

Abbey Court Independent Hospital

Quality Report

Ainscough Road
Birchwood
Cheshire
WA3 7PN

Tel: 01925854150

Website: www.alternativefuturesgroup.org.uk

Date of inspection visit: 11-13 January 2016

Date of publication: 27/05/2016

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

Requires improvement



Are services safe?

Requires improvement



Are services effective?

Requires improvement



Are services caring?

Good



Are services responsive?

Good



Are services well-led?

Good



Mental Health Act responsibilities and Mental Capacity Act and Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Capacity Act and, where relevant, Mental Health Act in our overall inspection of the service.

We do not give a rating for Mental Capacity Act or Mental Health Act, however we do use our findings to determine the overall rating for the service.

Summary of findings

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

Overall summary

Summary of findings

We rated Abbey Court as requires improvement because:

- Neither ward complied with Department of Health (DoH) guidance on same-sex accommodation because there were no separate lounges for male and female patients. The DoH (2015) states that women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse.
- Staff did not always complete a physical health assessment of every patient, both on admission to the hospital and as appropriate thereafter. Staff did not always fully record patients' physical health observations. This meant that staff did not have all the information available to make a prompt intervention should a patient's physical health deteriorate. However, staff did work well with other specialist services, such as GPs, dieticians, physio-therapy and tissue viability to optimise patients' physical health.
- Staff did not always explain to patients what their rights were when detained under the Mental Health Act (MHA). Where patient rights were explained, this was not routinely captured in patient care records. Where patients had been identified as lacking the capacity to understand their rights, their nearest relative had not been informed. This was partially mitigated because staff routinely referred patients detained under the MHA to Independent Mental Health Advocates. The advocates regularly attended the wards to offer independent advice and support.
- At the time of our inspection, there was limited occupational therapy input into the hospital, including a specialist occupational therapist in dementia care.
- This meant that specialist occupational therapy assessments were not always completed, specifically the 'functional behaviour profile' for patients diagnosed with dementia. This assessment was important because it should be used to assess how much assistance a patient with dementia needs to perform activities of daily living, such as washing, dressing and eating. The assessment should then form part of a patient's care plan. Senior management assured us that funding had been secured to recruit an occupational therapist in March 2016.
- The hospital had a high staff vacancy rate at a total of 17%, and a high a long-term sickness and absence rate at 11%. This meant that the hospital relied heavily on nursing agency staff that were not able to perform all the duties of a nurse employed directly by the hospital. Such duties included acting as a named nurse for a patient, which involves completing and regularly reviewing patient care plans and assessments. Consequently, we found that there were not enough named nurses to ensure that all care plans and assessments were fully completed and regularly reviewed thereafter.
- The hospital identified that any patient who had lived at Abbey Court for more than eighteen months, and had completed their treatment programme, were a delayed discharge. Although the hospital was actively working towards discharging patients to a community setting, four patients on Crossfield ward had been at Abbey Court for over eighteen months.
- Not all staff members were provided with a regular opportunity to provide feedback into the running of the hospital. This had had an impact on staff-morale. Senior management were aware of this and had plans in place to establish regular team meetings for all staff.

However:-

- Other than its failure to adhere to guidance on same-sex accommodation, the unit environment reflected best practice in dementia care. It had consistent flooring throughout the communal areas and contrasting handrails. Memory boxes were in place outside patients' bedrooms. These contained

Summary of findings

sentimental items, such as family photographs and post-cards, that patients were able to relate to as being significant to them. This helped patient's identify their own bedroom.

