Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Cambian - Storthfield House Hospital

Storth Lane, Normanton, Alfreton, DE55 3AA

Tel: 01773515600

Date of Inspection: 25 February 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Staffing	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	Cambian Healthcare Limited
Registered Manager	Mr. Charles Stima
Overview of the service	Storthfield House is an independent hospital service registered to provide diagnostic and screening procedures, treatment of disease, disorder or injury and assessment or medical treatment of persons detained under the Mental Health Act 1983 for up to 22 people, male only, under the age of 65 years.
Type of services	Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 25 February 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members and talked with staff.

What people told us and what we found

During our inspection we spoke with seven people who used the service, two relatives, four members of staff and a health care professional.

People using the service talked positively about staff and the way they were treated. One person said, "I am OK here, I feel I have done well. I like the staff and have no complaints." A relative told us, "This is the best placement X has ever had. X trusts them and likes being there and is always happy to return."

A health care professional told us, "I feel comfortable placing people there. Staff are cooperative, professional and communication is good. De-escalation skills are excellent."

We saw that people's consent to care and treatment was gained in accordance with legislation.

People were informed of the status of their detention and their rights under the Mental Health Act. Not everyone was aware of the length of their detention and when it would end.

We saw that people received the care and treatment they needed to meet their individual needs. A range of therapeutic activities and support were available to promote people's rehabilitation.

There were enough staff on duty at all times with the training, skills and experience to meet people's needs.

We saw there were effective systems in place to respond to any comments or complaints.

People had access to advocates who supported them in their monthly reviews and at other

times they needed them.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

We reviewed how the provider followed the principles of the Mental Capacity Act 2005.

Mental capacity is the ability to make an informed decision based upon understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability. In these circumstances other people can be authorised to make decisions on their behalf as long as they are in the person's best interests.

We saw that the majority of people had signed their care records. Some people unable to sign them had given verbal consent. This had been documented in their records. This meant that people had given consent to their care, treatment and support. The provider had acted in accordance with their wishes.

We saw that if people had been unable to make some decisions actions were taken in their best interests. For example we saw that a best interests decision had been made for a person vulnerable to financial abuse. We saw that assessments had been completed under the Mental Capacity Act where people did not have capacity to make a specific decision. Best interests meetings had been held. This meant the provider had acted in accordance with legal procedures.

We saw that It had been necessary to restrict a person's liberty under the Deprivation of Liberty Safeguards (DoLS) 2009 to protect the person from self harm. An application had been made to an authorised body (local authority). An assessment of capacity had been undertaken and a best interest decision made to ensure the person's health and wellbeing. This meant the provider was following the principles of the Mental Capacity Act 2005. .

Staff we spoke with told us they had received training in the Mental Capacity Act. Training records confirmed this. Staff were able to tell us about the principles of the Act and and how people were supported to make decisions. We saw examples of staff encouraging people to make everyday decisions relating to their care, treatment and support. This meant the principles of the Mental Capacity Act were being applied.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

There were 18 people living at Storthfield House. All were detained under the Mental Health Act 1983 with the exception of one person who was not detained. People spoke very positively about staff. One person told us, "The staff are great. I have lots of community activities including, horse-riding, gym, swimming as well as internal activities. I am given unescorted leave to do these things." A relative told us, "This is the most stable placement X has had. They are sorting out medication side-effects. There is a wonderful rapport with staff. I know X is safe and in good hands."

During our inspection we observed staff interacting positively with people. We saw that people regularly accessed the local community and were engaged in purposeful activities around the hospital. One person told us their activity programme for the day included "Going to the (external) gym, food shopping, cooking practice and woodwork skills this afternoon at college." Each person had a weekly activity programme. Support was available from nursing and support staff, two psychologists and occupational therapists. The hospital prioritised family contacts as a key part of treatment and rehabilitation.

We looked at three people's care records. We saw that comprehensive assessments had been completed before the person's admission to Storthfield House. This had included a detailed medical and social history. Risk assessments had been completed and had been reviewed regularly. Each person had a care plan. Regular four monthly reviews had been undertaken of each person's care programme approach (CPA) record. This is a requirement under the Mental Health Act. We saw detailed clinical notes and daily recording of each person's progress.

Some people presented behaviours that could present risks to themselves or others. Care records contained information about what might trigger individual behaviours. Risk assessments and risk management plans were also in place for these. There was evidence that the focus upon diversion and re-direction had been successful in managing behaviours. Physical restraint was used only as a final option if other methods failed and there was a risk to the person or others.

Whilst the standard of recording in care records was generally high we shared some

shortfalls with the manager. A person had a successful two week home leave period, but a home visit report had not been completed. Each person had a discussion their named nurse and key worker weekly to discuss their progress. Records showed gaps in recording meetings over several weeks. We saw that action needed to further investigate a potentially serious medical condition of a person had not been pursued following a letter from a GP. The responsible clinician and manager told us they intended to arrange a further re-referral to a consultant for assessment and treatment advice.

The hospital has a duty under Section 132 of the Mental Health Act 1983 to regularly inform people who are detained of their legal status of detention, their rights to apply for discharge and access to an independent mental health advocate. The hospital repeated this every three months. We saw from the records of two people that they had been given this information. Both had signed a confirmation that they had received a written copy of the information. Records showed that one person had "not understood" the information and two further attempts to repeat the information had similar recordings. Further attempts to explain the person's rights would be repeated in three month's.

