The day after the inspection, we were provided with evidence of daily audits and checks being put in place. These included room cleaning schedules and deep clean audits as well as consultation with patients of colour choices to repaint their bedrooms. Some patients kept their own bedrooms clean and tidy.

Domestic staff kept their equipment in locked cupboards and we saw cleaning schedules of the main areas within the hospital. The cleaning schedules were completed and up to date which demonstrated the units were cleaned regularly. Infection control procedures were in place and hand-cleaning gel was available on entrance to the hospital. In addition, staff prompted visitors to use the hand gels before accessing the unit. An identified infection control lead completed an audit of the environment in July 2017. The manager informed us that this did not address areas within patient bedrooms.

Every patient had their own private bedroom with en-suite facilities. Patients had a key to their own bedroom, which they could access at any time.

The layout of the unit did not allow staff to fully observe all parts of the wards. However, this was mitigated by use of risk assessments, mirrors, regular checks and good relational security arrangements. There was a visible staff presence on the ward and a designated staff member was responsible for carrying out observations. We saw these observations being completed.

The unit had a ligature risk assessment in place, which was completed annually and updated where necessary. The assessment was comprehensive and provided actions to manage or remove ligature risks, which could be used by patients to cause serious self-harm. There were some ligature points within individual bedrooms. However, patients were allocated bedrooms following a risk assessment, which was regularly reviewed. Staff were also able to increase observation levels if they felt it was appropriate to keep patients safe. Following an incident, work had been completed to make safe the patients wardrobes areas as well as the purchasing of various ligature cutters which were readily available to staff.

Where possible staff had made all areas as safe as possible and replaced fixtures and fittings with anti-ligature fittings for example, anti-ligature toilet rails, anti-ligature shower, and collapsible curtain rails. The outside courtyard had some ligature points, for example, the courtyard fence and railings. These areas were staffed when patients accessed

the garden area. Galvanised metal waste covers had been fitted above a certain height to limit the use as a ligature point. Where risks had been identified in certain areas the risk assessment identified they were only accessible by staff so were non-patient areas. If patients were assessed as, a high risk then this would be care planned accordingly and items removed as identified in their care plan/risk assessment. Patient observations were increased for any patient deemed a current high risk of suicide. If the risk was deemed persistent then a referral back to commissioner to find a more suitable placement for the individual would be completed.

Staff were provided with personal alarms and some visitors to the ward area were provided with personal alarms. Visitors were instructed in their use on entering the unit. Wall alarms in bedrooms and patient areas were also accessible. Alarms and security systems were checked regularly and maintenance records were in place.

Personal evacuation plans were in place for all patients as well as an emergency business contingency plan should this be required.

Fire tests were completed weekly and fire drills were implemented quarterly. A fire risk assessment was one day over being reviewed. This was completed during the inspection, and a copy provided to us.

Environmental risk assessment and equipment checks were in place and up to date. There was an internal property department team and health and safety managers to advise. An external health and safety management company provided external checks and reports in relation to water safety and asbestos registers. They completed internal checks at the fountains where all regulatory checks were noted, monitored and managed via a computerised reporting system. Repairs and maintenance were completed by qualified, accredited and vetted external contractors, which received all requests via a remote tracking system.

A property team attended operational meetings to discuss plans, progress and new ideas to better care for their patients. An example of this was where staff had reported the leak in one of the patient's bedroom. This had been reported at the morning meeting and the facilities manager had noted this and actioned it during our visit. They attended a facilities managers meeting monthly and a quarterly full estates meeting.

The hospital had access to fully equipped clinic rooms and had accessible resuscitation equipment with signage identifying the location. Drugs cupboards in the clinic room were locked and the allocated clinic nurse kept the keys. Fridge and clinic room temperatures were checked daily and logged, with no concerns noted. The resuscitation bag and defibrillator were kept in reception and were checked daily. The clinic room was kept tidy and equipment such as blood pressure monitor and weighing scales were available. Emergency drugs, such as adrenaline, were stocked and in date.

Safe staffing

The following staffing data was provided by the unit;

- between 1 March 2017 and 30 June 2017 there have been no shifts not filled by bank or agency staff to cover sickness, absence or vacancies
- for the same period there have been 83 shifts filled by bank staff to cover sickness, absence or vacancies 5% out of 1,456 shifts for support workers.
- the total establishment levels of qualified nurses, whole time equivalent (WTE) - 7.3
- total establishment levels nursing assistants (WTE) - 24
- total number of WTE vacancies for qualified nurses - 0.7
- total number of WTE vacancies nursing assistants – 0

Between June 2016 and June 2017 the Fountains had;

- total number of substantive staff - 67
- total number of substantive staff leavers in the last 12 months -4
- total % turnover of all substantive staff leavers in last 12 months - 6%
- total percentage of vacancies overall (excluding seconded staff) - 2%
- total percentage of permanent staff sickness overall - 8%

The Fountains did not use agency staff. There was a regular pool of bank staff that was available to cover annual leave, sickness and training. They had seven bank members of staff. Three of these were working through their induction programme. All of the bank staff received the same full induction programme that contracted staff received. This included two weeks of shadowed shifts, face-to-face training including observation and engagement training and e learning.

Long stay/rehabilitation mental health wards for working age adults

Good

The interim manager was able to adjust the staff needed for the unit in response to patients' needs' and activity on the ward. Staffing levels and the use of staff for observation were discussed daily in a multi-disciplinary team meeting. A dedicated staff member was allocated at these meetings to complete observations of patients and to manage any physical interventions if needed.

Staff were present in communal areas throughout the hospital and patients had time allocated with their named nurse in weekly key sessions.

Staff had access to on call managers and an on call rota was in place. The responsible clinician was on call as well as having access to a responsible clinician on call rota if needed to cover the hospital day and night. On each shift, there was a first aider and fire marshal/warden identified as well as a staff member who was trained in the management of aggression.