- The hospital demonstrated a strong commitment to introducing innovative and evidence based ways of working with patients diagnosed with dementia. This included the activating communication potential group for patients who had difficulty communicating their needs verbally. They also used the pool activity level assessment tool to develop personalised activity plans for patients with dementia. The hospital was also committed to developing staff skills and knowledge base in evidence based dementia care. This included providing specialist staff training in the dementia care matters initiative for person centred care, called the 'footsteps' training programme.
- For patients who did not have the capacity to provide meaningful input their care plan, staff used person-centred documents, such as 'this is me', to ensure that patients' views and preferences were captured. This included information about a patient's hobbies, significant family members and what they liked to eat and drink.
- Patients' care records were comprehensive and contained assessments and care plans that related to patients' individual needs. Staff regularly monitored and assessed patients' nutritional and hydration needs.
- All carers we spoke with were positive about the care their relative had received. Carers said that staff were highly skilled and motivated to meet individual patients' needs.
- The hospital had formed effective relationships with other agencies that were involved in the care of patients at Abbey Court. This included the local clinical commissioning group, local authority and primary care services. The hospital worked in partnership with a local NHS Trust to deliver specialist dementia training to five local care homes. The hospital was also a member of the Warrington Dementia Alliance Association (WDAA). The WDAA worked together to raise awareness and improve service provision within the local community for patients diagnosed with dementia.
- There was an established care pathway for patients admitted to Abbey Court. All patients were admitted from one ward based at a local NHS Trust. Three of the consultants psychiatrists employed by Alternative Futures Group worked between the ward and Abbey Court. This meant that patients received continuous care from the same consultant psychiatrist when moving from one service to another.
- All staff received supervision every six to eight weeks. All staff received an annual appraisal of their work performance. Staff we spoke with said that the senior management team were supportive and approachable.
- The provider had a comprehensive mandatory training package that included a support essentials programme. This comprised seven courses, including health and safety, food hygiene, manual handling, fire awareness, infection control, safeguarding, and basic first aid. All staff had completed the support essentials course. Agency staff training was compatible with that provided by Alternative Future's Group.

Summary of findings

Contents

Summary of this inspection

	Page
Background to Abbey Court Independent Hospital	6
Our inspection team	6
Why we carried out this inspection	6
How we carried out this inspection	6
What people who use the service say	7
The five questions we ask about services and what we found	8

Detailed findings from this inspection

Mental Health Act responsibilities	12
Mental Capacity Act and Deprivation of Liberty Safeguards	12
Overview of ratings	12
Outstanding practice	28
Areas for improvement	28
Action we have told the provider to take	29

Requires improvement



Abbey Court Independent Hospital

Services we looked at:

Wards for older people with mental health problems.

Summary of this inspection

Background to Abbey Court Independent Hospital

Abbey Court Independent Hospital in Birchwood, Warrington, is run by the Alternative Futures Group. It had a registered manager and provides the following regulated activities:

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

Abbey Court provides care for up to 30 people with complex mental health problems. It cared for informal patients (those there by choice) and patients who were detained under the Mental Health Act 1983. The hospital had two mixed-sex wards, one specialising in dementia care (Wilderspool ward) and one for patients with a variety of complex mental health problems, which could

include depression, bipolar affective disorder and schizophrenia (Crossfields ward). At the time of our inspection, there were 14 patients on Wilderspool ward and six on Crossfields ward.

The service planned to stop providing services to patients who did not have a diagnosis of dementia so Crossfields ward was closed to new admissions.

The hospital had an accountable officer for controlled drugs.

We have inspected Abbey Court three times since it was registered with CQC on 21 March 2011. The most recent inspection was conducted in January 2014 and the hospital complied with all the essential standards.

Our inspection team

Team leader: Lisa Bryant, Inspector, Care Quality Commission (CQC).

The team that inspected the service comprised two CQC inspectors, a specialist older people's nurse and an

expert by experience (someone who has developed expertise in relation to health services by using them or through contact with those using them – for example as a carer).

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

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?

Is it well-led?

Before the inspection visit, we reviewed information that we held about the hospital and asked other organisations for information.

During the inspection visit, the inspection team:

- visited both wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service

Summary of this inspection

- spoke with nine carers of patients who were using the service
- spoke with the registered manager and clinical nurse manager
- spoke with the regional director of the service
- spoke with the director of quality and performance for the service
- spoke with 15 other staff members, including doctors, nurses and occupational therapists
- spoke with three commissioners
- spoke with an independent mental health advocate
- attended and observed four multidisciplinary meetings
- attended and observed one service user lunch
- attended and observed one service user activity group
- looked at nine patients' care and treatment records
- looked at seven patients' medication charts
- carried out a specific check of the medication management on both wards
- looked at policies, procedures and other documents relating to the running of the service.

What people who use the service say

At the time of our inspection, we were unable to speak to any of the patients on Wilderspool ward due to the severity of their dementia. However, we closely observed how staff were caring for patients and attended an activity group led by staff that patients with dementia were encouraged to participate in. We observed excellent interaction between staff and patients. Staff took into account patients' preferences and planned care to meet their individual needs. Staff knew the patients well and were very caring and respectful towards them.

We were able to speak to four patients on Crossfields ward. They were mostly positive about the care they received. However, they also told us that there was a lack of structured activities available on the ward.

Across both wards, we spoke with nine relatives of patients who were using the service. Relatives praised the

staff and management, and gave positive feedback about most aspects of care. They commented on the caring and supportive attitude of staff towards the patients. Relatives told us that staff and management would go the extra mile to support their emotional and practical needs, as well as those of the patients. Relatives expressed confidence about the safety of patients in the hospital. They also said that the environment was always clean and well maintained.

However, on Crossfields ward, some carers told us that there was a lack of structured activities available to occupy patients during the day. They said that this was since the full time occupational therapist had left the service in September 2015.

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?

We rated safe as **requires improvement** because:

- Neither ward complied with Department of Health guidance on same-sex accommodation. There were no separate lounges for male and female patients.
- The service had four outstanding vacancies for nurses that they were struggling to recruit into. This meant that the hospital relied heavily on nursing agency staff that were not able to perform all the duties of a nurse employed directly by the service. This also meant there were not enough nurses to complete and regularly review all patients' care plans and assessments.
- The hospital had a high long-term sickness rate at 11%.

However:-

- The environment reflected best practice in dementia care with consistent flooring throughout the communal areas and contrasting handrails. Memory boxes were in place outside patients' bedrooms. This helped patients identify their own bedroom.
- The provider had a comprehensive mandatory training package that all staff had completed. Nursing agencies delivered mandatory training to agency staff that was compatible with that of the hospital. All agency staff were compliant with mandatory training or were booked on the relevant course.
- The service did not use prone restraint or rapid tranquillisation.

Requires improvement



Are services effective?

We rated effective as **requires improvement** because:

- Staff did not always complete a physical health assessment of every patient, both on admission to the service and as appropriate thereafter.
- Staff did not always fully document patients' physical health observations. This put patients at risk, as staff did not have the information available to determine when a patients' physical health may be deteriorating, and therefore to take prompt intervention where required.
- Staff did not always explain to patients what their rights were when detained under the Mental Health Act. Where staff had explained to patients what their rights where, they did not routinely record this in patient care records.

Requires improvement



Summary of this inspection

- At the time of our inspection, there was limited occupational therapy input into the hospital. This meant that specialist occupational therapy assessments were not always completed and there was limited professional support for staff that were leading patient activity groups.

However:-

- Patients' care records were comprehensive and contained assessments and care plans that related to patients' individual needs.
- All patients had a personalised activity plan. Staff used an evidence based tool, the pool activity level instrument, to assess what activities patients with cognitive impairment could participate in. The tool is recognised as good practice within the national clinical practice guideline for dementia

Are services caring?

We rated caring as **good** because:

- Staff treated patients with kindness, dignity and respect.
- Staff understood and responded to patients' individual needs. Staff were mindful to promote patients' independence as much as possible.
- For patients who did not have the capacity to provide meaningful input their care plan, staff used person-centred documents, such as 'this is me', to ensure that patients' views and preferences were captured.
- Carers said that the staff involved them, where appropriate, in decisions regarding the care of the relative.
- All carers we spoke with were positive about the care their relative had received since living at Abbey Court. Carers said that staff were highly skilled and motivated to meet patients' individual needs.
- The hospital arranged for prospective patients to have settling days before committing to a place at Abbey Court.
- Independent advocacy services visited patients on the wards on a weekly basis. This was to provide support to patients who had been detained under the Mental Health Act. Advocacy services also provided support to patients who had been assessed as having limited capacity to make decisions regarding their care and treatment.

However:-

- Patients, or their relatives, did not always have a copy of their care plan. However, where patients lacked capacity, their relatives demonstrated a good understanding of what it included and how it informed patient care.

Good



Summary of this inspection

- The hospital had not established a regular group or meeting for patients and carers to provide feed-back into the running of the hospital.

Are services responsive?

We rated responsive as **good** because:

- Beds were available for people living within the local community where needed.
- There was an established care pathway for patients admitted to Abbey Court. All patients were admitted from one ward based at a local NHS Trust. Three of the consultants psychiatrists employed by Alternative Futures Group worked between the ward and Abbey Court. This meant that patients received continuous care from the same consultant psychiatrist when moving from one service to another.
- The hospital provided a wide range of evidence-based activities to meet the needs of patients diagnosed with dementia. Every patient had an individualised activity plan.
- Patients had a choice of what they could eat or drink. Snacks were available to patients both during the day and night. Pictorial menus were also available for patients who had difficulty in understanding a written menu.
- Staff knew how to handle complaints appropriately in accordance with Alternative Futures Group's policy.

However:-

- The hospital identified any patient who had lived at Abbey Court for more than eighteen months, and had completed their treatment programme, as a delayed discharge. Although the hospital was actively working towards discharging patients to a community setting, four patients on Crossfield ward had been at Abbey Court for over eighteen months.