We spoke with the two people whose records we had seen. They both confirmed they had each received copies of the information about their rights. They were unable to tell us the period of their detention and when it would end. The manager said they intended to review how this important information could be re-enforced with people in ongoing meetings and reviews.

People detained under the Mental Health Act are able to leave the hospital if granted leave under Section 17 of the Mental Health Act by the responsible clinician. This may be either escorted leave (with staff) or unescorted leave, for short periods or several hours. We saw that several people had been granted leave for regular overnight stays with their relatives. Records we saw relating to their Section 17 leave had been completed by the responsible clinician. The records were clear and detailed when and where leave could be taken, the purpose of the leave and the level of support needed. We saw imaginative use of leave. For example a person needing motivation to rise had been given 20 minutes shadowed leave before 10.00 a.m.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others

Reasons for our judgement

We looked at the arrangements in place where care and treatment was shared with or transferred to other providers.

Storthfield House provides a rehabilitation service for people detained under the Mental Health Act 1983. Discharge planning commenced when the person was admitted to the service. This is ongoing and involved discussions with a range of other providers in achieving the most appropriate placement for the person in the community or with another provider.

We saw there had been detailed assessments of people prior to their admission. Assessment information had been shared with other providers. The person and their family had attended visits and meetings to Storthfield House prior to admission. Other providers and professionals had been involved those meetings. This meant the provider completed assessments and shared information with other providers.

We saw that similar arrangements were in place for planned moves to alternative placements. Information was shared with potential providers and a range of professionals involved with the person's care and transfer. We saw that future placement providers had attended review meetings at Storthfield House in advance of transfers. Storthfield House staff co-ordinated the transfer of each person's care, treatment and support to ensure continuity.

The hospital had a protocol for sharing confidential information with other providers. Information sharing was important to ensure continued safe delivery of care, treatment and support Staff were aware that information could be shared in line with the Data Protection Act 1998. This meant the provider ensured the safe transfer of information with other providers.

We saw examples of information sharing for people who had moved from children and adolescent mental health services. Information had been provided to a local hospital when a person was admitted for urgent medical reasons. A member of staff had stayed

overnight to support the person and to liaise with hospital staff. The service worked closely with the local safeguarding team. A community police officer had visited the hospital to see a person several times following a recommendation of the safeguarding team.

We saw that written requests had been made for continuing psychology support following people being transferred to other settings. This showed the provider had worked in cooperation with others in providing appropriate information to ensure the continuity of safe care and treatment.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

At the time of our inspection there were 18 people who used the service at Storthfield House.

There were two nurses and seven support workers including a team leader on duty. Additional staff in the hospital included the manager, the head of care, a clinical psychologist and occupational therapist. We looked at the previous four week's staffing rosters. We found that there had been two nurses and a minimum of five support workers working during the day. Mostly there had been seven support workers on duty. Rosters showed that there was one nurse and four support workers on duty throughout the night.

We saw that there was a daily risk assessment for the hospital in place. This graded the risk for each person. For instance we saw that one person had 24 hour observation and two other people had individual support at mealtimes due to the risk of choking. Staffing levels were sufficiently flexible to take account of people's changing needs and risks. This meant the number of staff on duty was based upon the level of risk and need.

We spoke with a nurse and a support worker. They confirmed they had received the necessary training to meet people's needs. Each staff member had undertaken training in the management of violence and aggression and were able to tell us about factors that would trigger potentially violent behaviours and the strategies in place to manage those behaviours. Each staff member told us they felt confident in dealing with difficult behaviours and there were behaviour management plans in place to avoid the need for physical interventions. This meant that staff had the knowledge, skills and experience to meet people's needs.

Two members of staff told us that there were sufficient staff on duty at all times. One staff member said, "Yes there are enough staff on duty to maintain safety and quality of life for people." We asked two people who used the service if there had always been enough staff on duty and whether there had been circumstances where support had not been available for them. Each person said they felt there had been enough staff on duty and there had been no circumstances where their activities had been cancelled or compromised due to inadequate staffing levels. One person told us, "Staff are always available, for instance when I go out on escorted leave". This meant that people who used

the service and staff believed there were usually enough staff on duty to meet people's needs.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately

Reasons for our judgement

People we spoke with were able to tell us how they would complain if they were unhappy about their care. One person said, "I would speak to a member of staff if I needed to complain". Another person said, "I would not hesitate to complain if there was something I did not like." This meant that people were aware of their right to complain.

People told us that they had been given a copy of the complaints procedure and we saw a copy of the procedure was posted in the hospital. This stated how people could complain, who they could complain to, how the complaint would be investigated, with a timescale of 20 days when people would receive a written response. We saw that a complaint received had been acknowledged in writing as well as verbally. This meant the complaints procedure was available to all people using the service and visitors.

We looked at the complaints register. We saw that since our last inspection one formal compliant had been received and dealt with appropriately as outlined in the complaints procedure. We saw that 'informal' complaints had been received and had been recorded in the complaints register. Informal complaints were mainly of a domestic nature or where people had agreed the matter could be resolved easily with discussion within the hospital. Each type of complaint had been recorded with outcomes and any actions taken. This meant that complaints had been recorded, investigated appropriately and actions taken to improve the service.

An independent advocacy service was available in the hospital. An advocate visits every two weeks and is involved in reviews to advise and support people. Information about the service was available in the hospital, explaining the role of the advocate and how the advocacy service could assist people with any areas of concern they may have.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk