NAVIGO Home from Home Service

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

Overall summary

Overall we rated this service as good. We rated safe as requires improvement;, effective, responsive and well led as good and caring as outstanding. This was because:

We rated safe as requires improvement because we found that whilst patients were protected from avoidable harm and abuse, they were not assessed for all risks. We found that staff compliance with mandatory training was low and we found that some medicines were not kept

Summary of findings

locked up. However we also found that staffing levels were good and that staff knew how and when to report incidents and that they received feedback and the learning from incidents.

We rated effective as good because we found that there were policies and pathways in place to support staff when caring for patients but these did not always have reference to best practice guidance. Audits were undertaken and when necessary action plans were created. There was clear, effective multi-disciplinary team working and positive collaboration with external partners in care. Staff were qualified but not all had an up to date appraisal.

We rated caring as outstanding because we saw consistently positive interaction between patients and staff and the feedback we received from patients and those close to them was also positive.

We rated responsive as good because services were planned to meet the needs of patients. The patient group cared for were vulnerable, in that they were confused due to an acute illness or they had a diagnosis of dementia. The unit was designed specifically around the needs of these patients. There had been no formal complaints about the service.

We rated well led as good because staff were aware of the vision and strategy for the unit. Staff told us that managers were visible and supportive. We saw that staff and patient engagement was seen as a priority by the provider and staff were encouraged to suggest ideas for improvement and innovation.

Summary of findings

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Good

Navigo Home from Home

Services we looked at
Community health inpatient services;

Summary of this inspection

Background to NAVIGO Home from Home Service

The "Home from Home" project was a joint improvement programme between an acute NHS care provider and NAViGO Health and Social Care Community Interest Company (a Social Enterprise providing Mental Health services). The project was established in response to the "Healthy Lives Healthy Futures" scheme which was a review of health and care services in Northern Lincolnshire, led by both North East Lincolnshire and North Lincolnshire Clinical Commissioning Groups (NEL and NL CCG) in partnership with local health and care organisations. The aim of Healthy Lives Healthy Futures is to look at how an improved health and care system may be developed that delivers safe, high quality and affordable services for the foreseeable future.

The Home from Home Project has focused on improving care pathways for patients admitted to Diana Princess of Wales Hospital in Grimsby when there was evidence of confusion and/or dementia. Care was provided using an in-reach, out-reach model, providing acute inpatient care in a 15 bedded, dementia friendly environment alongside intensive community support in the service user's home. The Operational Policy and referral criteria included provision of care to people who were medically stable and also those with palliative care needs.

Prior to our inspection the outreach community support service in patients' own homes had been stopped therefore our inspection focused on the in-patient unit only.

During our inspection, we visited the ward; we spoke to 13 members of staff including nurses, care support workers, doctors, therapists, domestics and administrators. We also spoke with five patients and three relatives and carers. We looked at the ward environment including the bedrooms,bathroom, dining and other communal areas. We observed lunch being served to patients. We looked at the medical and nursing records of seven patients

Our inspection team

The team that inspected the service comprised CQC inspector Kerri Davies (inspection lead), and one other CQC inspector.

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 get to the heart of people who use services' experience of care, 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 visiting, we reviewed a range of information we hold about the core service. We carried out an announced visit on 19 August 2016. During the visit we spoke with a range of staff who worked within the service, such as nurses, doctors, therapists. We talked with people

Summary of this inspection

who use services. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service.

What people who use the service say

We received consistently positive feedback about the unit and the staff from patients and their families. This included people telling us that the unit was a 'home from home' and that the staff were exceptional, caring and brilliant.

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. This was because:

- NHS safety thermometer submissions showed that low numbers of patients were being risk assessed and treated prophylactically for venous thromboembolism.
- We had concerns about infection control due to patient rooms being carpeted and other soft furnishings such as sofas and cushions being used.
- We found some medicines were not locked away however this was immediately addressed.
- We found low compliance in mandatory training figures for staff.

However we also found that:

- Staff knew how and when to report incidents and actions were taken to address concerns for example patients who were at high risk of falling.
- Medical and nurse staffing levels were good.
- The quality of nursing and medical record keeping was good and in line with professional guidance from registering bodies.
- The service had a business continuity plan and policies in place to manage anticipated risks and major incidents.

Are services effective?

Good

We rated effective as good because:

- Staff were aware of and used evidence based practice when planning and providing care although not all pathways had references to best practice guidance.
- We saw that patients received timely pain relief and were supported with hydration and nutritional needs.
- Patient outcomes were positive.
- There was clear and effective multi-disciplinary working.
- Referral, transfer and discharge processes were straightforward and effective.
- Staff had access to shared electronic systems and gained consent to share information and before providing care and treatment to patients.

However we also found that:

- Low numbers of staff had an up to date appraisal. However relevant staff were being supported through the process of revalidation.