Good



Are services well-led?

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

- Alternative Futures Group had an established quality assurance and development team. They supported the registered manager in the review of the clinical audit schedule and identified and addressed any issues relating to this.
- All staff received supervision every six to eight weeks. All staff received an annual appraisal of their work performance.
- Staff we spoke with said that the senior management team were supportive and approachable.

Good



Summary of this inspection

- Alternative Futures Group provided additional training courses for staff to develop their skills and knowledge. This included a diploma in dementia care.
- The hospital demonstrated a commitment to providing innovative, evidence-based practices to patients diagnosed with dementia. This included the hospital's participation in person-centred care initiatives, including the 'dementia care matters' programme.
- A member of staff worked had conducted evidence-based research into person-centred dementia care at a local University. This research informed part of the staff induction to Abbey Court.

However:-

- Not all staff members were provided with a regular opportunity to provide feedback with regard to the running of the hospital. This had had an impact on staff morale. Senior management were aware of this and had plans in place to establish regular team meetings for all staff.

Detailed findings from this inspection

Mental Health Act responsibilities

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

All eligible staff were up-to-date with MHA training, deemed essential for their roles. This did not include staff who were currently on long-term absence. Eligible staff received training in the MHA annually, and this was delivered by a MHA administrative team from the local NHS trust. This included training in the new MHA Code of Practice (2015).

There had been a MHA monitoring visit in May 2015 (Crossfield ward) and in June 2015 (Wilderspool ward). The review identified issues relating to inconsistencies in recording patients' capacity to consent to treatment. The review also identified that patients were not always provided with the opportunity to access their leave under Section 17 of the MHA. By the time of our inspection, the provider had addressed these issues.

MHA documentation, such as detention records and approved mental health professional reports, were in place and up to date. All patients who required them had certificates authorising the administration of medication of consent to treatment (T2) and certificates of second opinion (T3) in place.

However, of the eight care records we reviewed for patients detained under the MHA, we found five who had not had their rights explained on admission or regularly thereafter. Furthermore, in the cases where the patient

did not have the capacity to understand their rights, their nearest relative or carer had not been consulted. This issue was also highlighted during the MHA monitoring visits in May 2015 and June 2015, but had not been adequately addressed by the hospital by the time of our inspection.

The local NHS trust provided administrative support and legal advice on implementation of the MHA and its code of practice to the service. At the time of our inspection, there were two dedicated MHA administrators from 5 borough's NHS foundation trust providing the service with MHA administrative support. A senior nurse practitioner, based at Abbey Court, also held a professional qualification in mental health act law. The senior nurse practitioner provided further administrative support regarding the proper use of the MHA to staff and patients daily.

Patients had access to independent mental health advocates (IMHA). In the MHA monitoring visits in May 2015 and June 2015, it was identified that automatic referrals on detention for patients were not being consistently completed. However, by the time of our inspection, staff were completing timely and regular referrals to the IMHA service on behalf of their patients. IMHAs also visited the wards regularly to offer patients independent support and advice. The IMHA service told us that the hospital provided appropriate support to patients who were detained under the MHA.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act and Deprivation of Liberty Safeguards Following the Mental Health Act (MHA) monitoring visits in May 2015 and June 2015, it was reported that the hospital had experienced difficulties establishing the appropriate legal status for some of its patients. This was because the hospital and local authority had differences in opinion regarding when to use the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) or the MHA for patients at the hospital. This had resulted in an increase in the number of

informal patients on both wards who lacked capacity and were deprived of their liberty. If there were delays in authorising patients' DoLS applications, the hospital would assess patients under the MCA to ensure they were being kept at the hospital under an appropriate legal authority. At the time of our inspection, 19 patients were detained under the MHA, and no patients were subject to DoLS. One patient on Crossfield's ward had agreed to stay at the hospital as an informal patient.

Detailed findings from this inspection

All staff were up to date with training in the MCA. This did not include staff who were currently on long-term absence. The provider delivered MCA training to all eligible staff on induction to the service. A refresher course was then delivered every two years.

Staff demonstrated a good understanding of the principles of the Mental Capacity Act (MCA), in particular, the assumption that people have the capacity to make decisions, and that the consideration of capacity is specific to the decision being made.

In the patient care records we reviewed, we found good examples of thorough capacity assessments associated with patients' 'do not attempt resuscitation' (DNAR) request. We also found good examples of thorough capacity assessments associated with patients' covert medication plans, (where medicines are disguised and given to a patient in food and drink because they would otherwise refuse to take them).






Patients had access to independent mental capacity advocates who visited the hospital on a weekly basis.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Wards for older people with mental health problems	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
Overall	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement

Wards for older people with mental health problems

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

Are wards for older people with mental health problems safe?

Requires improvement 

Safe and clean environment

- On both wards, the ward layout did not allow staff to observe all parts of the ward. However, the risk was adequately mitigated by regular staff presence across the unit and increased patient observations where necessary.
- The environment reflected best practice in dementia care with consistent flooring throughout the communal areas and contrasting hand rails along all corridors. For patients diagnosed with dementia, memory boxes were placed outside of their bedroom. A memory box is an evidence based resource that contains items of sentimental and memorable value to the person with dementia. In placing a personalised box outside of their bedroom, a patient with dementia can associate these items as significant to them and therefore identify the rooms as their own.
- On both wards there were kitchens that led onto the main dining area. These could be used by patients during the day and night under staff supervision.
- Both wards had a large communal bathroom with a Gainsborough bath installed (a bath with a seat that can lower to assist patients with limited mobility).
- Larger bedrooms were available for patients who required mobility equipment to move safely. All bedrooms contained adjustable (profiling) beds. All windows had restrictors fitted.
- The hospital had completed a ligature risk assessment (to identify items that patients intent on self-harm could use to strangle themselves). Alternative Future's Group health and safety lead completed a monthly environmental ligature risk check. An anti-ligature bedroom was available on each ward. At the time of our inspection, neither of the bedrooms were occupied. This was because none of the patients were at risk of deliberate self-harm.
- All patients had individual bedrooms with en-suite facilities. On Crossfield ward there were two corridors leading to individual patients' bedrooms, whilst on Wilderspool ward there were three corridors. None of the corridors was designated as male or female sleeping areas. Patients had to pass bedrooms occupied by patients of the opposite sex to reach the communal bathroom. Senior management provided a rationale for why this was the case. For example, patients who were frequently awake at night were located together on a corridor where they could access a lounge to communicate with others. This meant that those patients who slept well were not unnecessarily disturbed. This had the positive effect of reducing conflict between patients during the night.
- Both wards did not comply with Department of Health (DoH) guidance on same-sex accommodation. On Crossfields ward there were two lounges and one quiet lounge. On Wilderspool ward there were four lounges and two quiet lounges. None of the lounges was designated to male or female patients. The DoH (2015) states that women-only environments are important because of the increased risk of sexual and physical abuse and risk of trauma for women who have had prior experience of such abuse. All were warm, comfortable and well furnished. However, staff told us that most

Wards for older people with mental health problems

patients had a preference for which lounge they preferred to use. Individual patient preferences included the noise level within the lounge, and how far it was located from their bedroom.

- Resuscitation equipment was available on both wards in the clinic room. An automated external defibrillation machine was kept at the nurses' station on both wards. Emergency drugs were in date and checked every day by nursing and pharmacy staff.
- All ward areas were clean. Domestic staff cleaned once a day and there was a night staff cleaning rota that was consistently completed.
- Sinks were available along ward corridors, and we saw that staff encouraged patients to use them. We also saw that staff used them following personal contact with a patient.
- The building was modern, well-furnished and well maintained. The Alternative Futures Group maintenance team, from the estates department, regularly attended the hospital to do routine maintenance work and safety checks. Staff recorded any repairs in an environmental risk assessment folder that was kept in the senior management team's office. The service's health and safety lead completed monthly environmental checks, including testing the nurse call alarm system.

Safe staffing

- At the time of our inspection, Abbey Court's total staffing complement was 67 whole time equivalent (WTE). Thirteen members of staff had left between November 2014 and November 2015. The total vacancy rate was at 17.1%, while long-term sickness was at 10.5%. The vacancy rate was based on the service providing care for up to 30 patients. However, the hospital was planning to stop providing a service for patients not diagnosed with dementia. The hospital was negotiating the proposed number of available beds with the local clinical commissioning group. This meant that Crossfield ward was closed to new admissions. Senior management estimated that the number of available beds would reduce to between 20 and 25. However, at the time of our inspection, senior management told us that they still needed to recruit more permanent nursing staff to reduce their reliance on agency nurses. This was because agency nurses were not able to perform all of the duties of a nurse employed directly by the service.