We checked five staff personnel files. There was a recruitment and selection policy in place. At the start of their recruitment process, staff completed a previous convictions declaration and then completed an enhanced disclosure and barring service checks. If any convictions were highlighted on the certificate, the manager completed a risk assessment to determine whether that person was suitable to work with the client group. Disclosure and barring service checks were completed every three years. Where staff were registered with the disclosure and barring service, checks were completed annually. All of the staff files we checked had these checks in place. All clinical staff members (nurses, doctors, occupational therapists, and speech and language therapists) provided their registration details at the start of the recruitment process, and they were checked on an annual basis.

Compliance with mandatory training was above 90%. There were regular mandatory training sessions available throughout the year. This allowed staff to access required training. Bank staff were also provided with the relevant mandatory training at the earliest opportunity. Managers had a training matrix in place to monitor training across the whole staff group. They ensured that all staff was able to attend.

Assessing and managing risk to patients and staff

We reviewed six sets of care records across the hospital. All patients had up to date, detailed risk assessments. Any new patients referred or admitted to the unit had a full assessment of risk completed and pre admission risk assessment completed.

The data of their incidents across the hospital for the last six months as at 31 May 2017:

- The total number of incidents of use of restraint for this period was 46.
- The number of different patients where restraint was used in this period was five.
- There was no use of seclusion or long-term segregation.
- There were no prone restraints of patients reported.
- There was no use of rapid tranquilisation.

The Fountains have a restrictive practice policy to review any restrictive practice and this links with their management of actual or potential aggression procedure.

Staff completed a management of aggression incident report form to report and review any restraint of patients. Staff viewed restraint as the last resort, with staff using de-escalation before any physical interventions. Staff told us they routinely used de-escalation techniques and we observed staff calming patients who were distressed. Staff was trained in the management of aggression training including how behaviour can escalate. The training identified strategies to de-escalate and this was achieved through theoretical work and scenarios using the least restrictive approach. Debriefs were provided to staff and patients post incident or could be facilitated immediately after the incident if needed.

A short-term assessment of risk tool was used to assess various risk issues that patients may present with. This was completed and reviewed every eight weeks or daily if needed. We observed that for some patients these were being completed daily as presenting risk issues appeared and or after every incident. An incident severity rating scale was also completed and included an antecedent, behaviour, consequences chart, and the function of the behaviour accompanied this. Positive behavioural support plans were produced for patients after a period of unstable behaviour and after reviewing the amount of short-term assessments of risk in relation to individual patients. These were discussed as a multidisciplinary team and all staff inputted into the positive behavioural plans with the psychologist taking the lead in this area.

Long stay/rehabilitation mental health wards for working age adults

Good

Training on the management of aggression and the use of restraint was delivered to all staff by the interim head of care and interim senior registered mental health nurse at the Fountains. Both had attended a two-week instructors training programme course in the management of aggression training in September 2016 and had cascaded training to all staff.

There were restrictions on patients within the service. The majority of these were individually risk assessed. Where a patient had identified risks related to the purchasing of illicit substances or dangerous items they may be subject to restrictions. These included being required to open post in the company of staff, supervised visits and being subject to a pat down or metal detector search when returning from leave. Some patients were also required to store identified items in a locker, which could only be accessed with staff. These items included lighters, razors, alcohol based aftershave and aerosol sprays such as deodorant.

The decision to impose these restrictions was taken by the multi-disciplinary team and reviewed in weekly ward rounds. There was a care plan to support the process and patients were informed why the restriction was in place. Some patients asked staff to support them when opening their post. This was so they could ensure staff were aware of hospital appointments and that these were booked into the ward diary.

However, there was a blanket restriction in place. A blanket restriction is a restriction that is routinely applied to the whole patient group without individual risk assessments to justify the need. Patients had 24-hour access to the patient kitchen for drinks, snacks and fruit. However, items such as cutlery were locked away and only accessible to patients when staff accompanied them. Staff we spoke with told us that this was due to the potential for items to be used as a weapon.

The provider had a reducing restrictive practice policy in place and there was a restrictive practice group that met to review restrictions that were in place. The policy required the unit to record restrictive practices on the local risk register. We found that individual restrictions had been captured. However, access to cutlery and kitchen utensils had not been identified as a blanket restriction. This meant that the restriction was not being reviewed.

Arrangements were in place for informal patients to leave the hospital and information was noted on the door to inform patients of the need to speak to a staff member to exit the building. This was observed during our visit.

There were policies and procedures in place for the use of observation and whereabouts of patients. Staff attended morning meetings and staff handovers where observation of patients was discussed. These meetings were documented and verbally handed over to staff that were unable to attend the meeting. This ensured that all staff was kept up to date around observation, risk and patient activity on a daily basis.

We checked 31 prescription charts. Of these, three prescription charts had doses, which were greater than 100% of British National Formulary doses for antipsychotics. Where patients had been prescribed greater than 100% of British National Formulary dose of antipsychotics, then monitoring had been completed in accordance with the guidance from the Royal College of Psychiatrists. All of the charts had an allergy status documented and photographs attached in order to correctly identify the patients. The responsible clinician was interviewed and was able to show that a risk/benefit analysis had taken place when prescribing and this was documented in the individual patients' notes.

The controlled drugs cupboard and register were both inspected. An audit trail was visible of medicines received and used. The clinic nurse had completed a daily balance check and all records were up to date. Both the nursing staff interviewed on the day was aware of the controlled drugs policy. Controlled drugs were audited by the hospital manager as the lead in this area, annual declarations and submissions were completed using the online tool.

Nursing staff completed medicines reconciliation on admission of new patients and medication received was checked against the prescription. The patients were then registered with a local GP surgery.

Rapid tranquilisation was rarely used, but monitoring sheets were evident in the notes on the occasions it had been used. Where patients had declined monitoring, it was documented that they had been visually observed for any adverse effects.

Independence in the use of patient self-medication was assessed across four stages according to the policy, and patients were gradually progressed from being

administered medication to gradually managing their own medication. Currently twenty-five patients had their medication dispensed to them. Four patients were at stage one of self-medication, where they were involved in the dispensing process. No patients were at stages two or three and two patients were at stage four, where they received a full week's medication at a time.

Physical health monitoring was completed, with blood tests and electrocardiograms documented in the notes. A side effect rating scale was completed by nursing staff every four months and discussed with the doctors when needed.

