Abbey House

Quality Report

Abbey House
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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.

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

Summary of findings

Overall summary

We rated Abbey House as good because:

- Patients had up-to-date care plans. These focused on rehabilitation and helped patients move forward with their recovery.
- Staff carried out good risk assessments for patients.
- All but one patient had received a copy of their care plan.
- There was a wide range of therapeutic activity available for patients, including horse riding, golf and voluntary work opportunities.
- Patients could grow fruit and vegetables, which the chef used to make nutritional meals in the hospital kitchen.
- Patients told us they felt safe, and all but one patient told us they were happy with the service they received at Abbey House.
- Different professionals worked well together to assess and plan for the needs of patients.
- Patients had access to psychology and nurse-led therapies to aid their recovery.
- Managers routinely held supervision and annual performance reviews with staff. These were largely up-to-date.
- Staff had mandatory training, which managers monitored to ensure compliance.
- There was an ongoing recruitment programme to fill vacancies and managers were recruiting a bank of temporary staff to support the permanent team.
- Staff routinely helped patients to address their physical healthcare needs.
- Staff completed advance statements with patients who wanted them. This meant patients could say how they wanted to be supported by people if they experienced a mental health crisis.
- Staff had a good understanding of the Mental Capacity Act and completed mental capacity assessments with patients.
- Staff routinely advised patients of their rights under the Mental Health Act.
- The service had recruited a new hospital director with the skills and experience needed to drive forward further improvements.
- Patients had good recovery and rehabilitation opportunities because Abbey House employed a range of professionals to support them.
- Abbey House was a comfortable and suitable facility for patients.
- The service sought patient and staff feedback then made changes to reflect the feedback.
- The company was responsive to the needs of staff and provided support for them when they needed it.
- Systems were in place that allowed local and national managers to audit the quality of care.
- The service had a good relationship with commissioners and was open to receiving challenge and suggestion.
- Abbey House had a good track record on safety.
- Staff knew how to report incidents. Managers investigated these and shared any relevant lessons learnt with staff.
- Abbey House had safe systems to manage medication.
- A good governance structure ensured safe and effective running of the service.

However:

- Staff did not record mental capacity assessments separately. These were recorded in daily care records, which made them hard to find.
- It was not clear if staff gave patients and other relevant parties copies of their section 17 leave forms.
- Eighty one percent of staff were up-to-date with their mandatory training, but this fell to 50% for basic life support.
- The service did not always advise informal patients about their right to leave the hospital.

Summary of findings

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Summary of this inspection

Background to Abbey House

Abbey House is owned and operated by Partnerships in Care. The service opened in 2008 to specialise in the care and treatment of men with a mental illness. Abbey House provides short and long-term locked rehabilitation in a 20-bed unit. The site also houses five semi-independent flats, providing step-down support to patients before they move on from the hospital.

The hospital is in a rural location on the edge of a village, next to farmland and near a golf course. The building is a converted manor house and is set within extensive well-kept grounds.

Abbey House is registered for the following activities:

- assessment or medical treatment for persons detained under the Mental Health Act 1983
- diagnostic and screening procedures
- treatment of disease, disorder or injury.

There were 24 patients registered at the hospital when we carried out the inspection. Of these, 23 were detained under the Mental Health Act and one patient was there informally.

The registered manager left in September 2015. When we carried out the inspection, a new registered manager was being registered with the Care Quality Commission.

We last inspected Abbey House in July 2013 and found that it met the essential standards. The last Mental Health Act monitoring visit was carried out in January 2014.

Our inspection team

Team leader: Claire Harper

The team that inspected the service at Abbey House comprised three Care Quality Commission (CQC) inspectors and a team of specialists, including a nurse and an occupational therapist. Our Mental Health Act reviewer carried out a separate, unannounced inspection within three weeks of the comprehensive inspection and these findings are included in this report.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Before the inspection visit, we reviewed information we held about Abbey House, asked other organisations for information, and sought feedback from patients using comment cards.

During the inspection visit, the inspection team:

- visited the main hospital ward and the semi-independent living flats
- looked at the quality of the ward environment and observed how staff cared for patients
- spoke with six patients using the service

Summary of this inspection

- spoke with the hospital director/registered manager and manager of the ward
- spoke with 10 other staff members, including doctors, nurses, care support workers, an occupational therapist, a psychologist, a Mental Health Act administrator and an educational tutor
- received feedback about the service from local commissioners
- attended and observed a handover meeting and a multidisciplinary patient meeting
- collected feedback from three patients using comment cards
- looked at nine patient care and treatment records
- carried out a specific check of the medication management for all patients
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us they felt safe at Abbey House. All but one patient said they liked the service and felt supported by staff. Two patients told us Abbey House was the best service they had used and one hoped to stay there.

Patients said they had copies of their care plans and were involved in their care. Patients knew how to access advocacy and all but one said they knew how to make a complaint.

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:

- Staff knew how to protect patients from avoidable harm.
- Staff carried out appropriate risk assessments to keep patients, staff and the community safe.
- Ward had a mix of staff from different professions, including managers, nurses, care support workers, psychiatrists, a social worker, a psychologist and occupational therapy staff.
- Mandatory training was in place for staff and managers monitored their attendance to ensure compliance.
- Abbey House had the correct medication management policies in place and managers carried out regular medication audits.
- Staff knew how to report incidents of harm, or risk of harm. Staff logged incidents and managers investigated them. Staff used meetings to share information about incidents so they could learn lessons from anything that had gone wrong.
- The ward area was visibly clean, clutter free and well maintained. We saw cleaning taking place during the inspection.
- Polices for protecting patients and visitors were in place and all staff understood how to recognise and report safeguarding concerns.

However, we also found:

- Eighty one percent of staff were up-to-date with their mandatory training, but this fell to 50% for basic life support.

Are services effective?

Good

We rated **effective** as good because:

- Clinical staff planned and delivered patient care and treatment in line with current guidelines, such as National Institute for Health and Care Excellence (NICE) Guidelines for Access to Psychological Interventions, and the Department of Health's 'Positive and Proactive Care: reducing the need for restrictive interventions'.
- Patients received thorough physical health checks and medical support to promote their wellbeing, in line with the Mental Health Act Code of Practice (2015) and NICE guidelines. Patients had access to a GP and a physical healthcare lead nurse. They had access to other health services when they needed them.
- Staff assessed and treated patients in a timely manner.

Summary of this inspection

- Care plans were up-to-date, showed patient involvement, and staff regularly reviewed them.
- Psychological therapies, such as cognitive behavioural therapy (CBT), were available and routinely used by patients.
- Staff could easily access patient records, which enabled them to deliver effective care and treatment.
- The service provided staff from a variety of professional backgrounds to ensure patients received a full multidisciplinary service.
- Staff had a good understanding of the Mental Health Act and Mental Capacity Act, including mental capacity assessments.
- Abbey House stored Mental Health Act legal paperwork correctly and staff could access it easily.
- Patients had routine access to third tier mental health review tribunals, managers' hearings, and mental health advocacy.
- Staff made patients aware of their rights under the Mental Health Act.
- Staff routinely obtained patient consent to treatment, then effectively recorded and stored it.
- Staff had annual appraisals and most received regular supervision.

However, we also found:

- Information about capacity assessments was stored in general care notes, which meant it was not easy to locate.
- It was not clear if patients were given copies of their section 17 leave forms.

Are services caring?

Good

We rated **caring** as good because:

- Staff involved patients as partners in their care, treatment and rehabilitation. Staff supported patients and treated them with dignity and respect. Patients could make advance directives and decisions about their care. This meant they could plan and record the support they might need if they had a mental health crisis in the future.
- We spoke with a local commissioner of the service who spoke positively about the care and treatment provided.
- We observed kind and caring interactions between staff and their patients.
- Staff responded compassionately to their patients.
- Patients were encouraged to develop their independence. Staff supported them to manage their own physical health needs as well as their emotional and mental health needs.
- Patients understood their care plans and were involved in developing them.

Summary of this inspection

- Community meetings and daily diary meetings encouraged and enabled patients to have an active say in the running of their wards.
- There was an independent mental health advocacy service that was easy for patients to use.

Are services responsive?

Good

We rated **responsive** as good because:

- Staff assessed patients for the service in a speedy and timely manner.
- The way the service was organised and delivered meant patients were supported to achieve their goals and develop a better understanding of their own needs.
- Patients could understand their pathway toward discharge. Abbey House provided 'step-down' accommodation in the hospital grounds, which meant patients could learn how to look after themselves. Staff had developed good relationships with local agencies to support patients with their discharge.
- Patients could access the right care at the right time because they had a range of professionals available to support them. They could also use community health facilities when they needed to.
- Abbey House provided patients with a modern and comfortable environment.
- The service worked with other organisations and local groups to provide support to patients so they could take part in education, work and voluntary roles within their community.
- Patients knew how to make complaints and there were opportunities for them to provide feedback on the service.

Are services well-led?

Good

We rated **well led** as good because:

- The service was well led at ward level. The new hospital director had established changes needed to make the service more responsive and had effective plans to bring about changes.
- There was a commitment towards improvement.
- The service was responsive to feedback from patients, staff and external agencies.
- Morale among staff was good and they felt supported by each other and their managers
- The leadership, governance and culture within the service promoted the delivery of quality, person-centred care.
- Staff were confident they could speak up if they had concerns and felt they would be supported.

Summary of this inspection

- There were leadership and other learning opportunities available for staff so they could develop their career. Most staff who had left the service had done so to take up professional training courses.
- Arrangements were in place to monitor quality within the service and managers carried out audits.
- Local and regional managers were visible and available to staff and patients.

Detailed findings from this inspection

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

- The use of the Mental Health Act (MHA) was consistently good across the service. The documentation we reviewed was up-to-date and all relevant paperwork was present.
- Consent to treatment forms were present and arrangements for managing section 17 leave were effective. However, leave forms did not routinely show if staff had given patients a copy.
- Staff had a good understanding of the MHA and 83% were up-to-date with their MHA mandatory training.

Mental Capacity Act and Deprivation of Liberty Safeguards

- Almost all patients at the hospital were detained under the Mental Health Act (MHA).
- Staff received training in the Mental Capacity Act 2005 and in Deprivation of Liberty Safeguards (MCA DoLS). On the day of the inspection, there was a sign advising patients of their rights under the MCA DoLS. However, when we returned to carry out an unannounced Mental Health Act monitoring visit, the sign was no longer present.
- Staff demonstrated a good understanding of the MCA and said they completed mental capacity assessments with patients. However, they recorded capacity assessments within the main body of the patient daily records, so assessments were not easy to find.

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

- There was a secure double door entrance to the side of the main hospital building for visitors and staff. This protected patients and staff from unwanted visitors. There was a separate entrance at the front of the main building for patients. Informal patients were issued with entry / exit swipe cards so they had free access. Access to non-patient areas was by staff-operated keys only. The building was a converted historic manor house so there were small corridors and stairs. The layout did not enable full observation for staff but the ward area was small so staff could see and hear what was happening. Staff visited patients living in the flats at shift handovers and at lunchtime.
- Staff carried personal alarms, pagers and radios. We saw the storage, collection and testing system, which was effective. There was a hands-free telephone in the main hospital. Patients in the flats had access to a telephone to call staff in the main hospital. One patient told us staff did not always answer the phone when they called.
- Staff carried out annual environmental audits of ligature risks. They checked the building for any fixtures or fittings that patients could use to hurt themselves. Staff carried out the last audit in October 2015. The same nurse who completed the audit paperwork also countersigned it, which meant there was limited scrutiny
- The ward area and flats appeared well maintained and the corridors were clear and clutter free. The service had sought patient views over changes and improvements to the ward.
- Patient bedrooms were en suite and had a window. Patients were responsible for cleaning their bedrooms, with support from staff. The bedrooms we looked at were visibly clean. Staff locked the patient bedroom corridors when cleaning took place to ensure safe lone working for staff. Patients could be escorted to their room during the designated cleaning times if needed.
- Patients had a small lockable cupboard in their rooms so they could keep private possessions safe.
- Cleaning logs were available for patient kitchen areas, including a log for the fridge. Patient items in the fridge were clearly labelled and in date.
- Hand hygiene signs were visible. Hand gel and sinks were available.
- Staff conducted regular infection control and prevention audits to ensure patients and staff were protected against the risks of infection.
- Staff disposed of sharp objects, such as used needles and syringes, appropriately.
- The clinic room in the hospital was visibly clean and well ordered. Records showed that equipment was maintained and serviced appropriately. Servicing dates were visible. Emergency equipment, including defibrillators and oxygen, was in place. Staff checked this regularly to ensure it was fit for purpose and could be used effectively in an emergency. Check and service dates were up-to-date. The checklist logs in clinic rooms were seen to be effective and up-to-date.
- Staff said repairs were carried out in a timely manner. We saw an effective maintenance reporting system in operation. However, one patient told us the vending

machine had been out of order for more than three weeks before it was repaired. Abbey House carried out some building improvements just before the inspection which included the installation of a new patient "activity planning" board along with painting and decorating in communal areas.

Safe staffing

- Almost all staff reported they had enough staff on duty to do the job. One member of staff told us they thought it would be better if they had an extra member of staff on duty because this would mean they could offer more support to patients living in the flats. Two other staff told us that more staff on shift would mean there could be additional time to support patients with activities. The staffing establishment for the hospital was 12 qualified nurses and 11 care support workers. There was also a part-time educational tutor, a part-time social worker, a psychologist for four days a week, two part-time consultant psychiatrists, a ward manager for each shift (not included in the nursing numbers for the shift), a full-time occupational therapist and two technical instructors in the occupational therapy team (one designated as activities co-ordinator). The psychiatrists and general practitioner provided out of hours medical cover. Abbey House had a number of administrative staff, including a Mental Health Act administrator, a chef and a team of hospitality staff for housekeeping and kitchen roles. A maintenance person was employed by the company and this worker came when required. A team of regional and national managers supported the hospital director.
- Staff had undertaken training relevant to their role, including safeguarding adults; fire safety; health and safety; immediate life support; basic life support; infection control; and management of actual or potential violence. More than half of staff (67%) had received training in safeguarding vulnerable adults. Basic life support (BLS) compliance was low at 50%. The director explained they had sourced a new training provider for this and two staff were booked to complete a "train the trainer" course in January 2016, so they could increase onsite training opportunities for BLS. All but two nurses had completed their immediate life support (ILS) training. This represented 82%. One of the nurses who was not up-to-date with ILS was soon leaving Abbey House. Safeguarding children was not a mandatory training subject. However, all staff we spoke to showed a good understanding of how to identify and deal with potential safeguarding concerns. The social worker led on safeguarding issues. The hospital director told us they planned to introduce safeguarding children as a component of the mandatory training syllabus in spring 2016. The target for staff compliance with mandatory training was 95% but only 81% of staff were up-to-date. The director said increasing staff's compliance with mandatory training was a priority for him.
- Staff and patients told us planned escorted leave from the hospital almost never got cancelled. We looked at audits carried out by the service and saw that between 1 November 2014 and 1 November 2015, 2,472 periods of leave took place, of which only 26 had been cancelled. One patient told us their hospital appointment had been cancelled because of short staffing. However, overall, we could see almost all planned leave took place.
- Staffing establishment was four staff at night and five during the day, including two qualified nurses on duty at all times. The ward manager was not counted in the staffing establishment so could be called on to perform nursing duties if needed. We sampled rotas for a three-month period and saw there was a mix of male and female staff on duty at all times. We found there had been several occasions when there were fewer than the establishment requirement but at no times were there fewer than two qualified nursing staff on duty.
- There were four vacancies for care support workers. Managers were actively recruiting for these vacancies. The service had established a bank of staff who could work at short notice. There were five staff on the bank and they received the same mandatory training as permanent staff. Most bank staff had once been students on placement at the hospital or were permanent staff that had left to become students but still wanted to work some shifts there. This was beneficial for patients and staff because it meant bank staff were familiar to them.
- The service did not use agency staff.
- Staff told us there was adequate medical staff available day and night. Medical staff could attend the hospital quickly in an emergency.
- The service worked with local universities and provided placements to occupational therapy and nursing students.

Long stay/rehabilitation mental health wards for working age adults

Good

Assessing and managing risks to patients and staff

- Patients and staff we spoke with told us they felt safe in the hospital. Patients could store their possessions safely.
- Staff carried out individual risk assessments for all patients. Risk assessments were clear and linked to individual care plans. Staff regularly updated them and routinely assessed patients before they took leave and when they returned to the hospital.
- The approved Mental Health Act professional's paperwork was available so staff could easily review a patient's history and the risks that had led to their detention.
- The Historical Clinical Risk Management 20 tool (HCR20) was used to record and analyse historical risks for patients as an indicator of potential future risks. We found risk assessments were thorough, involved patients and were up-to-date in all the records we inspected.
- The handover process included discussion of individual patient risk, incidents and leave arrangements. The meetings were effective which meant staff shared important information well. However, one patient told us staff handovers could be more effective for patients living in the flats and felt communication between staff could be better.
- There was no seclusion room at the hospital. Patients could use a quiet room if they were agitated and needed a quiet space to help them calm down. It contained comfortable seating and a window. Some patients liked to lie on the sofa in the quiet room. There was a private toilet in the room but staff were considering plans to alter the layout and remove the toilet because no one used it. The service was considering options to renovate the space into something more useful for patients because there were other toilet facilities within easy reach of the quiet room.
- Training on the management of actual and potential aggression was mandatory for all staff on the wards and we saw this was up to date for 82% of staff.
- Restraint was occasionally used on the wards. Staff and patients told us staff used de-escalation techniques in the first instance. There was one report of restraint having been used in the previous three months but this was a holding hand and not a prone position restraint. This means that the agitated patient was not restrained in a face down position on the floor but was gently held by staff, with a firm hand, until they calmed down and posed less risk to other people.
- A patient had injured one member of staff within the last three months when they slammed a door on the staff member's hand. However, staff said injuries to them were rare.
- We reviewed the medicine administration records of 22 patients from the ward and the flats. We saw no reported errors in administration of medication. Medication was covered by the appropriate T2 and T3 documents. Safe and effective medication procedures were in place and Abbey House had a system to recommend and record medication reviews. Staff dispensed medication from the clinic room using a "stable door" system. Patients were seen privately in the clinic if they preferred. Patients in the flats managed their own medication as part of their rehabilitation treatment plan. Staff assessed and monitored self-medication programmes using a graded system. A pharmacist visited the hospital every week and monitored medication systems and management. We looked at audits which confirmed good practice was taking place. Records showed the administration of medicines were clear and fully completed, which showed us patients were given the right medication when they needed it.
- The service had up-to-date polices for family visits, including visits from children. A visitors' room was available although it was cluttered and not welcoming. The room contained a desk, office chair, beanbag, wheeled mobile telephone unit and armchairs. The hospital director said they looking at ways to redesign the layout and function of the room. Patients told us they were able to see their families in the main hospital building but not in the flats. Staff told us patients had not requested any child visits for over a year and despite a number of patients being parents, visits from children were rare.
- The service held monthly risk meetings where staff openly discussed risks and actions. Staff identified and discussed potential risks and incidents. The minutes were available for staff to refer to if necessary.

Track record on safety

- In the 12 months leading up to the inspection, there were no serious incidents requiring investigation.

Long stay/rehabilitation mental health wards for working age adults

Good

Duty of Candour

- Abbey House had an up-to-date policy on Duty of Candour so staff knew how to deal with "notifiable safety incidents". This meant that if staff made a mistake, for example with a patient's medication, managers would tell the patient and they would investigate the incident. Managers would then be open and honest with the patient about what had gone wrong. Staff we asked, understood what the Duty of Candour was.

Reporting incidents and learning from when things go wrong

- Staff we spoke to knew how to recognise and report incidents of harm or risk of harm. They were confident they could report incidents. They felt confident using the electronic reporting procedures. Staff were made aware of any incidents in team meetings and handovers, which minutes confirmed. Staff were involved in de-brief meetings following incidents.

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

- Care plans were in place to address individual patient needs. They were holistic, covering all aspects of the patients' needs. Staff reviewed and updated care plans regularly.
- Occupational therapy staff were based at the unit. They supported the assessment process and provided group activity therapies on the wards. Patients were very positive about the support they received from the occupational therapy team.
- Occupational therapy, social work, medical and nursing staff worked together to plan and deliver patient care. Social work staff maintained contact with the patients' home teams and families or carers. There were two identified nurses who ran family and carer groups.
- Staff routinely held Care Programme Approach (CPA) reviews to collect and monitor patient outcomes.

Best practice in treatment and care

- Abbey House employed a psychologist and patients could access psychological therapies as part of their treatment. There were no waiting lists for psychological interventions. Therapies that patients could access included cognitive behaviour based therapies, anxiety management and anger management.
- The service had identified a physical healthcare lead nurse and they had an electronic "dashboard" which highlighted patients' physical healthcare needs. Records showed staff effectively identified and managed patients' physical healthcare needs. Abbey House had a contract with a local GP who visited every Thursday to run a clinic at the hospital. The GP provided out-of-hours medical cover and extra appointments when patients needed them. A local diabetic nurse regularly visited to support patients. End of life care was available and they had used it effectively to support a dying patient who did not want to leave the hospital. Patients accessed local health facilities services for specialist healthcare services.

Skilled staff to deliver care

- Staff working at Abbey House came from a range of professional backgrounds including nursing, medical, occupational therapy, hospitality, pharmacy, psychology, social work and catering. The hospital used external staff for specialist assessments such as speech and language therapy and dietetics. All patients registered with the private GP.
- Staff received appropriate training, supervision and professional development. Some staff told us they had been given a lot of support to update their skills and to undertake new development opportunities such as time off for study leave and financial support to undertake higher education programmes including Masters degrees. Staff told us they received supervision but this was not usually monthly as the policy stipulated. The company had introduced a supervision passport for clinical staff. The passport was a small booklet designed for staff to record supervision and distinguish between clinical and managerial supervision meetings. It also encouraged staff to reflect on their practice and contained the company values. Supervision addressed performance issues, encouraged staff to reflect on their practice and development needs and considered incidents that had occurred at the hospital. Managers

were able to identify how they dealt with issues of poor staff performance and sickness absence. A regional human resources team supported managers with staffing and recruitment issues. The new hospital director had noted gaps in supervision and put a plan in place to ensure more frequent supervision took place. He had also reminded staff of the absence policy and audited mandatory training in order to achieve better compliance.

- There were regular team meetings for sharing information. Newsletters kept staff informed of company updates and developments.

Multidisciplinary and inter-agency team work

- Multidisciplinary and Care Programme Approach (CPA) meetings are designed to look at patient progress and discuss things that have gone really well for them or things that have not gone so well. They usually involve staff from a variety of professions as well as the patient and their family or advocate if they have one. MDTs and CPAs took place regularly and patients routinely attended. Staff typed CPA notes during the meeting so they were transparent to the patient. Patients were included as full partners in their CPAs and staff sensitively managed patients' comments and views.
- Abbey House maintained links with commissioners. One commissioner told us they visited the unit to carry out their own reviews and regularly attended meetings and patient reviews. They told us the unit staff communicated well with them and always advised them of relevant issues. They said staff were open to discussion and challenge.
- Multidisciplinary assessments took place and different professionals worked well together. Patient records showed there was effective multidisciplinary team (MDT) working taking place. Staff gave examples of having involved external professionals when the patient needed this, such as specialist physical healthcare nurses and local hospice staff.

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

- The use of the Mental Health Act was consistently good across the service. The documentation we reviewed in detained patients' files was up to date. Relevant paperwork such as approved mental health professional's reports and Mental Health Act tribunal reports were present.
- Ministry of Justice approval for section 17 leave was present and up-to-date in files.
- Patient records contained completed consent to treatment forms.
- Patients were administered medication which was covered by their T2 or T3 paperwork.
- The responsible clinician completed paperwork for section 17 leave. However, leave forms did not routinely evidence that staff had given patients a copy of their leave forms.
- Patients were able to access Mental Health Act tribunals and managers' hearings when they needed them. These took place on site.
- There were no covert medication plans in place, which meant all patients knew they were taking medication.
- Abbey House displayed information about the rights of detained people. Independent mental health advocacy services were readily available to support patients. Staff and patients were aware of how to request an advocate.
- Staff were aware of the need to explain people's rights to them and attempts to do this were routinely recorded each month.
- Staff completed training on the MHA as part of their mandatory training and compliance rates were 83%. They knew how to contact their Mental Health Act administrator for advice when needed.
- The Mental Health Act administrator had received training for the revised Code of Practice, which came into operation in April 2015. Other staff had not received training but we were shown the company online e-learning module which staff could access. Some policies we looked at had been updated to reflect changes in the Code of Practice. These included the Child Visiting (child-patient contact) policy and the Safeguarding Adults policy. Our Mental Health Act Reviewer gave the hospital director a list of policies which would need to be updated in line with the revised Code of Practice.

Good practice in applying the Mental Capacity Act

- Almost all patients at the hospital were detained under the Mental Health Act (MHA). There was one informal patient who had been issued with an entry / exit "swipe card" so he could freely move around the hospital and grounds.
- On the day of the inspection there was a sign advising patients of their rights under the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (MCA DoLS).

Long stay/rehabilitation mental health wards for working age adults

Good

However, we returned to carry out an unannounced Mental Health Act monitoring visit, the sign was no longer present. Staff acknowledged this and said they would display a sign so informal patients could be made aware of their rights under MCA DoLS.

- Staff demonstrated a good understanding of the MCA and said they completed mental capacity assessments with patients. However, staff recorded capacity assessments within the main body of the patient daily records so were not easy to locate.
- Staff had access to internet based MCA training but the service was not able to tell us how many staff had completed it.
- Staff knew who to contact for further advice and guidance about issues relating to the Mental Capacity Act and said the social worker was a good source of knowledge.

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

Good

Kindness, dignity, respect and support

- Patients told us staff treated them with respect. However, one patient told us if staff were stressed, they sometimes talked to him in a way that was not respectful and kind.
- One patient told us staff worked very hard, especially the occupational therapy technical instructor and tutor.
- We talked to staff about patients and they discussed them in a respectful manner and showed a good understanding of their individual needs. We saw patients were able to approach staff freely when they wanted help or support.
- We observed staff interacting with patients in a caring and compassionate way. Staff responded to patients in a calm, respectful way and interactions were open and natural.
- Staff appeared genuinely interested and engaged in providing good quality care to their patients.
- Staff supported patients to keep in contact with their families and home communities. The service paid for transport so patients could visit their families, even when the patient was travelling unescorted. The service had two vehicles which were used to facilitate patient transport. However, two staff and a patient said there were often not enough staff on duty who were designated drivers and this made booking transport more difficult.
- Carer and family meetings took place. Several bimonthly meetings had taken place and also some social activities. There were plans for more social gatherings to take place. Staff tried to arrange a focus group of family and carers to meet with CQC but no one turned up at the designated time.
- We saw staff knocked a patient's door before entering their room and patients confirmed this was routine.

The involvement of people in the care they receive

- Abbey House provided patients with information about the service before they were admitted to the hospital. Patients could visit the hospital before agreeing to move there and they could stay overnight for a trial stay.
- Welcome pack information was available to patients and they recalled being given a tour of the premises when they arrived.
- Patients were encouraged to actively engage in developing their assessment, care plans and risk assessments. Staff gave patients copies of their care plans and we saw only one record where this had not happened.
- The hospital made sure patients could use an independent advocacy service as well as the independent mental health advocacy service. They displayed advocacy information on the ward and in the reception area. Patients we spoke to knew how to get an advocate. The worker came to see patients every week and saw patients without an appointment if necessary. One patient told us they felt the advocate was not effective.
- Abbey House held patient and staff "community meetings" every week. Daily "diary" meetings took placed where patients planned their activity and leave for the day.
- There was evidence that families could attend care programme approach meetings when patients wanted them to.
- There were comment boxes in the reception area for patients, visitors or staff to post comments. The service

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Good

had recently introduced a "You said, We did" television but we did not see this in operation. "You said, We did" is a widely used system which reflects patient comments and how a service has responded to them.
- Patients could nominate staff for awards if they wanted to show particular appreciation.

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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

- Staff carried out pre-admission assessments quickly, within 48 hours of receiving the referral. Most patients were admitted from the local geographic area but some came for further afield. The psychiatrist carried out pre admission assessments for patients detained under section 37/41 of the Mental Health Act. Nurses carried out all other pre-admission assessments. Abbey House admitted eight patients between March-October 2015. Patients came to the hospital from a variety of places, including secure services and NHS hospitals.
- Between January and July 2015, bed occupancy averaged 100% for the flats and 85% for the main hospital Despite bed occupancy rates being high in the flats this did not have a negative impact on patients. Patients were keen to move into the semi-independent flats as soon as they were ready.
- Average length of stay for patients in the main hospital was 35 months and it was 18 months in the flats.
- Staff planned discharge arrangements in conjunction with their commissioners and identified move-on services. Some patients stayed locally and others returned to their home areas. The hospital had developed good links with local housing providers, which meant that patients could remain in the local area if they wanted to. Between January and October 2015 there had been eight patients discharged from the service. Three were discharged to their own tenancies, three to a care home and two to NHS inpatient services.
- We saw no evidence of patients having to move because of non-clinical reasons.
- One patient told us they felt they were making good progress with their treatment and liked the hospital. Another two told us it was the best place they had stayed for treatment. One patient told us they hoped they could stay at Abbey House because they like it a lot and felt they were doing very well there. One patient told us they felt there was not enough support to help them progress and they did not like the hospital.
- Patients were able to understand how to progress through the service and how to develop more independence. However, one patient told us there was not enough information about what was expected of patients when they moved to the flats. They felt patients should be given a better understanding of how to live in the semi-independent environment and what kind of rules there were so it would be easier to get along with their co-patients.
- Patient discharge was sometimes delayed due to circumstances beyond the control of the service. Delays usually occurred because the patients' responsible commissioners needed to secure funding for a move on placement or there was a waiting list for suitable housing. The service liaised with commissioners in order to address this as best they could, even though they had no control over the availability of other resources within the sector. When there had been a delay because of a local funding problem, the service had found innovative ways of supporting a patient to move into the community, which included Abbey House staff visiting the patient every day after they had moved out of the hospital
- The service considered discharge planning throughout the admission, with the acknowledgement that some patients would move through the service more quickly than others, based upon individual need and context of their illness, history and recovery. Some patients who were motivated and doing well with their rehabilitation moved forward quickly. Progress could be slow if patients struggled with motivation, or had complex needs. One member of staff felt discharge planning should involve patients at an earlier stage.

The ward optimises recovery, comfort and dignity

- The hospital had a full range of rooms and equipment. This included space for therapeutic activities, relaxation and treatment. There was a large communal room,

which patients could use for activities, meetings and therapy sessions. We observed patients playing table tennis, pool and chess. Others were reading, snoozing or chatting when we visited. There was a therapy kitchen and occupational therapy room in the grounds. Patients used the kitchen to meet for coffee and a chat or to take part in therapeutic activities. There was a learning suite with computers but several patients and staff told us the internet access had been poor since August 2015 and they were unhappy about that. The new hospital director was aware of the issue and was working to improve the situation. There was space for craft activities and one to one therapy sessions. A new outdoor building had been erected and the service was considering options for how to use it. One proposal was for gym equipment to be installed, for patients who did not use local community gym facilities. However, staff were aware that because a number of patients were physically very heavy people, specialist equipment would be required. Patients had access to a large outdoor space. There were extensive grounds to walk in or to engage in gardening activities. Patients also used local facilities if they wanted to go horse riding, fish or play golf. Patients could tend to the gardens or look after the chickens if they wanted to and a number of patients enjoyed these activities. Some patients liked to grow fruit and vegetables then take them to the chef who cooked them for all the other patients and staff to eat.

- The flats shared a kitchen and the main hospital had recently renovated and redesigned the kitchen to make it more accessible and inviting to patients. Staff supported patients to learn how to cook nutritious meals. Patients were also able to order takeaway meals if they did not want to eat at meal times.

- There was a room for patients to meet relatives in private, including visits from children. . The hospital director had plans to renovate and redesign the room to make it more functional and welcoming. Even though he acknowledged it had been some years since any patient had requested a child visit, he felt the room could be made more comfortable should they need to provide a suitable space. At the time of the inspection, the room had a desk and chair, a beanbag on the floor and the mobile telephone unit was stored there. There was no comfortable seating area and there were no toys or activities for visiting children. Patients could use the room to make private telephone calls. They also had access to the ward telephone and could have their own mobile phone. They could access the internet.

- Pat dog therapy was available to patients and some enjoyed this.
- Board games and books were displayed in the communal areas and patients could use them freely.
- Patients could take part in educational activities such as literacy and numeracy. They could learn computer skills on site too. Staff were able to support patients to attend local colleges of further education. Staff supported them with transport if they needed it.
- Some patients did voluntary work and two patients had paid jobs in the community.
- Occupational therapy staff developed individual therapy plans for patients. At evenings and weekends patients said there was less to do than there was during the weekdays.
- Patients could manage their own laundry as part of the rehabilitation process. There was a laundry room for them to use and the service provided free laundry products.
- Patients could personalise their rooms, if they wanted to and they could store important items in a locked cupboard in their room.
- Many patients had their own mobile phones and there was a telephone in a private area for anyone who wanted to use it. Patients could access their own internet if they wanted.
- Patients could smoke in designated areas and there was no time restriction for this. However, staff said they did try to encourage good sleep hygiene so as a routine, patients did not go out to smoke overnight. Staff supported patients who wanted to stop smoking and the GP was able to provide smoking cessation products.
- Culturally appropriate meals were available for patients who needed them. Patients had a choice of menu at meal times. All food was cooked fresh on the premises by the chef and catering team. Patients in the main hospital ate in a dining room, which was locked outside of meal times. Staff said the dining room was kept locked because the serving plates were hot which made them a health and safety risk. One patient told us they would like the dining room to be open outside of meal times so they could sit and enjoy a drink in there. A member of staff monitored cutlery “in and out” at meal

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Good

times. Staff told us they introduced this following a risk incident and the lessons learned, because a knife had gone missing from the dining room. The hospital director said staff had considered this was the least restrictive option. They believed that monitoring cutlery use during meal times meant that patients could enter and leave the dining room freely. They also noted that the procedure reduced risks and reduced searches. Staff ate their meals with patients. Patients told us the food was good and the food we tried during the inspection was of a very high standard. However, one patient complained there was Italian food on the menu. Abbey House provided a variety of meals for patients to choose. They had recently introduced a salad bar, which increased patient choice and helped those who wanted to lose weight. The chef and patients routinely cooked meals using fruit and vegetables which had been grown in the garden. The service also used other locally sourced fresh produce. The chef met with new residents and drew up a list of likes and dislikes as well as nutritional requirements based upon specific health needs. Patients in the flats cooked their own meals and bought their own shopping but were also able to use the garden produce if they wanted to.

- Staff supported patients to be independent with money management. Staff carried out capacity assessments if patients were not managing well and they looked at ways to support them.

Meeting the needs of all people who use the service

- Staff respected patients' diversity and human rights. Staff made meaningful attempts to meet patients' individual needs including cultural, language and religious needs.
- A local vicar offered regular spiritual support to patients and visited the hospital weekly. There were voluntary work opportunities available in a local Christian café.
- The unit was able to support patients with physical health and mobility needs. One bedroom was adapted for wheelchair users. There was a lift to the first floor for people with restricted mobility.

Listening to and learning from concerns and complaints

- Abbey House displayed information in communal patient areas about how to make a complaint. Information about the independent mental health advocacy service and CQC was also displayed. Patients told us they knew how to make complaints and were confident they could do so.
- Patients could raise concerns and complaints in the community meetings and morning diary meetings or by completing a comment card. Patients could also raise concerns and complaints directly with staff. The service had no formal complaints recorded for 2015. Staff said they dealt with negative feedback at a ward level, before it escalated into a formal complaint. The chefs served meals so were easily available to receive feedback from patients and staff.
- Staff and managers told us they were open to receiving both positive and negative feedback and considered all feedback in team meetings.
- The service produced a patient satisfaction survey but patient participation was very low which meant the results were not wholly reflective of the service. The service had noted how few patients had taken part in the survey so was considering how to address this before the next survey was due to take place in 2016.
- One patient had made suggestions for improving the clinic facilities. The service had listened to these and had installed a privacy curtain around the examination couch.
- "Suggestions, ideas and complaints" training had been added to mandatory training for staff. Compliance for the training was 87%.

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

Good

Vision and values

- Abbey House displayed the company values. They were also printed on the "supervision passport" so staff could refer to them easily. The values were: valuing people, caring safely, integrity, working together and quality. Staff showed a clear understanding of the service's values.
- Staff told us they felt valued by the company and believed they could express their views.

- Staff knew who the senior company managers were and said regional visited the hospital.
- If staff were concerned, wanted to share an idea or wanted to make a complaint, they could email the company board directly and the contact details were printed in the supervision passport along with a Partnerships in Care freephone “concern line” number.

Good governance

- The service had systems of governance in place such as the electronic incident reporting system, which assisted staff to manage and monitor risk in the ward environment. These systems provided information to managers in an open and transparent way.
- The hospital was part of a large provider and there was a substantial governance structure to support local staff.
- The service gathered performance data, which managers used to address quality and staff performance issues. Managers could get support from colleagues in the human resources team.
- The ward manager told us they had enough time and autonomy to manage the ward effectively and the hospital manager was supportive.
- Staff had appraisals and almost all were up to date (four were outstanding but one member of staff was new and another was on long term sick leave due to a non-work related issue, so only two appraisals were really overdue). The hospital director reminded managers by email if appraisals were due or overdue.
- Systems for auditing Mental Health Act (MHA) compliance and documentation were effective. A recent audit showed an error in the MHA process, which the hospital corrected.
- Clear and safe systems were in place for medication management. We saw audits relating to medication management.
- Abbey House had an electronic patient “dashboard”. This showed staff the dates when patients’ physical healthcare assessments and CPA review meetings were due. It also showed when patients were scheduled to have their one to one meetings with staff and if they had taken place as planned.
- An independent pharmacy company visited weekly and we saw evidence of the audits they performed to ensure medication management was safe and effective. The checks they carried out included medicines management audit, disposal of unwanted drugs and checks to ensure drugs were within date.

Leadership, morale and staff engagement

- There was evidence of clear leadership at a local and senior level. Managers were visible during the day-to-day provision of care and treatment and were accessible to their staff. Patients and staff knew the new hospital director. They were familiar with him walking around the hospital and engaging with patients and staff.
- Staff appeared to be enthusiastic and engaged with their roles. They told us they felt able to report incidents and raise concerns without fear of recrimination. Most staff told us they loved their jobs and enjoyed working in the service.
- Staff had access to confidential counselling and support if they needed it. There was occupational health support and flexible working when staff required it, for example during health recovery or pregnancy.
- Staff were kept up to date about developments in the service with newsletters and team briefings.
- Staff told us they had access to leadership training and development opportunities and a number of staff had made use of the opportunities. Some administrative staff felt they had very limited development or learning opportunities. Other staff said a restriction had been placed on "costed training" opportunities, which meant they could not attend as many external training courses and conferences. However, the company had introduced a new training academy, which managers hoped would enhance training and development opportunities for staff.
- Staff told us they felt supported and valued by their immediate line manager and by the service. They told us they enjoyed their jobs and liked working at the hospital.
- Staff were involved in sharing ideas for improvement within the service but not all staff were confident senior managers in the organisation listened to their ideas.
- Managers supported staff to come into the hospital and be part of the inspection process. Staff were paid to be there, even if they were not scheduled to work that day.

Commitment to quality improvement and innovation

- The hospital had won the company “Green Fingers” award for the work they did engaging patients in horticulture and nutrition.

Long stay/rehabilitation mental health wards for working age adults

Good

- Managers had given staff the opportunity to look at innovative ways of increasing patients' access to exercise and healthy living. Discussions were taking place about how best to support patients with this and staff were excited to share their ideas with inspectors.
- The new hospital director had sought feedback from staff and patients about how to redesign aspects of the building layout. Some renovation and redesign work had been carried out and more was planned. The aim was to provide patients with better, more modern facilities that would promote recovery and rehabilitation.

Outstanding practice and areas for improvement

Outstanding practice

Patients could be involved in the growing of food and the raising of chickens at Abbey House. The work was available every day and some patients found the opportunities very rewarding. There were strong links between the occupational therapy and kitchen teams, which meant patients routinely, presented their garden produce to the chef who then planned meals around it. The programme engaged patients in meaningful activity, which promoted both their physical and mental wellbeing. It encouraged patients to work together for the benefit of all and enabled patients to widen their palette and eat a variety of nutritious vegetables. The programme gave patients responsibilities and encouraged them to care for others. Abbey House had won a national Partnerships in Care "Green Fingers" award for the programme.

The company had introduced "supervision passports" which staff used to record their supervision and differentiate between managerial and clinical supervision. The supervision passport also gave staff the opportunity to record reflective practice sessions.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure mental capacity assessments are recorded clearly, in a way which makes it easy for staff to find them.
- The provider should ensure that staff undertake safeguarding children as part of their mandatory training programme.
- The provider should ensure staff routinely complete their mandatory training.
- The provider should ensure they comply with the revised Mental Health Act Code of Practice.
- The provider should ensure all staff have regular supervision in line with company policy.
- The provider should ensure they give patients and relevant people copies of their section 17 leave authorisation.
- The provider should ensure they make informal patients aware of their rights under the Mental Capacity Act Deprivation of Liberty Safeguards