Cambian - The Fountains 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?	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.

Summary of findings

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

Overall summary

We rated Cambian Fountains Hospital as good because:

- 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.
- There was a programme of ligature risk assessment in place along with policies to support the management of this risk
- Staff displayed a good understanding of their roles and responsibilities in relation to safeguarding. Safeguarding was embedded within practice
- Staff accessed mandatory and specialist training. Staff were appraised and supervised regularly
- There was an open and transparent culture within the hospital. Staff were aware of the provider's incident report and complaints processes.
- Staff received debrief sessions after incidents and feedback when things had gone wrong
- Ward shift establishment were developed using a staffing analysis tool. Actual staffing levels matched the identified need. There was access to a regular cohort of bank staff
- There was a multi-disciplinary approach to care and treatment. Patients were able to access a range of psychological therapies and activities. Patients had released a charity CD and won awards for art projects
- Feedback from patients was positive. 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.
- Senior management were a visible presence. Staff felt supported in their role and there was good staff morale. A whistleblowing policy was in place. Staff told us they were confident in raising concerns
- There were good governance structures in place to support the delivery of care. Key performance indicators were used to monitor performance

However

- We found two instances where physical health checks had not been carried out on patients receiving high doses of medication.

Summary of findings

Contents

Good

Cambian The Fountains

Services we looked at

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

Summary of this inspection

Background to Cambian - The Fountains Hospital

Cambian 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. These include schizophrenia, schizoid-affective disorder, bipolar disorder, personality disorder and depression. The unit includes five self-contained flats used to help prepare patients to return to the community.

The unit accepts informal patients and those detained under the Mental Health Act (MHA). The unit accepts patients with challenging behaviour, forensic histories and issues with substance misuse.

The hospital manager was the registered manager for Cambian Fountains. There was an accountable officer in place.

There have been five previous Care Quality Commission (CQC) inspections carried out at The Fountains.

The most recent CQC inspection was in May 2013 when a comprehensive unannounced inspection was carried out. The service was found to be non-compliant in relation to staffing. There was an unannounced follow up inspection in January 2014 which found that appropriate action had been taken and that the service was compliant.

Our inspection team

The team that inspected Cambian Fountains hospital was comprised of

- two CQC inspectors
- one Mental Health Act reviewer
- one specialist advisor who was a pharmacist

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit we reviewed information we held about the service, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited the unit and looked at the quality of the environment
- spoke with 11 patients
- spoke to two carers
- spoke with the manager and head of care
- spoke with 10 other staff members, including the psychiatric consultant, nurses, support workers, psychologist, occupational therapist and administrators
- spoke with one independent mental health advocate
- looked at seven care records and 25 medication 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 spoke to eleven patients. Feedback on the service was largely positive. Patients felt staff were caring and supportive. There was positive feedback on the environment and the range of activities available to patients. Several patients expressed optimism about the effectiveness of their treatment. However one patient did not feel he was being listened too by staff.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- Patient risk assessments were comprehensive and carried out in a timely manner
- Ligature risk assessment had been carried out and identified risks were being managed
- Managers had access to a cohort of regular bank staff and did not use agency staff
- Staff were aware of incident reporting procedures. Staff received debriefs and support post incidents and feedback on outcomes
- Ward staffing establishments had been determined against patients' needs
- Staff had a good awareness of safeguarding. Appropriate processes and structures were in place to support this
- Staff compliance with mandatory training was high

Are services effective?

Good

We rated effective as good because:

- Patients were assessed in a timely manner using a recognised tool
- Patients progress and care plans were reviewed regularly in multi-disciplinary ward rounds
- Staff were appropriately skilled to deliver care.
- There was a range of staff disciplines that contributed to care and treatment
- There was good access to psychology and a range of therapies
- Outcome measures were used to review patient progress and the quality of care delivered
- A programme of clinical audit was in place and staff were engaged with audit
- There were systems in place to ensure adherence with the Mental Health Act (MHA) and the Mental Capacity Act

However

- We found some instances where physical health checks had not been carried out on two patients receiving high doses of medication

Are services caring?

Good

We rated caring as good because

Summary of this inspection

- Patients were treated with compassion and respect
- We saw several positive interactions between patients and staff
- Feedback from patients about staff and staff attitudes was positive
- Patients felt staff were caring and interested in their recovery and welfare
- Patients using the service were given the opportunity to be involved in decisions about their care
- Patients had regular 1:1 sessions with key workers and attended ward rounds
- Carers and families were involved in care where applicable
- Patient meetings were held on the ward
- There was a patient representative who attended unit meetings

Are services responsive?

Good

We rated responsive as good because:

- There was active discharge planning from the point of admission
- Staff maintained contact with care coordinators including those for out of area patients
- Patients had access to a range of activities both within the hospital and in the community. The OT department was well resourced and had strong links with local organisations including colleges. Patients had released a charity CD and won awards for art projects
- Patients had access to a range of facilities. This included a gym area, a music area, activity rooms and outdoor space
- Patients were supported with their cultural, spiritual and religious needs
- There was a range of information available to patients and access to translation services
- There was good management of complaints

Are services well-led?

Good

We rated well-led as good because:

- Staff were engaged with the vision and values of the provider organisation. These were reflected in the hospital's culture and practice
- Senior managers were well known and had a visible presence on the ward
- There was an open and transparent culture evident in the hospital. Staff were aware of the providers whistleblowing policy and stated they would be confident about raising concerns

Summary of this inspection

- Staff stated they felt supported in their role
- Performance was monitored against key performance indicators. There was benchmarking against similar services provided by the company and a programme of peer review

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.

All staff received mandatory training on the Mental Health Act (MHA) as part of their induction. There was an additional level two course for identified staff. Seventy percent of identified staff had completed this training and courses were scheduled for the remaining staff.

Staff we spoke to showed a good understanding of the MHA and its application. Support for staff was available through a MHA administrator. There was a programme of audits in place to ensure compliance with the MHA and documentation standards.

Patient care records were in good order with relevant documentation and assessments completed. Patients were informed of their rights on a regular basis. Patient leave was appropriately recorded however; evidence of how the leave had gone and the patients' view of it was not always captured.

Patients had access to an independent mental health advocacy (IMHA) service.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received mandatory training on the Mental Capacity Act (MCA) as part of their induction. There was an additional level two course for identified staff. Seventy percent of identified staff had completed this training and courses were scheduled for the remaining staff. There was a programme of audits in place to ensure compliance with the MCA.

Staff we spoke to displayed a good understanding of the MCA and the five statutory principles. They were applying the MCA in practice. Capacity assessments were in place where appropriate and these were reviewed regularly. There was evidence of patients being supported to make decisions and the involvement of family members and carers.

T2 and T3 forms were in place and completed. T2 forms are used to record patient consent to treatment. T3 forms are used to record the authorisation of treatment by a Second opinion appointed doctor (SOAD). However we found that in one case a T3 form had been completed to authorise medication to a patient who did not have capacity. The SOAD had authorised the medication for a time limited period. That period had recently expired. A further SOAD visit had been requested but not yet taken place. This meant that staff were giving the patient medication without the necessary authority.

The unit had made one Deprivation of Liberty Safeguard (DoLS) application in the past six months. The individual was on standard authorisation and all paperwork was in place in the patients care file.

Overview of ratings

Our ratings for this location are:

Detailed findings from this inspection

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

Long stay/rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

Cambian Fountains was housed over two floors in a standalone building. The layout of the unit meant that there were some blind spots and staff could not observe all parts of the ward. However staff were able to explain how this was managed by risk assessments they carried out and the use of observation. Patients were individually assessed prior to admission to determine their suitability for the environment. 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 service did not use seclusion and the building did not have a seclusion room.

The ward had a ligature risk assessment in place which was completed annually. 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.