The prescriptions charts were checked against the consent to treatment forms; no errors or discrepancies were noted. The Fountains does not currently receive any visit from a pharmacist to complete any medication audits or highlight any prescribing issues. The nursing staff completed medication audits internally and errors were emailed to the staff concerned by the clinical lead as investigated and discussed accordingly.

Disposal of medication was done according to the policy and staff were able to provide documented evidence of nursing staff signing their drug disposal record to provide an audit trail.

The clozapine prescribing was clinically appropriate. There was monitoring of full blood counts and electrocardiograms had been undertaken where patients were prescribed this medication. Clozapine plasma levels had been taken and were within therapeutic levels. The responsible clinician was registered with the clozapine patient monitoring service.The pharmacy also sent weekly emails highlighting all individuals who require a clozapine prescription and bloods. Senior support workers ensured that all clozapine bloods were taken and sent in a timely manner.

The pharmacy highlighted any possible drug interactions and they sent any intervention reports for the attention of the responsible clinician. The intervention reports were assessed within a traffic light system and ranged from possible contra indications to advice for physical monitoring. There were no issues identified in relation to calibration of equipment.

Staff were up to date in all areas of safeguarding training with 99% of staff having completed this.

Staff facilitated patient visits from their children and young family members. Child visits were risk assessed and if appropriate, a member of staff would remain outside the room during the visit. There was a visiting room away from the main ward area. A visitor's policy was available for patients to access.

Track record on safety

CQC received no safeguarding alerts and eight safeguarding concerns in relation to Fountains in the last 12 months, as at 19 June 2017.

The interim manager was the identified safeguarding lead at the hospital. They attended the regional and clinical governance meetings and onto the corporate governance board meetings.

The Care Quality Commission received 10 notifications in relation to Fountains in the last 12 months, as at 19 June 2017. One of these was in relation to a Deprivation of Liberty, eight in relation to safeguarding notifications and one about a serious injury.

Managers reviewed their practices following incidents and looked at ways they could improve. These have included changes such as clinic nurses not being disturbed when dispensing medication, having separate boxes for patients stock and prn medication, having daily stock counts or using a highlighter pen on medication charts where medications sound the same for example bisoprolol and bisocodyl. There had also been changes to ensure hospital stock medications were counted weekly to highlight the need to order replenishments. Staff recorded dates of depot injections due both in the diary and on the whiteboard in the clinic to prevent these being missed. Managers ensured there were two nurses in clinic available on Mondays to help with signing out and checking of self-medication packs so that two nurses could check these against the chart. Managers had also looked at areas where there may be a potential for error such as patients being on self-medication packs but being on a controlled drug and this being placed in the pack rather than kept separately from the pack so it can be signed out each day.

Reporting incidents and learning from when things go wrong

All staff at the Fountains was required to report any incidents to the nurse in charge regardless of severity. Staff we spoke with was aware of how to report an incident. The

Long stay/rehabilitation mental health wards for working age adults

Good

nature of the incident determined what documentation was completed. Documentation included an incident form and/or incident data recording forms. The appropriate incident forms were completed and incidents involving patients were documented in their daily records.

The multi-disciplinary team reviewed submitted incidents monthly. This included the identification of themes and trends, monitoring of actions and the dissemination of learning. Incidents were also reviewed within local and regional governance meetings. Staff received feedback from incidents during handover and at daily meetings. There was a process to offer staff and patients debriefs if this was appropriate following an incident.

Learning from incidents was shared through the governance structure and in multi-disciplinary team meetings. We saw examples of learning that had been shared across the organisation, for instance a design of wardrobe had been decommissioned across the company in response to a patient incident. The provider had also introduced on-line personality disorder training for staff following an incident review.

Duty of Candour

Duty of candour is a statutory requirement that ensures services are open and transparent with patients and carers. This includes informing patients about adverse incidents related to their care and treatment, providing support and offering an apology.

All staff employed at the Fountains completed an achieve module on the Duty of candour, this also formed part of the safeguarding module training. Staff who was completing the care certificates also covered this in the duty of care and safeguarding modules. The Fountains had a positive reporting culture with effective investigation and lessons learnt which was shared across the hospital and wider organisation.

We reviewed an investigation report that identified the Duty of candour requirements and made reference to the actions that would be taken.

The Fountains had a Duty of candour policy and this was reviewed in the adult and risk governance meetings.

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

(for example, treatment is effective)

Good

Assessment of needs and planning of care

Patients received a full assessment on admission. The assessment process was multi-disciplinary and included a risk assessment, nursing and medical assessments, psychological assessments and assessment for occupational therapy. We reviewed six patient records. All of the records had relevant assessments in place. Assessments were comprehensive and were reflected in patients care plans.

Each of the patient records we reviewed had care plans in place. Care plans captured patient's personal, psychosocial, mental health and rehabilitation needs as well as care plans for any restrictive practices. They were recovery focused and developed with the involvement of patients, and where applicable family and carers. Short and long-term treatment plans and objectives were recorded. Care plans were reviewed monthly and as required in multi-disciplinary patient review meetings and in 1:1 sessions with patients.

All patients had received physical examinations and there was ongoing management of physical health needs.

Care records and assessments were available on paper and computerised formats, and were readily available for staff to access.

Best practice in treatment and care

The manager informed us in the information we requested before the inspection that the quality team reviewed the national institute for health and care excellence (NICE) website monthly. This was to check for updated/published guidance. Any new or updated guidance would be reviewed and any required action taken. This included updating any relevant policy and loading it onto their computerised system for staff to access. The adult risk and governance meeting would highlight the updated and or changed guidance and actions taken to ensure that registered managers were aware and apply the guidance to

practice within their hospital. Registered managers, clinicians and staff were responsible for the implementation of national institute for health and care excellence guidance to the practice.

Managers had a policy around the implementation of national institute for health and care excellence guidelines. We found that although the guidance was being implemented in monitoring of physical health care needs and monitoring the use of antipsychotic medication as well as clozapine monitoring there were no audits in place to check the implementation of this with individual patients. There was no clinical pharmacy input into the multi-disciplinary team to discuss national institute for health and care excellence guidance, drug interactions and prescribing issues. However, we saw evidence that the responsible clinician completed prescribing and monthly returns in relation to the number of patients on high dose antipsychotics, the number of off-licence medication used as well as medication alerts raised by the pharmacy used by the company. These audits were reviewed by the medical director and fed into the clinical governance system where necessary.

There were psychology and occupational therapies teams that inputted into care. Patients were able to access a range of psychological therapies including cognitive behavioural therapy, dialectical behavioural therapy, acceptance and commitment therapy, schema therapy, psycho educational therapy and mindfulness. The psychology team was also involved the assessment of referrals and in risk assessment and formulation. Psychology staff had their own section within care plans and worked with staff to deliver support. We saw one example of a patient with memory loss where the key worker had collaborated with psychology to create prompt cards.

Patients had access to a range of occupational therapy. These included cooking and life skills, yoga, men's health sessions, personal shopping trips, social groups and relaxation sessions. Occupational health completed functional assessments on each patient and contributed to the development of care plans. They worked with key workers to identify interventions that could be delivered to support the patient and their rehabilitation. We saw one example of a patient who was anxious about leaving the unit and accessing the community. The key worker and occupational therapy team used a graded approach and supported the patient to travel further from the unit each time he had leave. Patients had access to vocational college courses and access to voluntary work and work experience. These included volunteer work at a homeless shelter, gardening project as well as volunteer work at a local foodbank. During our visit, we saw patients were being encouraged to attend an external gym session.

The service used different outcome measures to monitor the progress of patient's rehabilitation. These were completed in the first four to six weeks of a patient being admitted to allow for initial observations and to allow patients to settle on the unit. They used a daily life skills observation scale to assess;

- how patients communicate,
- skills for shopping, budgeting,
- vocational work being undertaken,
- personal care and hygiene
- Two stages of cooking and preparing meals.

The occupational therapy team utilised the daily life skills observation scale, which was reviewed monthly in the ward round. Occupational therapists also used the model of human occupation screening tool. These were reviewed quarterly.

We attended two patient review meetings and these addressed access to community, social and rehabilitation activities. The occupational therapists attended the meetings to update and plan individual activities including rehabilitation with the patients. From these meetings we observed patients discussing their progress and or deteriorations in relation to travel into the local community and improvements in managing their finances as well as discussions to progress onto the management of their own medications.

Psychology used regular reviews of the short-term assessment of risk and treatability to produce graphs of patient progress at eight weekly intervals. The graphs highlighted where strength scores had increased and vulnerability scores decreased or if the reverse was happening. Baselines measures to capture wellbeing and the presence of distress symptoms were repeated six monthly and annually respectively.

Long stay/rehabilitation mental health wards for working age adults

Good

The service also used the global assessment of progress tool. The tool brings together assessments and scores from occupational therapy, psychology, nursing staff and medics. It provides an overall score. The global assessment of progress tool was reviewed quarterly.

The service had a schedule of monthly and quarterly audits, which covered care, health and safety/infection control, medication, consent to treatment and care files. As well as in house audits, there were peer audits carried out by other registered managers and heads of care from other hospitals as well as quality reviews by the quality team.

Although the hospital had many audits in place some of the audits did not highlight areas of improvement or sufficient checks in place. For example, the infection control audit did not identify any issues in relation to the dirty linen, dirty mattresses and pillows in patient bedrooms. Nor did the quality checks completed by their peers and cleaning audits did not identify any issues around these areas. However, the quality checks in relation to medication management were improved since the last inspection in 2015.

Staff completed audits on a monthly basis looking at various themes in relation to medication. The audits covered gaps in charts, reconciliations, reviews of as needed medications, temperatures of fridges, and the controlled drugs register was checked. Staff completed medication stock audits on a weekly basis as well as first aid checks and emergency equipment audits.

Physical health monitoring was completed, with blood tests and electrocardiogram results documented in the notes. A side effect rating scale was completed by nursing staff every four months and discussed with the doctors when needed.

All patients had their physical observations completed monthly as part of the health improvement programme. Recording of blood pressure, pulse, temperature, oxygen saturations and respirations were taken. Some of the patients had their physical observations carried out more regularly, daily and up to twice a day due to being on high dose medication and other physical health issues. The Fountains and the local general practitioner (GP) completed monitoring of physical health.

Blood tests were carried out by six phlebotomy-trained staff and were sent to local pathology laboratory for analysis to monitor clozaril /clozapine and entered onto the patient monitoring service.

Electrocardiogram tests were carried out on admission to check the heart's rhythm and electrical activity, and every 3 – 6 months, prior to a new medication being commenced and following a new medication being commenced. If there were any concerns or abnormalities with the electrocardiogram results, the responsible clinician would liaise with the general practitioner.

Urinalysis (test of urine to detect and manage disorders such as urinary tract infections, kidney disease and diabetes) was also carried out on admission and any abnormal results were discussed with the general practitioner.

All physical health needs and interventions were individually care planned. These included arranging appointments with dentists, opticians, chiropody and smoking cessation needs. Where a patient declined to attend the appointments, this would be clearly documented within the patient notes. Staff liaised with general practitioners and out of hours services if there were any concerns around a patient's physical health and followed any advice/recommendations from them.

We observed physical health was also reviewed monthly within the patient review meetings we attended.

Skilled staff to deliver care

A full range of mental health disciplines and workers provided input to the hospital. This included occupational therapists, psychologists, support workers, doctors and mental health and learning disability nurses. Staff were employed as therapy coordinators. There was a hotel services and administration team, including a medical secretary and a Mental Health Act administrator, a full domestic and kitchen team. Staff were experienced and trained for their role.

All staff was required to attend local induction on site where they shadowed more experienced staff for a minimum of two weeks. During the induction, staff had a comprehensive training schedule, which included online learning, face-to-face discussions, and induction workbook. New starters were monitored during their

induction and probationary periods. Regular supervision sessions were also maintained to support staff in their new role and to discuss any training or performance requirements.

All staff had regular managerial supervision with their line manager at least quarterly. The targets were for staff to receive four managerial supervisions per year. The supervision rate was 100% for all staff within the last 12 months.

There were no clinical staff where appraisal rates were less than 75% and the total number of permanent non-medical staff who has had an appraisal within the last 12 months was 86%. Data submitted stated that all of the qualified staff maintained their registration with professional bodies and continued to meet the standards required and this was evidenced at their time of revalidation. The data told us that all staff that was registered under a professional body either had revalidated or were working towards revalidation. Staff received group supervision and support regarding any complex risk issues from the psychologist.

Staff received the necessary specialist training for their role including;

- advanced fire marshal training,
- substance misuse,
- boundaries and restrictions,
- controlled drug competencies,
- schizophrenia and autism,
- case formulation,
- phlebotomy,
- additional independent mental health advocate and independent mental capacity advocate training to inform staff about their roles.

Poor staff performance was addressed promptly and effectively and policy and procedures supported this. The managers were able to confirm how poor staff performance was managed and this included supervision sessions with staff, and support from human resource team were any disciplinary action is needed. There was a recruitment and selection, staff policy in place.

Multi-disciplinary and inter-agency team work

There was a multi disciplinary team meeting every morning attended by the Mental Health Act administrator, administration, occupational therapy, and head of care/ manager, senior support workers, nurses, psychologists, responsible clinician and the medical secretary. We attended two of these meetings. They reviewed and discussed patients identified as a red risk, observation levels, and any specific patient issues. This included, for example, patient sleep patterns or any use of as required medication. The short term assessment of risk and treatability forms were discussed, patients monies, discharge visits to other locations, positive behaviour support plans, staffing, environmental issues, health and safety checks, visitors to the unit, advocacy support, patient appointments, meetings for the week, discharge paperwork and managers availability appointments, medication issues and audit actions, any other business.

Staff maintained contact with commissioners and care coordinators through phone calls, emails and letters. This included the care coordinators for out of area patients. We saw evidence of this in notes that we reviewed. Care coordinators were invited to attend ward rounds and review meetings and care programme approach meetings. When they were unable to attend, they were sent notes of the meetings and any updated care plans. The manager told us they had good links with commissioners and most care coordinators for patients in their care.

Adherence to the MHA and the MHA Code of Practice

The Mental Health Act reviewer last visited the Fountains unannounced in July 2016. No actions were required at that time.

All staff had received training in the Mental Health Act (1983) and code of practice. Staff we

spoke to showed a good understanding of the Mental Health Act and its application. A training programme had been devised for new starters. Support for staff was available through a Mental Health Act administrator on site. There were regional Mental Health Act leads that were available and they reported to the operations directors.

The Mental Health Act administrator submitted data to the quality leads that ensured checks were in place in relation to the application of the Mental Health Act. Regular audits and supervision of more junior staff were completed by the Mental Health Act administrator on site to ensure compliance with the Mental Health Act and documentation standards. There were completed audits, which demonstrated their compliance with the Mental Health Act and the Mental Health Act code of practice. This included audit checks by the regional Mental Health Act

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Good

administrator twice per year. In addition to that, the Mental Health Act administrator on site completed a monthly activity schedule recording details of holding powers used, Section 62 (urgent treatment authorisations) and second opinion appointed doctor requests. The Mental Health Act administrator had three ongoing schedules for, renewal of detention, Section 132 patient rights and consent to treatment requirements. These were updated on a regular basis and highlighted when paperwork had been given to the Responsible Clinician; nursing team then recorded when completed paperwork had been returned.

The manager discussed with us that one patient that had been transferred from a local NHS acute hospital without appropriate Mental Health Act section papers in place as well as no medication for his addiction. The manager promptly raised this and the patient was transferred back to the acute mental health hospital until this could be facilitated.

Patients had access to independent mental health advocates who visited the hospital regularly. The advocate confirmed they had regular contact from the Mental Health Act administrator They told us there was a good relationship with staff and that patients were fully aware of the advocacy service and their role. The advocates attended the multi disciplinary meetings as well as the Mental Health Act tribunals and best interest meetings. Information about the independent mental health advocacy service was clearly displayed in the hospital patient areas. Staff was aware of how to refer patients to advocacy services. The service were able to provide another service should individuals not be happy with the service provided.

Risk assessments were completed before the patient went on leave and copies of the Section 17 leave forms were kept in the reception area to facilitate patients leave and originals were kept in patient files. Patients were offered a copy of their leave form.

Good practice in applying the MCA

All staff received training in the Mental Capacity Act. There were no Deprivation of Liberty safeguards applications in the last six months, as at 1 July 2017.There was a policy and procedure in place in relation to the Deprivation of Liberty safeguards.

Staff we spoke with displayed a good understanding of the Act and the five statutory principles. They were applying the Act in practice. Capacity assessments were in place and completed on admission and where appropriate and reviewed regularly. Care records we reviewed contained assessments that were appropriate and decision specific. Patients were supported to make decisions where appropriate and when they lacked capacity, decisions were made in their best interest and best interest meetings were in place.

The manager was aware of where to get advice regarding the Mental Capacity Act and the Deprivation of Liberty safeguards application, as a patient had previously been under a Deprivation of Liberty authorisation.

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

Good

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Patients were treated and spoken to with dignity and respect and in a caring and compassionate manner. The full multidisciplinary team showed a good understanding of each patient's personal circumstances and needs. We observed staff knocking before entering patient bedrooms as well as asking patients' permission to come into their bedrooms.

We spoke with six patients on an individual basis and spoke with six more patients informally whilst observing and during the tour of the building. They told us that staff were caring, available and they felt safe.

Patients reported staff to be friendly, nice and approachable and were available to talk to. Patients told us that they had regular individual contact with their named nurse and when they had been on continuous observations staff had been as un intrusive as possible. Patients reported they were seen as an individual and that staff had knowledge of their likes and dislikes.

The involvement of people in the care they receive

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Good

The admission process informed and orientated the patient to the hospital. Staff provided information to patients (patients guide) on admission. New patients were orientated to the ward and introduced to staff.

We reviewed six care plans and records. They illustrated evidence of patient participation and showed that patient views were taken into account. We saw that patients were involved in decisions about their care at the patient review meetings we attended. The hospital had a patient representative that attended part of the clinical governance meeting we attended. The representative had consulted with other patients at the hospital to highlight and request particular issues or raise concerns or patient requests. Some of the issues raised were around a request for an outside graffiti wall, requests for staff to facilitate pool games in the evening, to advise on poor TV reception in patient bedrooms. The clinical governance team could provide immediate answers to some of the questions and concerns raised and others were noted and would be raised and discussed with the staff team.