Summary of this inspection

Are services caring?

Outstanding 

We rated caring as outstanding because:

- Feedback from people who use the service and those close to them was continually positive about the way staff treat people. People said that staff go the extra mile and the care they receive exceeds their expectations. Patients and their relatives described the staff as 'exceptionally kind, caring, and brilliant'.
- We witnessed staff who were highly motivated and providing care that was kind and promoted people's dignity.
- Relationships between people who use the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders.
- Staff recognised and respected individual people's needs. Patient's personal, cultural, social and religious needs were taken into account.
- People who use services were active partners in their care. Staff were fully committed to working in partnership with people and making this a reality for each person.
- People's individual preferences and needs were always reflected in how care was delivered.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Are services responsive?

Good 

We rated responsive as good because:

- The service was planned to meet the needs of the patients cared for on the unit.
- Staff respected the equality and diversity of each person they cared for.
- The unit was developed to care for people who were in vulnerable circumstances or who have complex needs.
- There had been no formal complaints about the unit since it opened in June 2015.

Are services well-led?

Good 

We rated well led as good because:

- The vision and strategy for the unit was embedded and staff were aware of this and based the care of their patients on the organisation's values.
- Leaders were visible and staff told us that they were supportive and approachable.
- We found that the culture in the unit was positive and staff said that they worked well as a team.
- Staff and public engagement mechanisms were good.

Summary of this inspection

- There was good evidence of improvement and some positive examples of innovation.

However

- We found that not all risks applicable to the unit, for example low compliance with mandatory training, were highlighted on the corporate risk register.

Detailed findings from this inspection

Good

Community health inpatient services

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

Are community health inpatient services safe?

Requires improvement

Safety performance

- The NHS Safety Thermometer is an audit tool that allows organisations to measure and report patient harm in four key areas (pressure ulcers, urine infection in patients with catheters, falls and venous thromboembolism) and the proportion of patients who are “harm free”. The England average for harm free care is 95%.
- We looked at the safety thermometer submissions for the unit for the period March 2016 to July 2016. We spoke to the unit manager and asked if the results of the safety thermometers were provided and displayed. We were told that this information was not provided; this meant that feedback on harms or harm free care was not available.
- However, from the submissions we looked at in April 2016, 13 patients were surveyed and none of those patients had been risk assessed for venous thromboembolism and none of the patients were receiving prophylaxis (medication to prevent blood clots occurring). In June 2016, only one of ten patients surveyed had been risk assessed and this patient had received appropriate preventative treatment. We were concerned that this might mean patients were not being protected from avoidable harm.
- We raised our concerns with the ward manager about this issue and were told that this had been discussed with the medical staff on the ward. The ward manager said that she would raise this again and ask that medics ensure that venous thromboembolism assessment was clearly documented in the medical notes in future.
- All patients arriving in the Home from Home service have been through the local acute trust's admission process where this assessment had been completed prior to admission to home from Home. Home from Home repeated this if it was an identified need on the patient's discharge plan from the acute trust.

Incident reporting, learning and improvement

- This core service had no reported never events. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers that are available at a national level and should have been implemented by all healthcare providers.
- The unit had reported 77 incidents in the six-month period prior our inspection. We looked at the incidents and found that the majority, 50 (65%) related to patient falls. All the reported falls were low harm. The other 27 incidents related to communication (three), medication issues (three), patient care (three), information governance (one), violence and aggression (eight) and deaths (nine). The unit reported patient deaths as part of their routine reporting and these reported deaths were expected.
- Due to the high numbers of falls on the unit, work had been undertaken to look at ways to reduce falls. We saw a report which had been produced by NAViGO’s performance team in August 2016. This highlighted the actions implemented to reduce falls. This included the

use of sensor mats for patients identified as high risk of falls or post fall and ensuring observations were increased as recommended in the falls risk assessment. In addition to this, we were told that activities were done with groups of patients who were at risk of falls.

- We saw minutes of team meetings which showed that incidents and the lessons learned were shared with staff at all levels.
- In November 2014, the duty of candour statutory requirement was introduced and applied to all NHS Trusts. The regulation sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- Staff we spoke with were aware of the duty of candour and were able to give examples when this would be used.
- We saw that information about duty of candour had been provided for staff by NAViGO. This included an explanatory poster and a flow chart for staff to follow.

Safeguarding

- NAViGO's operational and workforce policies outlined staff's responsibilities in relation to safeguarding.
- Staff we spoke with told us that they felt competent and confident to raise a safeguarding concern and could give examples of when this might be needed.
- NAViGO had a safeguarding lead. The operational policy included the company's safeguarding lead and local authority contact details.
- Training figures provided showed that 52% of staff were up to date with mandatory adult safeguarding training. We discussed this with the ward manager who told us that some ad hoc training sessions had been arranged to take place in August, September, October and November 2016 and that once completed all staff would be fully compliant with both adult and children's safeguarding training. Also, staff induction included an introduction to safeguarding which meant that staff were able to recognise safeguarding concerns and would know to raise these with their manager.
- At the time of our inspection, 75% of staff were up to date with children's safeguarding training.