There was a fully equipped clinic room which was clean and well maintained. Emergency equipment, medical devices and emergency medication were stored in the clinic room. Resuscitation equipment was also available at other locations throughout the unit. All equipment was in date and fit for purpose. A named nurse was allocated on a daily basis to ensure that checks on the clinic room and equipment were completed. These were documented in daily and weekly monitoring sheets. There was a controlled drugs cabinet in place and medication was stored appropriately. Fridges used to store medication were checked daily.

The unit was clean and well maintained. Cleaning schedules were in place and being adhered to. Domestic staff told us they felt supported in their role. Controls of substances hazardous to health (COSHH) folders were in place and hazardous substances were stored in locked cupboards. Patients we spoke to told us that standards of cleanliness were high. Staff adhered to infection control principles and hand gels were available throughout the unit.

The unit only admitted male patients. Bedrooms were spacious and comfortable and all provided en-suite shower facilities. There was also a separate communal bathroom that patients could access if they wished to have a bath. There was access to external garden areas. One garden area included a smoking shelter. The garden areas were well maintained and one area had just been refurbished in consultation with patients.

There was an environmental risk assessment in place. This was comprehensive and reviewed regularly. A full fire risk assessment was in place and identified actions had been completed. Each service user had an individual personal emergency evacuation plan.

Staff had access to personal alarms. There was controlled access to the unit for visitors. Visitors accessing the main

ward area were provided with a personal alarm and were instructed on its proper use. Alarms and security systems were checked regularly and maintenance records were in place.

Safe Staffing

The following staffing data was provided by the unit;

Establishment levels: qualified nurses (WTE): eight

Establishment levels: nursing assistant (WTE): 22

Number of vacancies: qualified nurses (WTE): one

Number of vacancies: nursing assistant (WTE): 0

The ward did not use agency staff. There was a bank cohort comprised of permanent staff with experience of the service. This ensured that when bank staff were used there were familiar with the service and continuity of care was protected.

The number of shifts filled by bank staff to cover sickness, absence or vacancies in the three month period prior to the inspection was 109. The number of shifts that had not been filled by bank staff to cover sickness, absence or vacancies during that period was three.

Staffing levels on the unit were identified using a staffing needs analysis tool. The tool and staffing needs were also discussed daily in a multi-disciplinary team meeting. A staffing analysis and minimum staffing levels policy was in place to support this. The unit management was able to adjust staffing levels in response to patient's needs' and activity on the ward.

Staffing rotas we reviewed showed that actual staffing levels matched established levels. None of the staff or patients that we spoke to raised concerns over the level or availability of staff. A qualified nurse was on duty at all times. During Monday to Friday (9am to 5pm), the head of care was responsible for overseeing nursing care on the ward. If they were absent a senior nurse was allocated as nurse in charge.

Patients we spoke to told us there were appropriate staffing levels to ensure their needs were met. There was a strong staff presence on the unit and patients were able to access 1:1 support. Each patient was allocated a nurse and clinical support worker who they met weekly.

Escorted leave and ward activities were rarely cancelled. One patient we spoke to commented that a planned activity had been cancelled on one occasion. However an apology and explanation had been given and cancellation was not a regular occurrence. Patients who had been granted leave that required a staff escort had this facilitated. Care records showed that leave was being utilised routinely with the specified number of staff escorts. Patients told us they had not had planned leave cancelled.

There was medical cover provided by a consultant psychiatrist during the week, including out of hours. At weekends there was a rota of eight consultants who provided cover. The consultants on the weekend rota were based off site but were able to attend or provide advice when required. Staff did not raise any concerns over access to medical input.

A programme of mandatory training was available to staff. This included both online and class room sessions. Compliance was monitored through an electronic system and staff were alerted when they were due to attend training. 91% of staff were up to date with mandatory training requirements.

Assessing and managing risk to patients and staff

The unit was a rehabilitation unit and did not have a seclusion room. In the previous six months there had been two incidents of restraint. Neither of these incidents involved restraint in the prone position. Restraint was used as a last resort when de-escalation techniques had not been successful. Care plans identified that de-escalation techniques should always be used first and training was provided to staff.

Staff undertook risk assessments on admission. These were updated regularly and in response to any change in the patients' circumstances. Assessments were reflected in patients care plans. Risk assessments were comprehensive and utilised the START risk model (short term assessment of risk and treatability). Identified risks were assessed using a traffic light system that clearly identified the risks with the highest being red, with amber as medium and green as the lowest risk level. Individual patient risks were discussed each morning during a multi-disciplinary meeting. These assessments and discussions fed into decisions around factors such as observation levels and room allocation.

There was a policy in place to support the use of observation. The policy laid out different levels of observation and included guidance on the appropriate use of each level. The policy also included the roles and

Long stay/rehabilitation mental health wards for working age adults

Good

responsibilities of staff when conducting observations. Staff demonstrated a good knowledge of the policy and we observed it in practice whilst on the ward. There was a policy in place to support the searching of patients returning from leave and a wand available for staff to use. Searches were not routine and only took place if the need had been identified through a risk assessment. Sniffer dogs also attended the unit.

The service had worked with patients to carry out a review of restrictive practices. There was clear evidence that changes had been made in response to the review. For example restricted access to the courtyard area had been removed. Previously this had only been granted on patient request and the area was locked at other times. In addition access to the kitchen was changed so that it was available to patients 24 hours a day.

All staff received safeguarding training annually as part of their mandatory training programme. At the time of the inspection 84% of staff were compliant with training. Compliance was monitored centrally and staff that were overdue with their annual refresher were being booked onto training. Staff displayed a sound knowledge of safeguarding procedures and understood their responsibilities in raising alerts and concerns. There were safeguarding policies in place to support staff in this regard. The unit had good relationships with local safeguarding teams and authorities.

There was good medicines management practises on the unit. Medication counts and reconciliation completed by nursing staff were documented and demonstrated that checks were completed regularly in accordance with the unit's policies. Medication was disposed of in accordance with policy and best practice. Documentation showed that two nurses were signing the drug disposal record. The unit was in the process of changing its contract for pharmacy support. The new contract will provide for external monitoring of prescribing and medication audits.

There were visiting rooms available for patients to meet with family and friends. This included child visitors where applicable. The visiting room was off the main ward area. Where required visits were risk assessed and may be supervised. Policies were in place to support this.

Track record on safety

The service had reported one serious incident (SI) in the previous 12 months. This related to the unexpected death of a patient in August 2015. A coroner's report had identified that there were no suspicious circumstances. The service had commissioned an independent investigation into the incident. Debrief sessions had been provided to other patients and staff.

Reporting incidents and learning from when things go wrong

The service had systems in place for reporting and reviewing incidents. Information provided by the service showed that over the previous six month period they had reported 78 incidents using internal reporting processes. The most common type of incident was violence and aggression. There were 42 of those incidents reported. These were low level incidents mainly involving verbal aggression. They were managed by staff and did not result in harm.

There was an IR1 form that was completed to report an incident. An incident data pack was produced monthly. Incidents were discussed within multi-disciplinary team meetings and there were monthly adverse incident meetings which analysed trends. Incidents were also discussed within the monthly clinical governance meetings.Staff were able to explain the adverse incident reporting process and showed a good understanding of what should be reported. Feedback from incidents and complaints was provided in team meetings and supervision sessions. Staff were positive about the debriefs and support they had received following the SI.

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 an initial assessment on admission. The full assessment process included a risk assessment, nursing and medical assessments, psychological assessments and assessment for occupational therapy (OT). Assessments were in place and completed in all of the

patient files that we looked at. Assessments were reflected in patients care plans. Physical examinations had been undertaken and there was ongoing management of physical health needs where required.

Care plans captured patient's personal, psychosocial, mental health and rehabilitation needs. 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 regularly in multi-disciplinary meetings (MDT) and 1:1 sessions with patients.

Patient records were stored in both paper and electronic format. All clinical staff had a login to access electronic records. Paper copies were stored in locked files in the nurses' station. Staff told us patient information was always easily accessible.

Best practice in treatment and care

Information on National Institute of Health and Care Excellence (NICE) guidance and best practice was disseminated by the provider company. This was done through bulletins and emails and discussed within team meetings. There was access to relevant NICE guidance through the internet.

We reviewed 25 prescription charts. We found that 12 of these had more than one antipsychotic prescribed. There were seven charts where the dose exceeded 100% of British National Formulary (BNF) limits. We discussed this with the consultant. Where a second antipsychotic was prescribed there was agreement from a Second opinion appointed doctor (SOAD). The rationale for high dose prescribing and a risk / benefit analysis was in place but not immediately clear as it was captured in a separate part of the care record. Some patients had been admitted on more than one antipsychotic or on high doses of medication. Prescribing regimes were discussed in MDT ward rounds and treatment options were being considered. The Liverpool University neuroleptic side effect rating scale (LUNSERS) was being used. LUNSERS is designed to identify and monitor medication-induced side effects..

Patients had a physical health assessment. This was reviewed monthly in the ward round. Staff was trained in skills such as phlebotomy to support the monitoring of physical health. There were good links with local GP surgeries to facilitate additional tests where required. There was a policy in place to support high dose antipsychotic prescribing. Monitoring of physical health in relation to high level prescribing was in place. However we found two instances where physical health checks had not been carried out on patients receiving high dose medication. This included an instance where an ECG was overdue and one instance where haematological tests were overdue. One of the patients identified was an individual who was declining health checks. Prescribing and medication audits were carried out by staff. The unit was in the process of changing its contract for pharmacy support. The new contract will provide for external monitoring of prescribing and medication audits.

There was a psychology service within the unit. Patients could access a range of psychological therapies as part of their treatment. The psychology service was part of the ward team and psychology staff attended the MDT ward rounds. Patients had a programme of activities that were recovery orientated and tailored to individual need. Sessions were delivered in both 1:1 and group formats.

The service used a range of outcome measures. Each patient had a recovery star and brief psychiatric rating scale (BPRS) in place which were reviewed in ward rounds. The recovery star is a tool that enables patients to plan out their recovery and identify their objectives. It allows services to measure the effectiveness of the service they deliver by measuring progress against those objectives. The BPRS is used to measure psychiatric symptoms such as anxiety and depression. In addition the OT department utilised the daily living skills outcome measure and the global assessment of progress tool (GAP). These were reviewed monthly. The GAP measures the social, occupational and psychological functioning of individuals. It is part of the diagnosis and statistical manual of mental disorders.

Skilled staff to deliver care

A full range of professionals had input into care and treatment on the unit. These included nurses, support workers, doctors, psychologists and occupational therapists (OT). Domestic, administrative and maintenance staff also supported the unit. Staff were appropriately qualified for their post and senior staff were experienced within their roles.

There were policies in place to support medical revalidation, staff appraisal and supervision. Staff underwent an annual appraisal and received supervision

carried out in both 1:1 and group formats. 89% of staff who had been in post for 12 months or more had received an appraisal. 100% of non-medical staff had been appraised in this time period. The unit consultant had been revalidated.

Staff received an induction when starting their role. This included orientation to the unit, an introduction to the units policies and procedures and a programme of mandatory training. Care certificate standards were in place for support workers.

In addition to a programme of mandatory training there was additional specialist training available to staff. This included training on phlebotomy, intermediate life support, medicines management and use of the recovery star. In addition both the unit consultant psychiatrist and psychology department offered training sessions to staff covering a range of issues and diagnosis.

Managers were able to explain the process for addressing poor staff performance and disciplinary issues. There were policies in place to support this and assistance available from a central human resources team.

Multi-disciplinary and inter-agency work

There was a multi-disciplinary team (MDT) meeting held at the start of each day. This allowed for an exchange of information regarding activity on the ward, a review of upcoming activity and the planning of staffing needs.