Mostly patients told us that they felt involved in decisions about their care. Patients,

family members and carers were invited to attend patient review meetings where appropriate and patients were offered copies of their care plan if they wanted one. Patients were encouraged to maintain their independence as staff asked them if they wanted to participate in attendance at the local gym and in activities that were planned. Patients were actively involved in accessing advocacy and information was displayed. Patients were able to give feedback about the service they received, by giving their comments in a suggestion box, weekly community meetings and patient representative at the governance group. A patient and carer survey was completed on an annual basis. The last survey was completed in October 2016, 22 patients completed survey answering questions on a variety of themes for example environment and living conditions, staff, catering, family and friends, activities, complaints, advocacy, safeguarding and treatment and care.

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The results were analysed and report produced. From the most recent survey, patients reported:

- The location was safe, clean and had enough facilities.
- They liked their bedrooms and felt able to personalise their own private space.
- All said staff were approachable and felt that they are treated with respect.
- Good choice of food and drinks, 18% advised they did not like the food - food was an agenda item at the weekly community meeting for review.
- Happy with the visits they received from family and felt there was enough space though the room is small.
- Happy with activities on offer but felt they could be supported more with paid employment.
- They knew how to make a complaint and of those who had, all had received a response.
- Found the advocacy service supportive and helpful.
- All patients felt safe knew what to do and who to speak to if they were worried.
- Felt supported to manage their money.
- Felt involved in their care and treatment, had access to information to make informed choices, supported during their meetings.

Although there were no immediate actions from the most recent survey, should areas of improvement be raised (via either survey or community meeting etc.) the service would look at ways of working to implement the changes. There was evidence that actions had been implemented from the previous years' survey and improvement achieved. For example in the 2015 survey satisfaction around the provision of food was 64%. In response, the service had implemented healthy eating groups, supported patients to attend slimming clubs and consulted with patients on menus at patient community meetings. Satisfaction with the choice of food had risen to 72% in the most recent survey.

In addition to the surveys, there were weekly community meetings, patient review meetings; advocacy sessions, families (and patients) can feedback via care programme approach meetings, professionals meetings, and best interest meetings.

Some examples of change brought about via these forums have included:

- Takeaways
- Discussion on Ramadan
- Visit from aquatic specialist
- BBQ
- Group trips
- Trip to the fair

Long stay/rehabilitation mental health wards for working age adults

Good

- Pool table recovered and new cues.

Managers told us that on an annual basis, both patient and carer/parent surveys were distributed (where the patient allows contact with family). The survey looked at five different areas, staff, location, service, and suggestions for improvements. The results were analysed and report produced. From the most recent survey, it was identified that no one attended a relative support group. Previously, the service has attempted to generate interest in this area however, the response from carers was limited. As part of their service development plan, they were reviewing ways to address carer's involvement due to a change in the patient group at the Fountains. Patient review meetings are held every four weeks, patients are allocated a set time in which advocacy also attend to support the patient. Family members were welcome to attend these meetings to contribute to the patients care and treatment in agreement with the patient.

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

Good

Access and discharge

The Fountains accepted referrals from across the whole country. They accepted both NHS and private patients. Referrals came primarily from acute mental health wards and secure services. The Fountains provided a service to patients who needed a slower care pathway to facilitate their engagement with rehabilitation.

The service's admission criteria included patients with complex mental health needs, challenging behaviour, forensic history, and substance misuse and treatment resistance. Typical diagnosis included schizophrenia, schizoid-affective disorder, bipolar affective disorder, personality disorder and depression. The Fountains worked closely with commissioners to assess patients' suitability for longer-term rehabilitation. We saw one example of a patient who had been admitted following discussion with the local commissioning group. The Fountains had agreed to accept the individual on the basis that the patients' progress and suitability would be reviewed with the commissioners on a regular basis. The patient had improved since his admission and was making positive progress.

Potential patients had a pre admission assessment completed by the commissioning nurses. This document was then sent to the Fountains where a pre admission assessment form was completed. A full group of multidisciplinary team practitioners meet at the Fountains twice weekly to review the assessments. They would discuss if they could meet the needs of the patients before admission to assess the individual within a rehabilitation setting.

We saw records of patients that had been referred to the Fountains. These records identified that the patients suitability for rehabilitation was not always appropriate and refusal to admit patients was documented and appropriate agencies informed. This meant that the Fountains were considering and assessing referred patient's suitability for a rehabilitation facility. When the Fountains accepted the referral, short and long-term goals were addressed as well as initial care planning. The full assessment process included a risk assessment, nursing and medical assessments, psychological assessments and an assessment by occupational therapy. Assessments were in place and completed in all of the records we looked at.

The Fountains reported that their bed occupancy was 88.7% over the last six months, as at 1 June 2017. During our inspection there were 31 patients residing at the Fountains with one vacant bed.

Discharge planning was part of the care planning process. Care records we reviewed showed that discharge plans were discussed with patients. We spoke with three patients who were approaching discharge. Each patient had been involved in discussions with their key worker, local care coordinator and funding authority regarding suitable placements. One patient was due to visit the service he was being referred onto as part of his transfer pathway. One patient had a discharge-planning meeting booked to discuss their discharge back into the community and to identify required support. This included liaison with the patient's local GP and community mental health team. We observed a ward round in which discharge objectives and

plans were discussed with patients. Discharge planning was completed collaboratively with the patient and was a multi-disciplinary process including input from nursing, psychology and occupational therapy.

The Fountains reported an average length of stay of 939 days for their patients discharged in the last 12 months, as at 1 June 2017. Information we reviewed confirmed that between 30 September 2016 and 14 August 2017 there had been 12 patients discharged. Information provided before the inspection indicated the average length of stay for the current patients was 266 days. The manager confirmed that the length of stay would be around 30 months and this was sometimes dependent on the patient's mental health and relapse of their mental health.

Managers reported no delayed discharges as each patient's care pathway and discharge was carefully planned to meet the needs of the individual. There was always access to a bed for patients who may have been on leave. Patients were not moved between hospitals during their admission episode.