Medicines

- The ward received medications from an external pharmacy. We saw evidence that the pharmacy completed weekly audits of all medication charts and provided an action plan following the audits. It was noted that these audits included medicines reconciliation for all patients.
- We found that most medications were stored safely and securely on the unit. However, we found that some creams and sprays, including prescription only products were stored in an unlocked cupboard in the bathroom on the unit. We discussed this with the ward manager and immediate action was taken to address this. We were told that the cupboard had previously been locked. At the time of our inspection both the cupboard and bathroom door were unlocked although it was noted that there was a keypad lock on the bathroom door. Later we saw that the bathroom was locked and notice was displayed on the door advising that the room must be kept locked at all times.
- Only one incident relating to medications had been reported in the six months prior to our inspection. This related to a medication being incorrectly labelled by pharmacy. A member of staff noted this and immediate actions were taken to address this.
- We looked at the medication administration charts of seven patients. We found that all prescriptions were legible, signed and dated. All charts had evidence that patients' allergies had been checked. There were no gaps in the administration of medications and medications were prescribed in line with best practice for all patients. We only found one area of concern which related to an intravenous antibiotic prescription that did not have a stop date documented.
- We looked at the daily room and medication fridge temperature recording logs and found that these had

been completed daily. Staff we spoke with told us that if temperature recordings were out of range they contacted the maintenance department, who were very responsive.

Environment and equipment

- The unit accommodated up to 15 patients in single bedded en suite rooms. All areas of the unit were visibly clean and well maintained.
- Communal areas included a large day room, dining room and two seating areas at each end of the ward. All of these areas were tastefully decorated and designed to provide a homely environment.
- We looked at medical devices and found that these were in date for servicing in line with policy and manufacturers guidance. We were provided with a spreadsheet which confirmed that all medical devises on the unit had been appropriately maintained.
- We saw that domestic items such as lamps and televisions had also been tested for electrical safety.
- In the ward kitchen, we saw that the patient fridge and dishwasher had daily temperature record sheets. These were completed in full.

Quality of records

- NAViGO used an electronic nursing record. Patients NHS medical records were transferred from the acute trust at the time of admission. We looked at the unit medical and nursing notes of seven patients. Patients' risk assessments were paper based.
- We saw that, where possible, patients were involved with their plan of care and that they countersigned their records. Family involvement was clearly documented in the medical records we looked at.
- We saw that a daily medical review had taken place for all patients and that a diagnosis and management plan was documented.
- We found that records were completed fully and consistently for all patients. We saw comprehensive assessments of patients' needs and care plans in place to manage the risks. This meant that records were in line with staffs' registering bodies.

Cleanliness, infection control and hygiene

- Staff completed infection prevention and control training as part of their statutory mandatory training. Information provided showed that 90% of staff were compliant with infection control training and 84% of staff were compliant with food hygiene training.
- During our inspection, we found the unit to be visibly clean and well maintained. We saw that personal protective equipment (PPE) such as gloves and aprons were readily available throughout the ward. We saw most staff adhering to correct hand washing techniques and bare below the elbow. We did witness one member of staff removing a patient's wound dressing without first decontaminating their hands or using PPE; however this was however immediately challenged by another member of staff.
- Each bedroom had a clinical hand washbasin. In most rooms we saw that patient's toiletries, such as soap were stored on the side of the sink. It is not recommended that patients use clinical handwashing facilities for their personal hygiene needs.
- The ward manager completed infection control audits each month.We saw that when actions were needed to address deficits in the audits, an action plan was created and feedback was provided to staff.
- We noted that in the six months from February 2016 to July 2016 infection control audits had been 85% compliant in February, 92% in March, 96% in April, 94% in May, 94% in June and 98% in July. The results were red, amber or green (RAG) rated by NAViGO with green being 95% or above, therefore whilst four of the six audits were rated as amber, compliance levels were high.
- Staff on the unit wore their own clothes, rather than a uniform. We discussed this with the ward manager who advised that staff treated their clothes as they would a uniform, in that these were washed at high temperature. We were told that the rationale for staff wearing their own clothes was to prevent barriers between staff and patients.
- The bedrooms and some communal areas on the unit were carpeted. In addition to this each room had a bed settee, which was fabric covered. There were also other soft furnishings in the rooms such as cushions on the settees. We had concerns about this as soft furnishings are not recommended in clinical settings

due to the risk of cross infection and the difficulty of being able to adequately clean and decontaminate these types of materials (Health Building Note 00-09:Infection control in the built environment). We discussed our concerns with the ward manager who told us that all rooms are deep cleaned after a patient is discharged, this included steam cleaning of the carpet and settees in the rooms. Cushion covers were sent to the laundry. The ward manager told us that if soft furnishings, including carpets became stained they would be immediately relaced /disposed of. The Health Building Note 00-09:Infection control in the built environment recommends that it is essential that a documented local risk assessment is carried out with Infection prevention control involvement and a clearly defined pre-planned preventative maintenance and cleaning programme is put in place. We did not see any evidence of a documented local risk assessment.

- There had been no cases of methicillin resistant staphylococcus aureus (MRSA) reported by the unit since it had opened. Staff had cared for one patient with clostridium difficile; following investigation, this case had been deemed as unavoidable.

Mandatory training

- Staff completed a variety of mandatory training modules including dementia awareness, resuscitation, mental capacity act, mental health awareness, moving and handling, RESPECT (managing violence and aggression training) safeguarding adults, safeguarding children, PREVENT (counter terrorism), equality and diversity, fire safety, health and safety, food hygiene, infection control and information governance.
- We looked at compliance levels for mandatory training and found that compliance was low across most core elements as follows:
  - Dementia awareness 39%
  - Moving and handling 46%
  - RESPECT 51%
  - Safeguarding adults 52%
  - Equality and diversity 52%
  - Fire safety 49%
  - Mental Health awareness 52%
  - Mental Capacity act 69%
  - Resuscitation 74%
- This meant that staff were not appropriately trained to maintain patients or their own safety. We saw that a report had been produced by NAViGO which highlighted this concern and that additional ad hoc training sessions had been arranged.However one member of staff told us that these ad hoc sessions have been cancelled, at short notice, in the past.
- We found that compliance was above 75% for safeguarding children, PREVENT, food hygiene, infection control, information governance and health and safety training.
- We raised the low compliance rates as a concern with senior staff at the time of our inspection.

Assessing and responding to patient risk

- Advice is issued to the NHS as and when issues arise, via the central alerting system. National patient safety alerts (NPSA) are crucial to rapidly alert the healthcare system to risks and provide guidance on preventing potential incidents that may lead to harm or death.
- NAViGO had systems in place to share national patient safety alerts. Centrally the data was reviewed and then disseminated to any relevant services for action and sharing with staff through team leaders.
- We saw pressure risk assessments completed in all of the care records we looked at.
- Staff followed the local acute trust's recognition and escalation of care for acutely ill adults using the national early warning score (NEWS) policy
- The local acute trust had adopted the National Early Warning Score (NEWS) as part of its strategy to optimise the safety of acutely ill patients and reduce mortality. NEWS is designed to support clinical staff in the recognition of the often subtle signs and symptoms associated with deterioration, with a view to triggering early and competent intervention. The key advantage of NEWS over other 'track and trigger systems' is that it represents 'a single NEWS system for

Good

Community health inpatient services

early detection of the acutely unwell patient by measurement of specific physiological parameters in a standardized format' (Royal College of Physicians, 2012).

- We looked at the NEWS charts of seven patients and found that these were completed and that scores were documented.
- We saw evidence that the recent introduction of NEWS to the unit had been communicated effectively to staff. Staff we spoke to were aware of the escalation procedures relating to the NEWS score.

Nurse Staffing

- The planned staffing levels for the unit were displayed on the ward and were:
  - Three registered nurses and three care support workers on day shifts Monday to Friday.
  - Two registered nurses and two care support workers on day shifts Saturday and Sunday and each night duty.
- In addition to the planned nurse staffing, the ward manager worked Monday to Friday and was supernumerary.
- Staff we spoke with told us that they felt that the staffing levels enabled them to keep patients and themselves safe.
- The ward manager told us that if additional resource was needed to support more vulnerable patients this was supported by NAViGO and could be sought via the nurse bank or agencies

Medical Staffing

- Medical cover to the unit was provided by the onsite acute trust. This included a speciality doctor and a specialist registrar Monday to Friday 9am – 5pm.
- Out of hours, the onsite acute trust was responsible for providing a full on call middle grade doctor list for non-emergencies.
- In an emergency the onsite acute trust's emergency department and the crash team supported the unit**.**

Managing anticipated risks

- The unit was supported by NAViGO's business continuity and escalation policy. This policy highlighted the need to plan for, and respond to, a wide range of incidents and emergencies that could affect health or patient care. This included major incident planning.
- This policy was available to support staff in the event of an emergency and included key contact details for on call staff, escalation procedures and reporting processes.

Are community health inpatient services effective?

(for example, treatment is effective)

Good

Evidence based care and treatment

- The unit used a combination of NAViGO and the onsite acute trust policies.We saw that these policies had reference to and reflected national best practice guidance, for example The National Institute for Health and Care Excellence (NICE).However the unit's pathways and guidance documents, for example the guidelines for the management of community acquired pneumonia and the management of chronic obstructive pulmonary disease did not have any references to recognised best practice.
- Nursing and therapy staff we spoke with were aware of best practice guidance and they told us that policies were accessible via the acute trust's intranet.

Pain relief

- We saw that patients were prescribed pain relief and that pain assessments were completed at each medication round.
- Patients were also asked about pain during hourly comfort rounds. Comfort rounds are a structured approach whereby nurses conduct checks on patients at set times to assess and manage their fundamental care needs.
- Pharmacy audits that we looked at showed that the pharmacist highlighted if any patients were not prescribed pain relief.

- Patients told us that staff provided pain relief quickly when they needed it. Patient's records showed that a care plan was developed for patients who were experiencing pain.

Nutrition and hydration

- We saw that patients were assessed for risk of malnutrition and that food and fluid charts were completed to monitor patients' dietary intake and highlight any patients who were at risk.
- The food provided in the unit was freshly prepared on site. We saw a meal service on the unit and noted that the food looked appetising and was well presented.
- Patients were encouraged to use the dining room for meals and staff joined them to provide assistance, encouragement and to monitor intake. Staff we spoke to explained that patients with dementia would often mirror actions of others, so by eating with patients this encouraged them with their dietary intake.
- Food evaluation charts were completed and we saw the results of these which were predominantly positive.

Patient outcomes

- There was a local audit programme such as infection control, medicines and case notes which were performed weekly or monthly. The outcomes from these audits, including changes to practice were communicated to staff.
- We also saw a NAViGO rolling audit programme. The home from home discharge summary audit was assigned to the unit manager. This was not due for completion until September 2016 therefore we were not able to see the results of this.
- The unit collated patient outcome data including:
  - The unit's average length of stay for acute inpatient discharges for people with confusion was less than 12.65 days. Figures produced by the Alzheimer's society showed that 86% of patients with dementia admitted to an acute ward with a urinary tract infection stayed more than one week, 53% stayed two weeks or more and 30% stayed for more than one month.
  - The proportion of patients discharged to short stay care home placements was below 4.62%
  - 80% of patients were discharged to their usual residence.
  - Over 66% of patients were transferred to the unit between the hours of 07:00 and 22:00.

Competent staff

- Staff we spoke with told us they had attended an induction prior to starting work on the unit. Information provided showed that 67% of staff employed on the unit had undertaken NAViGO's induction.
- Information provided showed that 60% of staff on the unit had an up to date appraisal. This was in line with what we heard from staff during our inspection in that some said they had an up to date appraisal and others said that they had not. The unit held regular clinical supervision sessions facilitated by the ward manager and the senior registered nurses.Information we saw showed that all staff, except one, had attended supervision at least once in the three-month period May to July 2016. All staff were booked to attend supervision in August 2016.
- NAViGO had held revalidation roadshows in January, February and March this year for nurses who required revalidation through the Nursing and Midwifery Council (NMC).The ward manager held a log of the registration dates for all registered nurses.
- One member of staff told us that they were a non-medical prescriber and that this enabled them to support the unit.

Multi-disciplinary (MDT) working and coordinated care pathways

- A full multi-disciplinary team including medical, nursing and therapy staff as well as two mental health nurses supported patients on the unit.
- Staff we spoke with told us that specialist support, such as dieticians and speech and language therapy was provided from the acute trust. We were told that, because the unit was relatively new, some services had not been aware of the unit's purpose.This had sometimes caused problems in access to the services needed to support them but this was improving.

- MDT meetings were held on the ward. We saw minutes from these meetings and noted that where possible the meetings included patients and those close to them.
- There was a coordinated care pathway for referrals from the acute trust to the unit.

Referral, transfer and discharge

- We saw the referral pathway from the acute trust to the unit. This was straightforward and staff did not raise any concerns about the referral or admission process.
- The referral pathway included inclusion and exclusion criteria. A member of staff from the unit provided an in reach service and visited the patient on the referring acute trust ward prior to the patients being accepted and transferred.
- Local authority representatives visited the unit on a daily basis so they were aware of patients who would be discharged in the near future.

Access to information

- Staff were able to access NAViGO and the local NHS trust policies via the relevant intranets. In addition to this staff could access patients' blood and other test results electronically.
- Medical records were transferred from the acute setting to the unit when the patient was admitted.
- Nursing and therapy staff could access patient's records via the electronic records system.
- The electronic system was linked to a patient status at a glance board in the staff office which displayed the patients' most recent NEWS score, resuscitation status, nutritional needs etc.

Consent, Mental Capacity act (MCA) and Deprivation of Liberty Safeguards (DoLs)

- Consent to treatment means that a person must give their permission before they receive any kind of treatment or care. An explanation about the treatment must be given first. The principle of consent is an important part of medical ethics and human rights law. Consent can be given verbally or in writing. For consent to be valid, it must be voluntary (the decision made by the person themselves) and informed, and the person consenting must have the capacity to make the decision. If a person does not have the mental capacity to make a decision about their treatment, professionals can make a 'best interest' decision. However, the professional must take reasonable steps to consult with the patient's family or closest person before making these decisions.
- We saw that patients' consent was documented in their nursing care record, by the patient or the person closest to them.
- We saw staff seeking and obtaining verbal consent before providing any care or treatments.
- Staff completed training in Mental Capacity Act and Deprivation of Liberty safeguarding. We saw information provided by NAViGO which showed that 69% of staff from the unit had completed this training.
- The unit had two mental health nurses who, we were told, completed Mental Capacity Act assessments. We saw that Mental Capacity Act assessments had been completed in all of the care records we reviewed.
- During our inspection, we looked at four do not attempt cardiopulmonary resuscitation (DNACPR) forms. We found varying compliance with best national best practice and the local trust policy. We found that where patients had mental capacity they were involved in the discussion about resuscitation and that these discussions were clearly documented in their medical notes. However, we had concern that all were signed by a registrar and not the patient's consultant. Two of the forms were correctly held in the front of the patient's notes but two were not. We raised our concerns with the ward manager who told us that this would be addressed.

Are community health inpatient services caring?

Outstanding ☆

Compassionate care

- The NHS Friends and Family Test (FFT) was created to help service providers and commissioners understand whether their patients are happy with the service provided, or where improvements are needed.

Good

Community health inpatient services

- The proportion of patients recommending the unit to friends and family between 1 July 2015 and 31 May 2016 was 94% (174/186). Only two service users for the year provided a negative response.
- We saw lots of thank you cards and complimentary letters displayed on the notice boards on the unit and also in a file in one of the communal seating areas.
- The unit had a suggestion/feedback box. We were provided with a sample of seven feedback forms and also saw a recent letter which had been received from a relative. The letter and the forms had consistently positive comments about the unit and the staff at all levels. The staff and the unit were described as 'amazing', 'fantastic', '10/10', 'exceptionally kind and caring', 'brilliant and can't do enough for you' 'cheerful and helpful' and a 'godsend'.
- During our inspection, we observed, without exception, staff providing compassionate care to patients. Staff and patient interactions were noted to be consistently positive.
- Four patients we spoke with told us:
  - They had been in the unit for five days and they 'love it'. There is nothing they would change about the unit. They also said that the staff were "fantastic, super". They felt safe and had been involved in conversations about their care.
  - They had been in the unit for three days and were enjoying their stay. They said that there was a friendly atmosphere and the staff had been excellent and that they admire them. They also told us that they felt safe and that the nurses have explained the care to her.
  - They had been in the unit for a week. The nurses were pleasant and very helpful. The doctor spoke very clearly and was informative. This patient also said they liked their room and had everything they needed. 'Everything is good and I feel at home'.
  - That they liked the staff and the food. That this was the 'best place I have been in years'; this patient also told us that if they did not like the food the staff would go to the shop for them.
  - Whilst speaking to one patient a support worker brought in a pack up box with some sandwiches in as this patient was being discharged later that day. The member of staff said that this would save her making them when the patient got home.
- A member of staff we spoke with told us that the unit's ethos was to "treat patients like own family"; they added this was more than just an ethos as it was actually embedded in service delivery.
- One member of staff told us they have the time to sit with patients unlike anywhere else they had ever worked. Another said 'where else would patients get this level of care?' and 'the smallest things make the biggest difference'.

Understanding and involvement of patients and those close to them

- We spoke to four relatives of patients who told us:
  - One told us that they felt their relative got exceptional personal care and could not get better care anywhere else. They also said that they feel that their relative is safe on the ward because they have mobility issues and are well supported. They received good communication from all staff and that when she contacts the ward 'I am listened to'. This relative said that the staff were "brilliant" and the environment lovely. We were also told they had been involved in discharge planning and they felt that staff understood their needs as a carer and were familiar with her circumstances.
  - Another said that their relative had been on the ward for three weeks and they 'loved the ward' adding that staff were 'welcoming and accommodating' and that they can visit whenever they want.
  - The third said that their relative was struggling to eat and that the staff made her food when they were visiting so that they could eat them together in her room and help to encourage her to eat. This relative also said the unit was 'homely'.
- All relatives we spoke with told us that the unit had open visiting.

Emotional support

Good

Community health inpatient services

- We saw staff providing emotional support to the patients they were treating and also positive interactions between staff and the patients' carers.
- We observed a reminiscence group which took place on the unit on the day of our inspection. We thought this was outstanding. Patients who appeared quiet earlier in the day, actively participated in this. Staff encouraged and supported the patients throughout this session.
- In addition, other activities including singalongs and games that encouraged dexterity took place each afternoon in the day room.
- Specialist support was available, for example for diabetes or tissue viability, from the acute NHS trust.
- We saw notice boards provided information about, NAViGO, peer support groups and memory groups**.**

Are community health inpatient services responsive to people's needs?

(for example, to feedback?)

Good

Planning and delivering services which meet people's needs

- NAViGO CIC, in partnership with a local acute trust opened the unit as an in reach model that aimed to care for and treat older people who are confused or living with other symptoms of dementia and in need of acute general hospital care.
- The initiative aimed to reduce the acute inpatient length of stay and re-admission rate for the patients on the unit and to attain excellent service user experience for people suffering with confusion by ensuring that:
  - Transfers took place between 07:00 and 22:00 hours and with the service user's/family's consent
  - Family and carer input about care and treatment was actively sought where consent allowed.
  - The unit environment was informal, relaxed and homely
  - Palliative care needs were planned to ensure dignity and respect
  - Service users were discharged to their usual place of residence wherever possible and as soon as possible to minimise delayed discharges

Equality and diversity

- Translation services were readily available and staff we spoke with knew how to access these if required.
- The unit had a multi-faith prayer room.This room was also used as an area where staff could speak to relatives in private.
- All staff we spoke with told us that they respected the individuality of all patients on the unit.

Meeting the needs of people in vulnerable circumstances

- The environment was dementia friendly and this allowed patients the freedom and space to carry out everyday activities in a homely environment.
- The unit had been planned and designed around the needs of patients with dementia or short-term confusion following an acute illness. This included pictures of local landmarks, some of which were from the past, comfortable seating areas with seats with high arms and dementia friendly, contrasting fabrics.
- In addition to this, we saw a leaflet rack which contained information about medical and mental health conditions.
- Books and magazines were available as well as daily newspapers and reminiscence books from the 1960s, 1970s and 1980s.
- All the bedrooms had pictures on the doors, which helped to orientate the patient to recognise their own room.
- All bedrooms were on one corridor with a seating area at each end and benches along the corridor for patients to rest or to allow staff to observe patients if necessary.
- NAViGO had a policy to support staff when admitting patients with a learning disability.

Good

Community health inpatient services

- Staff we spoke with said they had used visual menus and picture cards for patients who were deaf or hard of hearing.

Access to the right care at the right time

- The unit provided an integrated approach to deliver mental health and acute medical and nursing care.
- We were told that there was no waiting list for the unit.
- Referral processes were simple and staff did not raise any concerns about these.
- Staff we spoke with told us the unit was becoming more embedded and the acute trust wards were developing a greater awareness and understanding of its purpose.
- During our inspection we only heard one patient buzzer, we saw a member of staff respond to this immediately.

Learning from complaints and concerns

- There had been no formal complaints about the unit since it opened in 2015.
- Information about how to make a complaint or raise a concern was displayed on a notice board on the unit.

Are community health inpatient services well-led?

Good

Service vision and strategy

- NAViGO mission, values and goals were displayed on a notice board on the unit. Staff we spoke to were aware of these and used these as the basis to the care and treatment provided to patients.
- The company's mission was to deliver services that we would be happy for our family to use.
- The values were:
  - That humanity and equity is our approach to care
  - To create benefits for the wider community
  - To be passionate about all that we do
  - To promote independence and choice
  - To be an employer of choice
- Their goals were to:
  - Support and improve mental health and wellbeing of the local population
  - Utilise their membership as a key vehicle for decision making and organisational changes
  - Promote social inclusion and choice, support users to reach their true potential
  - Achieve equality between staff and service users
  - Ensure services are directly accessible where appropriate and prevent and/or intervene early

Governance, risk management and quality measurement

- We saw a corporate risk register, which highlighted risks across all areas of the company. We were told that there was not a unit specific risk register. We saw that some of the risks were identified on the corporate register would be applicable to the unit and that these had been addressed and actions to mitigate the risks were evidenced. However not all risks were included. For example, high numbers of patient falls and the low numbers of staff compliant with mandatory training.
- Clinical governance meetings were held. We looked at minutes from these meetings and found that risks were discussed. In addition to this, we saw that policies, clinical audit programmes and serious incident plans etc. were all discussed at this forum. The ward manager was then responsible for cascading this information to staff on the unit. We saw evidence of this in team meeting minutes.
- The governance committee also reviewed quality reports, for example, we saw that in July, the infection control and incident quality reports were reviewed.

Leadership of this service

- The leadership structure for the unit included the chief executive, associate director of operations, a medical director from NAViGO and one from the acute trust, a senior operational manager, a clinical team lead, a mental health liaison lead nurse and a senior administrator.

Good

Community health inpatient services

- Staff we spoke with told us that the local leadership team were visible and supportive.

Culture within this service

- We found that all staff we spoke with or witnessed during our inspection were consistently positive, friendly, helpful and approachable.
- Staff told us there was a positive culture on the unit and they worked as a team.
- We saw NAViGO's code of conduct displayed on the ward; this described the organisation's expectations of staff and what staff could expect from the organisation. Staff we spoke with were aware of the code of conduct.
- Staff we spoke with told us that the unit had 'a great atmosphere', that 'the passion of the staff is fantastic', and that they were encouraged to suggest new ideas for the unit.

Public engagement

- We saw information displayed about patient support groups.
- There was a suggestion box on the unit and we saw that ideas generated from this were displayed in a 'You said, we did' format. This included suggestions about activities and food that had been implemented by the team. This also highlighted that staff were difficult to recognise because they did not wear uniforms.We discussed this with the ward manager who told us that this was a NAViGO ethos not to create power. To resolve this issue all staff were asked to ensure they wore their name badges. On the day of our inspection all staff we saw were wearing their name badges.
- During our inspection, we saw that family and carers of patients were encouraged to be involved in their care and treatment.

Staff engagement

- One hundred per cent (15/15) of respondents in the staff survey in June 2016 said they would recommend the unit as a place to receive care or treatment.
- Staff employed by NAViGO were invited to contribute to corporative objectives for the organisation, the outcomes of which were then fed in to the quality priorities and strategic corporate objectives for the company.
- The organisation provided electronic updates on a monthly basis. These included feedback from the organisation and also invitations to submit entries for initiatives such as project of the year.
- We saw that staff received feedback from incidents and information at a local level through team meetings and notice board displays on the unit.
- We saw that NAViGO held events for staff such as netball, rounders, dance classes and fitness Fridays for all staff to join. In addition to these events NAViGO also held staff focus groups to ask staff what they felt the company did well and what could be improved. Also to seek staff views on how engaged and motivated they felt and how the company could reward accomplishments and value staffs' contributions more effectively. These events were strictly for staff and managers were asked not to attend.

Innovation, improvement and sustainability

- The unit opened in June 2015, a partnership between NAViGO and the local NHS trust. In a report produced just prior to our inspection it was felt that in terms of improvement the initiative has:
  - Offered a more appropriate treatment setting for confused patients. Maintained patient's independence and reduced admissions to mental health services.
  - Reduced delayed discharges and reduced length of stay
  - Reduced A & E presentations
  - Reduced inappropriate use of sedation
  - Improved parity of esteem between physical/ mental health care
  - Offered quality/efficient/effective/consistent and safer patient care and treatment protocols.
  - Provided a structured referral and crisis response
  - Provided better transitional planning

Good

Community health inpatient services

- Improved joint working with health and other partners
- Provided a safe and effective discharge process which has included the integration of social care
- Provided single en-suite accommodation and the ability for carers and family members to stay and be part of the care, reducing anxiety and assisting recovery
- Provided integration of adult social care into a model which expedited discharge
- Created a dementia friendly space where patients were able to walk and space to maintain their activities of daily living.

- Due to the evidence of innovation and improvement the unit had won the 'Across the Pennines' Quality Improvement Awards 2016.
- In June 2016 NAViGO invited staff from all areas to become departmental champions.This role was to enable staff from each service to represent the views of their team, to share information about organisational matters, share bright ideas and innovations and support staff to understand the issues/challenge/developments facing the workforce.
- Staff were also invited to be innovation champions and to attend the Horizon Scanning meeting which was held each month, to discuss new ideas or innovations.

Outstanding practice and areas for improvement

Outstanding practice

We felt that the standard of care and the compassion witnessed being provided by staff on the unit was outstanding. We saw consistently positive interactions between staff and patients, and feedback from patients and their families was outstanding in relation to the care provided.

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that compliance with mandatory training is improved. We were told that actions to mitigate this risk had been put in place, with a compliance level of 82% expected to be achieved in the near future.
- The provider must ensure that all patients are risk assessed for venous thromboembolism and that feedback from the safety thermometer is provided to ensure that harm or harm free care is recognised.

Action the provider SHOULD take to improve

- The provider should ensure that all risks are highlighted on the corporate risk register or that services develop location risk registers and that these show evidence of actions to mitigate the risks identified.
- The provider should ensure that all staff have an up to date appraisal each year

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 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not fully risk assessed all patients for venous thromboembolism. This was a breech of regulation 12

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Records showed that Navigo had not reached the required standard for mandatory training This was a breech of regulation 18