There was a weekly MDT ward round. These were well attended by all disciplines within the unit as well as patients, carers and advocates. All the staff contributed to the review of care. Effective reviews of patient care and progress were carried out and the care plan was agreed collaboratively with the patient. The unit included an Occupational therapy department (OT). The OT was embedded within the multi-disciplinary team and contributed to assessment, care planning and reviews. The department ran a range of activities and worked with staff and local organisations to arrange activities in the community.

Staff told us they had good relationships with local GPs, health services and safeguarding authorities. There were links in place with the local college and voluntary service.

Staff maintained regular contact with care coordinators. Care coordinators were invited to attend ward rounds and care programme approach (CPA) meetings. When they could not attend notes of the meeting were sent to them. In addition contact was maintained through telephone and email.

Adherence to the Mental Health Act (MHA)and the MHA Code of Practice

All staff received mandatory training on the Mental Health Act (MHA) as part of their induction. There was an additional level two course for identified staff. Seventy percent of identified staff had completed this training and courses were scheduled for the remaining staff. Staff we spoke to showed a good understanding of the MHA and its application. Support for staff was available through a MHA administrator. There was a programme of audits in place to ensure compliance with the MHA and documentation standards.

Patient care records were in good order with relevant documentation and assessments completed. There were good systems in place to ensure that all documents were reviewed on admission and that renewal dates for detention and lawful requirement for continuing detention were met. Detention paperwork was up to date and stored securely.

All patients we spoke to were aware of their rights under section 132 of the MHA and how to exercise those rights. Patients' rights under section 132 were explained on admission and at a minimum of three monthly intervals. Information was given both verbally and in writing. Systems were in place to ensure that this happened.

Section 17 leave was appropriately recorded and there was a standardised system in place to support this. There was evidence that patients were offered a copy of the leave form. Risk assessments were completed before the patient went on leave. However evidence of how the leave had gone and the patient's view of it was not always captured.

Patients had access to an independent mental health advocacy (IMHA) service. The IMHA was advertised on the unit and information was provided to patients. The IMHA attended the unit weekly to meet with patients and attend ward rounds. We spoke with an IMHA who was attending the unit on the day of the inspection. They told us there was a good relationship with staff and that patients were fully aware of the IMHA service and its role.

Good practice in applying the Mental Capacity Act

Long stay/rehabilitation mental health wards for working age adults

Good

All staff received mandatory training on the Mental Capacity Act (MCA) as part of their induction. There was an additional level two course for identified staff. Seventy percent of identified staff had completed this training and courses were scheduled for the remaining staff. There was a programme of audits in place to ensure compliance with the MCA.

Staff we spoke to displayed a good understanding of the MCA and the five statutory principles. They were applying the MCA in practice. Capacity assessments were in place where appropriate and reviewed regularly. Care records we reviewed contained assessments that were appropriate and decision specific. There was evidence of patients being supported to make decisions and the involvement of family members and carers.

However we found that in one case a T3 form had been completed to authorise medication to a patient who did not have capacity. The SOAD had authorised the medication for a time limited period. That period had recently expired. A further SOAD visit had been requested but not yet taken place.

The unit had made one Deprivation of Liberty Safeguard (DoLS) application in the past six months. The individual was on standard authorisation and all paperwork was in place in the patient file.

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 with dignity and respect and in a caring and compassionate manner. Staff showed a person-centred approach in their attitude and showed a good understanding of each patients personal circumstances and needs

We spoke to 11 patients. They told us that staff were caring, supportive and interested in their well-being. They considered staff to be friendly and approachable. Patients told us that staff had time to speak to them and that they had regular 1:1 contact. However one patient stated that he felt he wasn't being listened to. The patient was aware of independent mental health advocacy services and the provider's complaints process but had not pursued them.

The involvement of people in the care they receive

There was an admission process in place to inform and orientate patients to the ward and service. We spoke to patients who had visited the unit prior to admission. New patients were shown around the unit and introduced to staff. Patients told us that they and their family and carers were able to ask questions. A welcome pack was available which contained a range of information. Patients told us they found this useful.

We reviewed seven care plans. They illustrated evidence of patient participation and showed that patient views were taken into account. Patients told us that they felt involved in decisions about their care. Family and carers were involved where the patient wished them to be. Patients, family members and carers were invited to attend ward rounds. Patients were offered copies of their care plan if they wanted one.

Patients were able to give feedback on the service they received in a variety of ways. The unit held community meetings to gather patient feedback. There was a patient representative and deputy who sat on meetings to represent patients. The service undertook an annual patient survey. The independent mental health advocacy service also carried out patient surveys. Complaints and locally resolved issues were reviewed as part of a focus on patient experience. The unit also used a post incident questionnaire for patients. This allowed patients to comment on the incident, how they felt staff managed it, what could have been done different and how good the post incident support had been.

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

Good

Access, discharge and bed management

Long stay/rehabilitation mental health wards for working age adults

Good

The unit accepted both NHS and private patients. Referrals came primarily from acute mental health wards and secure services. A referral process was in place. A nurse assessor visited all referrals to carry out an initial assessment and all referrals were discussed within a multi-disciplinary meeting. Staff maintained contact with care coordinators through phone calls, emails and letters. This included the care coordinators 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. When they were unable to attend they were sent notes of the meeting.

Bed occupancy over the previous six months was 94%. Beds were protected when patients were on leave and were available for them when they returned. The average length of stay was 18 months.

Staff worked with patients and care coordinators to promote and facilitate discharge.

Discharge planning started on admission and was discussed in the first ward round. We saw evidence of discharge planning formulated in care plans. The service did not formally collate data on delayed discharges. However staff told us it was rare. Patients we spoke to were positive about the focus on discharge and did not raise any concerns.

Patients did not have direct access to a psychiatric intensive care unit (PICU) on site. Access to PICU services was arranged through care coordinators and commissioning bodies. There had been one instance of a referral to a PICU in the previous three months. Records showed the transfer took place quickly after the need for a PICU placement was identified.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environment was clean and comfortable. Furniture and equipment was in good condition and well maintained. There was a range of rooms and facilities to support treatment and care. These included a clinic room, occupational therapy (OT) facilities, group rooms, a music area and a gym.

There were quiet rooms available for patients to use and visiting facilities if required. The visiting room was away from the main ward area. Patients were able to make private phone calls and could also use their own mobile phones. Patients had access to the internet.

Patients were able to personalise their bedrooms and could securely store their possessions. There were five self-contained flats within the unit to help prepare patients for living in the community. Patients had access to warm drinks and snacks throughout the day. Patients told us that the food was of a good quality. Menus were displayed in advance and a choice was available. Patients also had access to kitchen facilities to make their own snacks.

There was good access to ward based activities as well as a range of activities outside of the unit for patients. Activities were available seven days a week. The OT department carried out assessments to identify patients' needs. This included community skills and functional assessments. Patients were able to access physical activities such as gym sessions, yoga, and swimming. There was also access to life skill sessions such as cookery and drug and alcohol awareness. Patients had access to musical instruments and recording equipment. The service had worked with patients to record and release a charity CD for MIND Lancashire. Patients had also won awards for art work they had completed through OT.

There were strong links with local community groups and facilities. This included patients attending courses at Blackburn College and going to swimming and football sessions. One patient had been supported to attend a music concert.

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. Staff took into account patients' individual needs' when allocating them a bedroom.

There was good provision of information on treatment, local services and how to complain. This was available on the unit in leaflet and poster form. Patients were also given a welcome pack and information on their rights. Staff had access to interpreting services for face to face and phone translation. Documentation and information leaflets could be translated where required.

Patient's diversity and human rights were respected. Staff were aware of patient's individual needs and tried to

Long stay/rehabilitation mental health wards for working age adults

Good

ensure these were met. This included access to food to meet the religious, spiritual or special dietary requirements of patients. There were good links with local places of worship and we spoke to patients who were being supported to access them.