The hospital had made improvements to their access for appropriate patients into the hospital. This had been due to a patient being admitted and their mental health deteriorating. They had revised their pre-admission assessment form. When patients were accepted into the Fountains, any special requirements around funding were addressed with contingency plans agreed and in place. This was to ensure that should patients' mental health needs deteriorate and need to be transferred to an acute hospital setting when needed that this could be facilitated.

A commissioning nurse completed a pre admission form. All referrals were discussed within a multi-disciplinary meeting with time allocated twice weekly to assess if the Fountains could meet the patient's individual needs within a rehabilitation setting.

Staff worked with patients, care coordinators and commissioners to promote and facilitate discharge. We observed staff discussing and planning for patients to be discharged and facilitating necessary arrangements for patients to visit perspective placements. We saw evidence of discharge planning within care plans.

The facilities promote recovery, comfort, dignity and confidentiality

There was a range of rooms and facilities to support treatment and care. These included a clinic room, occupational therapy facilities, group rooms, a music area and a gym.

There were quiet rooms available for patients to use and visiting rooms if required. Patients were able to make private phone calls and could use their own mobile phones. Patients had access to information technology and the internet in a separate room. There were two large lounges available for patients to access. The downstairs lounge was clean and tidy however, this lounge was dark due to the colour of the furniture and the walls. This was discussed with the director of operations and responsible individual who arranged for this room to be redecorated. The upstairs lounge had a pool table, table tennis another facilities were available. Pool tournaments and other activities were arranged in the evenings and at weekends.

There was a dining room available, which could accommodate most of the patients. Staff informed us that patients accessed lunch within a one-hour timeframe and not all patients chose to eat at the same time. Patients had access to an open kitchen facility where they could make their own drinks and access snacks throughout the day and night. This kitchen facility was also used by patients to make their own meals and snacks with support from the occupational therapy team where needed. Patients had access to laundry facilities and were supported by staff.

Patients could access a large enclosed garden area throughout the day and night. Patients were also able to access a designated smoking area in the garden. Patient meeting reviews and tribunals were held in a large meeting room.

Patients were able to personalise their own bedrooms and could securely store their possessions. There were five self-contained flats within the unit to help prepare patients for moving on into the community. Patients had access to their own bedrooms and had keys to access their rooms at any time.

The occupational therapists arranged some weekend activities and a full programme of activities was available during the week. Patient leave and family visits were often arranged at weekends. There was good access to hospital and community based activities. The occupational therapy

department completed assessments to identify patients' needs. This included community skills and functional assessments as well as motivational, communication and motor skills. They completed daily life skill observation scales. These were completed within the first four to six week to allow observations of patients. After this period, the full multidisciplinary team reviewed them monthly and interventions were identified. This allowed the hospital team to identify improvements or deficits in patients' daily life skills. These scores fed into the clinical governance meeting which we attended. These allowed the hospital team to assess percentage improvements of the patients, as well as where patients had stayed the same or were getting worse due to their functionality or their mental health declining.

Patients were able to access physical activities such as gym sessions and swimming. There was also access to life skill sessions such as group cookery with a new session in photography. The local college facilitated and provided classes for patients to access. Patients had access to musical instruments and recording equipment. Staff, and professionals from outside provided tuition. Patients told us that pet therapy was something they enjoyed. Various animals were brought into the Fountains and patients were able to spend time with them.

Meeting the needs of all people who use the service

There was disabled access throughout the building and a lift to access the first floor with ramps provided at the entrance to the hospital. Patients had personal emergency evacuation plans, which detailed the support they would need if there were an unplanned evacuation of the building. Patients who were new to the hospital environment were sometimes allocated bedrooms downstairs close to the main nursing office and when other rooms became available, they were able to move rooms.

There was information available to patients on treatment, drug and alcohol use, diabetes and local services as well as information to inform patients how to make a complaint. Information was also available to inform patients how to access local solicitors with phone numbers clearly displayed.

Patients were given a welcome pack on admission and information was included about how to make a complaint. However, the patient guide did not specifically relate to the Care Quality Commission when dealing with a complaint about their detention under the Mental Health Act.

Staff had access to interpreting services. We attended the patient review meeting where an interpreter had been arranged to assist with any difficulties in understanding where English was not the patient's first language. Documentation and information leaflets could be translated where required. The occupational therapists had developed easy read tools for patients to aid access to information.

Patient's diversity and human rights were respected. Staff were aware of patient's individual needs and during initial admission access to food or any religious, spiritual or special dietary requirements were discussed and accommodated. There were good links with local places of worship and the Fountains had their own prayer room with prayer mats and copies of religious texts.

Information we received before the inspection stated, "To address health inequalities we take into account ethnic background when prescribing medication, the dosage and the monitoring of this. We also take into account the individual's culture in regards to the administration of medication i.e. Patients may prefer male staff when receiving a depot." They also stated, "We invite interpreters to all patient meetings as well as individual sessions with various disciplines in order to ensure communication is clear in regards to all aspects of their care."

Listening to and learning from concerns and complaints

The Fountains reported there were ten complaints received in the last 12 months. One of the complaints was upheld, three were partially upheld and none was referred to the Ombudsman. Five of the complaints were from the same individual. There were no common themes to the complaints we reviewed.

At the point of closure of a complaint, staff asked whether the complainant was happy with the outcome and informed them of their rights to appeal. Information was provided in the patient guide to inform patients about the complaints process as well as information contact

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Good

numbers of the Health Service Ombudsman. In addition, there was a process in place where experience could be discussed at community meetings, which occurred weekly, in which complaints could be discussed.

All staff was required to complete an online training package around dealing with concerns. 85% of staff had completed the training as of July 2017.

The advocacy service independently supported people using the service to challenge both their treatment the support they were offered.

Information was readily available to patients on how they can make a complaint about their care and treatment at the hospital and was displayed throughout the hospital.

The Fountains reported that there were 48 compliments received in the last 12 months, as at 1 June 2017. Complaints were managed at a location level and then the information fed into regional, clinical governance and corporate governance boards and back down into the lessons learnt group. Complaints were on the agenda at the morning multidisciplinary team meeting we attended and staff would receive feedback the outcomes of investigations of complaints to act on the findings.

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

Good

Vision and values

Their organisations vision was to "actively enable each and every one of the individuals within our care to achieve their personal best however, this is defined by them."

All staff had completed an achieve module on the organisations visions and values. This was done using individualised care pathway using an active care approach. They adopted a multi disciplinary approach to achieve this utilising the range of skills that the team have. They aimed to provide an environment, which was secure and safe, and one, which offered independence and opportunities to grow and develop. Their belief was that everyone had a personal best, everyone could find something to aim for and everyone could achieve something special.

Staff were aware of who the regional manager was and they visited regularly to meet with the interim manager and was available to staff and patients. Staff also said the senior staff were visible on the ward and they were aware of any current issues in relation to the patients.

The unit was well led. There was an open, honest and supportive culture. Staff were aware of the whistleblowing policy and duty of candour procedures.

Good governance

There were local operational and clinical governance meetings in place underpinned by reporting processes such as;

- key performance indicators
- reporting of accident and injuries.
- reporting of patients being absent without leave,
- incidents,
- reporting if any restraint had been used,
- complaints received
- recording of training,
- medication management.

Staff had received their mandatory and additional training specific to their role. Staff had also received an appraisal and supervision. Sufficient numbers of staff the right grades and experience covered shifts.

The managers had sufficient authority and administration support. They were able to increase staffing levels at the hospital where required.

There were appropriate policies and procedures and assurance processes in place around safeguarding, the Mental Health Act and the Mental Capacity Act.

There was a lessons learnt group, a reducing restrictive practice group and these involved all levels of staff. Feedback was also provided through team meetings, supervision and morning meetings. Minutes of meetings were also available to update staff daily about the patients.

Monthly clinical governance meetings were held at the Fountains with three monthly regional governance meetings. Managers meetings were also held monthly as well as head of care meetings. Various forums fed into clinical board meetings and corporate governance, quarterly meetings. They had a service development plan/

risk plan and this was discussed and reviewed at these meetings. Any issues would then be addressed or added to the corporate risk register to action or signed off. This was then fed into the corporate board meetings bi-monthly.

Staff participated actively in clinical and environmental audits The audits that had been completed were reviewed by the quality team. Following the audits, a report was collated, submitted and distributed to the operations directors and any themes or risks were discussed at the relevant meetings for actions to be implemented. During our inspection, we raised concerns over the cleanliness of some patient bedrooms. Following our inspection, we immediately received updated audits and checks as well as confirmation of the redecoration of the bedrooms and some patient areas.

The hospital team had identified their own strengths and weaknesses as below. The strengths included;

- In-house training programme.
- Critical incident debriefs.
- Staff retention.

Weaknesses;

- Attendance and contribution at full staff meetings.
- Support worker attendance at patient review meetings and care programme approach meetings.
- Access to external training courses for the nurses.

Actions were in place to address the issues highlighted as a weakness and these were being discussed with staff.

Patient experience and complaints was overseen by the quality group, which fed into the lessons learnt group.

Leadership, morale and staff engagement

Staff felt comfortable raising concerns or suggestions to management without fear of victimisation. Staff spoke about the team being very cohesive and a happy team and that they were listened to with approachable and supportive manager.

Staff morale was good and staff were positive about their jobs and the care they provided.

There were regular staff meetings and staff told us they were consulted about changes. Staff were

involved in projects such as delivering a photography group.

The Fountains had completed a staff survey between March and May 2016. Forty-four staff responded. Most of the comments were positive about working at the Fountains.

Between June 2016 and June 2017, staff sickness at the Fountains was 8%.

Commitment to quality improvement and innovation

The Fountains was not involved in any accreditation for mental health services schemes.

The Fountains submitted examples of how they were committed to innovation and quality improvement and these included:-

- The introduction of new physical restraint training. This has been introduced to replace the management of violence and aggression approach. This was a new initiative across the organisation, using these techniques staff aimed to have a safe, reassuring, positive and respectful environment. This has provided staff with the skills to manage situations safely, using de-escalation techniques and minimising the use of physical interventions. Using their new physical restraint has been found to reduce the risk of accidents and injuries.
- Replacing the key performance indicator spreadsheets with online reporting tools, which covered a wider range of key performance indicators from occupancy, quality, and staffing perspectives.
- Becoming computerised with daily notes, improving computer systems and access.
- In house training session and case formulations - this was one of the areas in which staff had identified improvements in staff knowledge and skills. This had been provided using the knowledge and skills of the wider disciplines where they have identified gaps.
- The introduction of a service development plan/risk plan at location level. This included serious incidents, environmental health issues, team communication, reducing restrictive practices, pre-admission assessment and decision-making, development of the service, staff training and development, carer's involvement, communication and information sharing.

Equality and diversity

Long stay/rehabilitation mental health wards for working age adults

Good

Most staff have been trained in equality and diversity with 83% of staff having completed the online training module at 13 July 2017.

Workforce race equality standards had not been adopted to work towards improving workforce race equality. This was discussed with the manager and the director of operations who agreed they would look into this area for their staff. Workforce race equality standards apply to hospitals where there are NHS contracts worth £200,000 or more annually.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that all patients' bedrooms are cleaned and appropriate, robust checks are in place to ensure the premises are suitable in line with statutory requirements and best practice.
- The provider must ensure that the blanket restriction is reviewed and considered necessary and proportionate.

Action the provider SHOULD take to improve

- The provider should ensure that clinical audits are carried out and recorded in relation to National Institute for Health and Excellence in order to enable staff to learn from the results and make improvements to the service.
- The provider should work towards adopting the workforce race equality standards.
- The provider should ensure that clinical supervision is provided and recorded for all qualified professionals.

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 15 HSCA (RA) Regulations 2014 Premises and equipment How the regulation was not being met: Patients were not protected against the risks associated with unsafe or unsuitable premises because of inadequate cleaning of their bedrooms including linen, pillows and mattresses. This was a breach of regulation 15 (1)(a) (c)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: There was a blanket restriction in place. This had not been individually risk assessed. This was a breach of regulation 13 (1) (4) (b)