Listening to and learning from complaints and concerns

There was an established complaints process in place and a policy to support this. The first step was to attempt to resolve the complaint informally and if this was not possible to escalate to a formal complaint. The unit captured details of both informally resolved and formal complaints to promote learning. There was a key performance indicator in place to ensure complaints were managed within the timescales laid out.

Staff we spoke to were able to explain the complaints process and were aware of the units' policy. Feedback from complaints was provided through the clinical governance meeting, team meetings and supervision. Lessons learnt from complaints at other services ran by the Cambian group were shared across at regional meetings and through bulletins.

Patients knew how to raise complaints and concerns. Information on how to make a complaint was displayed within the unit and provided to patients in welcome packs. Patients told us that they had confidence that staff would manage their complaint appropriately and take issues they raised seriously. There was good support from independent mental health advocates who visited the unit weekly. Information on these services was displayed on the unit.

There had been four formal complaints made to the unit in the previous 12 months. Of these one had been upheld. This related to a meeting that had been cancelled without the patient being informed. An apology was offered and the meeting was rescheduled. There had been no complaints referred to the Ombudsman during that period.

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

Good

Vision and values

There was positive leadership at the unit and staff described shared vision and values. These were reflected in the practice and culture of the service.

Senior managers at the unit were a visible presence on the ward. Staff considered them to be supportive, open and approachable. Staff were aware of senior managers within the provider organisation. The regional manager attended the unit regularly.

Good governance

There were good governance processes and structures in place. There were clinical governance meetings held monthly on the unit which were attended by a range of staff. In addition there was a monthly meeting to review incidents and safeguarding referrals and regular staff meetings. Feedback was provided through team meetings and supervision. Minutes of meetings were also available for staff.

The unit was linked into the governance process of its parent company. There was a clear structure of local, regional and corporate governance forums. This provided a pathway for the unit to escalate concerns and for the company to disseminate information and learning. There was a risk register in place that staff could access and input to. There were processes in place to ensure learning from incidents and complaints and to share this with staff.

Staff were given an induction and a programme of mandatory training. There was access to additional specialist training when it was identified through appraisals. Electronic systems were in place to monitor compliance with training requirements. Staff received an annual appraisal and regular supervision.

Clinical managers had authority to increase staffing levels and adjust the staffing skill mix on the wards. They told us

they felt supported to do this by senior management. Actual staffing levels on shifts met the identified need. Staff had time to engage in direct care activities and to spend one to one time with patients.

There were appropriate polices and assurance process in place around safeguarding, the Mental Health Act and the Mental Capacity Act.

Performance was monitored through the governance structure. The ward used a range of outcome scales and a programme of audit to assure quality. Staff were aware of the audits being undertaken and participated in audits where appropriate. Results and recommendations from audits were fed back through the governance structure and in team meetings and supervision. Key performance indicators (KPI) were in place and reported on weekly. The service benchmarked performance against other similar services within the company. Managers from within the company carried out peer review quality assurance visits.

Leadership, morale and staff engagement

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

Staff felt comfortable raising concerns or suggestions to management without fear of victimisation. Staff spoke highly of the unit manager and considered her to be open and approachable.

Staff morale was good. They were positive about their jobs and the care they provided. Staff felt supported in their role and received regular supervision. Staff worked well together and there were positive relationships between staff groups. There had been no reports of bullying or harassment.

Staff could make suggestions regarding service development. There were regular staff meetings and staff told us they were consulted about changes. Staff were involved in projects such as the development of an in house gym.

Commitment to quality improvement and innovation

The provider was piloting accreditation for inpatient mental health services (AIMS) in some of its services. The Fountains were not currently part of this pilot. Staff told us The Fountains will consider applying for accreditation following the pilot programme.

Outstanding practice and areas for improvement

Outstanding practice

The service engaged with patients in a range of creative activities. Patients had released a charity CD. Some patients had won awards for art work they had produced during activity sessions.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that where patients are on more than one anti-psychotic medication or on high dosage levels, physical health checks are carried out in a timely manner.