- Of the 67 WTE staff, there were 13.5 WTE registered mental health nurses (RMNs) employed by Alternative Futures Group (AFG). Between 20 July 2015 and 18 October 2015, 1656 shifts had been filled by bank or agency staff to cover sickness, absence or vacancies.
- Due to the long-term absence of three WTE nurses, the hospital had employed five agency nurses on a temporary contract agreement. This ensured care delivery was consistent across both wards. However, despite these temporary nursing contracts, the service had four nursing vacancies that were advertised at the time of our inspection. Senior management told us that they were struggling to recruit for two of these vacancies. Interviews for two of the vacancies had been scheduled for March 2016.
- Six WTE support workers were on long-term sickness or suspension at the time of our inspection. The service had a bank system called a casual hub, and support workers regularly worked full and part time hours to cover staffing short-falls. This included student nurses and trainee occupational therapists. Staffing short-falls were also covered by support worker agency staff. The service used the same agency staff, from two different nursing agencies, to ensure consistency of care across the unit.
- On Wilderspool ward, day shifts comprised two qualified nurses and four support workers. Night shifts comprised one qualified nurse and four support workers. On Crossfields ward, day shifts comprised of one qualified nurse and four support workers. Night shifts comprised of one qualified nurse and three support workers. The staffing levels were increased as required to meet the needs of the patients. For example, at the time of our inspection there were two additional support workers, on both wards, on every day and night shift.
- Staff and relatives perceived there were sufficient staff to provide care, and escorted leave and activities were rarely cancelled because there were too few staff.
- There was medical cover day and night with arrangements for medical staff to attend the unit quickly in an emergency. Alternative Futures Group employed three consultant psychiatrists, and they all attended the unit a minimum of one day a week to review their specific group of patients. Enhanced GP services were in place from a local practice. There was a rota to cover medical emergencies out of hours. This was provided by the hospitals three consultant psychiatrists.

Wards for older people with mental health problems

- The hospital had a comprehensive mandatory training programme that included a support essentials programme. The programme comprised seven courses, including health and safety, food hygiene, manual handling, fire awareness, infection control, safeguarding, and basic first aid. 100% of staff had completed the support essentials course.
- Mandatory training in the Mental Health Act 1983 (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was also provided by a local NHS trust's Mental Health Act office. At the time of our inspection, all eligible staff had completed training in the MHA, MCA and DoLS. MHA training included material that covered the revised MHA Code of Practice (2015).
- The hospital also provided mandatory training in a proactive approach to conflict. However, the compliance rate amongst staff was 70%. Mandatory training for adult basic life support and automated external defibrillation was at staff compliance rate of 93%. Mandatory training for nurses in medication errors was also low at 64%. However, all of these compliance rates included nurses who were currently unable to attend the training due to long-term absence. This meant that all staff actively working at Abbey Court at the time of our inspection were up to date with mandatory training.
- Due to the high use of agency staff, senior management were able to provide us with a breakdown of mandatory training completed by individual agency staff. We identified that the mandatory training provided by the agency was compatible with that of the service. In two cases where an agency staff's compliance with mandatory training was out of date, we saw that they had been booked on the relevant course to gain compliance in the next two months.

Assessing and managing risk to patients and staff

- The hospital submitted data showing that two incidents of restraint (holding and/or stabilising), involving two male patients, had taken place between 01 September 2015 and 09 October 2015.
- The hospital did not use prone restraint or rapid tranquillisation. However, they occasionally used holding and/or stabilising techniques (lower level forms of restraint) when de-escalation techniques failed. We checked and found that staff had received appropriate training to undertake this type of restraint, that is, holding and stabilising techniques phases one, two,

three and four. We also checked and found that staff recorded these restraints as incidents, as required. An independent training company called SPACE (safety, prevention and awareness in challenging environments), provided a staff training package called the proactive approach to conflict. SPACE had been accredited to facilitate this training by the physical interventions accreditation scheme.

- The hospital did not use seclusion (isolation) and segregation (separation) practices.
- We reviewed care records for nine patients, which contained risk assessments that were up to date. Staff undertook an initial risk assessment of every patient on admission. A member of the senior management team attended the initial assessments for all new patients, and ensured full historical information was available. The service used two comprehensive risk assessments tools; one for patients with a diagnosis of dementia (the dementia comprehensive risk/benefit assessment) and one for patients who had a diagnosis of other complex mental health problems; START (short term assessment of risk and treatability).
- In addition, the service undertook other specific risk assessments as required, for example, for aggression, mobility and nutrition. The information gathered informed the patients' care plans.
- Policies and procedures were in place for the use of observation to minimise risks to patients. Staff reviewed patients' observation levels on a monthly basis or sooner if their circumstances changes. At the time of our inspection, four patients received 1:1 care.
- Staff received training on safeguarding and knew how to raise safeguarding issues. Staff we spoke with offered examples of situations that would require safeguarding alerts, and said that they would be confident in raising them. Recently, Alternative Future's Group had updated their incident report system, CARISTA. This was implemented because in the summer of 2015, the local authority and local clinical commissioning group (CCG) had raised concerns that safeguarding incidents were not being consistently reported to them by the hospital. The update meant that when staff logged a safeguarding incident on CARISTA, an automatic alert was activated to prompt staff to refer the incident for review by the local authority and CCG. Consequently, the local authority and CCG had a better knowledge of the safeguarding risk profile of the hospital.

Wards for older people with mental health problems

- We looked at seven medication charts. All of these were up-to-date and clearly presented to show the treatment patients had received. Where appropriate, the relevant legal documentation was in place for patient consent and treatment. Patients' legal documentation was reviewed by the consultant psychiatrist as part of a weekly multi-disciplinary team review and recorded on a standard clinical review form.
 - All patients were registered with a local GP practice. The hospital mostly worked with one particular GP to ensure continuity of care and familiarity for patients. The GP monitored the patients' physical health. The GP also prescribed medicines for the patients' mental health following discussion with the relevant consultant psychiatrist.
 - Patients were invited to attend a ward round once a week where they had the opportunity to discuss their care with their psychiatrist. All three psychiatrists working for the service had regular telephone and/or face-to-face contact with patients' relatives and carers.
 - We reviewed the hospital's medication management practices. Medicines were appropriately stored and emergency medicines were available, if needed. All controlled drugs were securely stored on Wilderspool ward and checked daily by qualified nursing staff. The service had identified an accountable officer for controlled drugs who maintained links with the local controlled drugs intelligence network (a group that oversees the safe management of controlled drugs).
 - The hospital had a contract with a pharmacy provider who dispensed and delivered medications to the hospital.
 - A clinical pharmacist attended the hospital once a week to support nursing staff in safe medicines management practices. This included providing guidance around the safe administration of medicines, completing regular audits to identify the quality of medicines management practices, and developing action plans to help them improve. We reviewed a medicines audit that was completed on a weekly basis by nursing staff. The audit was completed to identify whether medicines were regularly being administered and at the right time. On Wilderspool ward, we saw several examples where this audit had not been completed. Senior management told us that agency nursing staff did not routinely complete this check as requested. However, of the seven medications charts we looked at for patients, staff had completed them appropriately.
 - The hospital had a policy in place for the safe use of covert (hidden) administration of medications. A patient may need their medicine to be hidden in food or drink because they would otherwise refuse to take them. This is because they cannot understand the negative impact not taking the medicine may have on their health. Before a patient is administered their medicines covertly, this should be discussed with the patients' nearest relative or carer. There was documented evidence in patients' weekly clinical review or daily clinical notes that this discussion had taken place.
 - Staff were aware of and addressing high risks associated with older age and dementia, such as falls and pressure ulcers. Air-flow mattresses were available for patients who were assessed as being at risk of developing pressure ulcers. Specialist tissue viability service intervention was also requested, as appropriate, via the local GP service. Dietician and physiotherapy services were also requested via the local GP service. Nursing staff completed incident reports for all patients who were found to have pressure areas, or injuries caused by a potential fall, on admission to the hospital.
- ### Track record on safety
- Between 5 January 2015 and 10 September 2015, the hospital listed 22 reportable incidents under the serious incidents requiring investigation (SIRI) framework. Six of these incidents related to a physical altercation between different patients. Five incidents related to whistleblowing concerns. This included allegations regarding the institutional abuse of patients and allegations regarding the safe management of the service. We found that at the time of our inspection, the hospital had conducted thorough investigations of all reported incidents. This included working closely with the local clinical commissioning group and local authority safeguarding team. Where appropriate, the service had taken disciplinary action, and/or implemented staff performance management plans to monitor and improve staff performance.
- ### Reporting incidents and learning from when things go wrong
- Staff recorded all incidents on the hospital's electronic incident report system (CARISTA). Although agency staff did not have access CARISTA, they completed a formal

Wards for older people with mental health problems

report in paper format. We saw that agency staff promptly handed the paper incident reports to the senior management team who input the details onto the CARISTA system.

- Staff learnt from incidents and changed their practice and policies where necessary. For example, following several incidents where medicines errors were not accurately being captured on CARISTA, the provider developed a scoring system based on the Manchester patient safety framework (MapSaF). This meant that when staff reported a medicines error, the system prompted them to carry out further checks and interventions to maintain patient safety.
- Staff received debriefs following incidents. Debriefs took place at staff supervision sessions or during handover meetings. Staff told us that senior management were approachable and available to discuss individual incidents on a 1:1 basis upon request. Nursing staff also received information relating to incidents in a monthly nurses team meeting. At the time of our inspection, senior management were looking to establish a team meeting exclusively for clinical support workers.

Are wards for older people with mental health problems effective?

(for example, treatment is effective)

Requires improvement 

Assessment of needs and planning of care

- We reviewed care records for nine patients. These were comprehensive and contained a variety of assessments and care plans that related to patients' individual needs. Patients' care records could include care plans for mobility, continence, nutrition, tissue viability, communication, challenging behaviour and activities.
- The service had introduced a comprehensive physical health assessment tool that was specific to the older person with dementia. This assessment included rating the impact and severity of symptoms in advancing dementia; SPICT (supportive and palliative care indicators tool).
- SPICT is an evidenced based clinical tool that has been developed collaboratively by The University of Edinburgh and NHS Lothian. However, we found that for the six records we reviewed of patients who had a

diagnosis of dementia, only three had a SPICT assessment that was fully completed. We also found that only three of the SPICT assessments had been regularly reviewed following the initial assessment, (at a minimum of six months).

- Senior management were aware that some patients' care records were not being regularly reviewed because there were not enough nurses employed by the service to full-fill the role of named nurse. The duties of a named nurse included regularly reviewing and updating patients' care records, including their care plan and assessment on admission to the hospital. Senior management identified that agency nurses should not be given this responsibility because they were not directly employed by Alternative Future's Group. As a consequence, senior nurses were responsible for completing and reviewing some patients' care plan and assessments. However, due to their other responsibilities as a senior nurse, they did not have the capacity to consistently complete and review them all.
- Staff monitored patients' weight and vital signs (blood pressure, temperature, pulse, oxygen saturation levels and respiration rate) on a monthly basis, or more frequently if clinically indicated. However, although we saw evidence that these assessments were regularly taking place, these were not always fully completed. For example, the hospital used a monitoring early warning scores chart (MEWS) to monitor and record patients' vital signs. On six patients' MEWS charts, we found gaps where staff had not recorded the relevant clinical information. Although we acknowledge that some of the patients may have not been able to co-operate when their vital signs were being recorded, staff did not document the reason for missing information. This placed patients at risk because inconsistent recording of physical observations could result in staff failing to recognise when a patient's physical health had deteriorated.
- The service had access to a GP practice who knew the patients well, and supported staff with the service's assessment, care planning and reviewing process. One particular GP attended the service at least once a week to review patients. There were also two other GP's from the same GP practice who were familiar with the service. Senior management at Abbey Court were currently liaising with the GP's practice manager to attempt to re-instate a GP ward-round.

Wards for older people with mental health problems

- The nine care records we reviewed included care plans that were personalised to the individual patient. The service used a number of person centred planning tools such as the recovery star, my personal plan and all about me. These tools were effective in conveying information relating to a patient's life history, hobbies and food preferences, particularly as many of the patients had communication difficulties.
- Care plans placed emphasis on maintaining patients' independence, not just providing for deficits resulting from their illness. For patients with a diagnosis of dementia, activity care plans were designed to meet their individual preferences. Staff used the pool activity level instrument (PAL) to assess a patient's ability to partake in activities they had identified as enjoying. The PAL instrument is an evidence based tool for assessing level of ability for activities of daily living and leisure activity, recommended by the National Clinical Practice Guideline for Dementia (National Institute for Care and Excellence, 2006). The tool is also used to identify any modifications required so patients can continue to enjoy activities that may have become more difficult due to their progressing illness.
- Care plans and daily records were stored in the nurses' office based on both wards. The nurses office was locked at all times, however all staff, including agency, had access using their electronic identification badge. Although agency staff did not have access to the services' electronic system, all care records were available in paper copy. This meant that all relevant information regarding patient care was available to them.

Best practice in treatment and care

- Medication was prescribed and reviewed in line with National Institute for Health and Care Excellence guidance: Donepezil, galantamine, rivastigmine and memantine for the treatment of alzheimer's disease (2011) and Low dose anti-psychotics in people with dementia (2015). Staff completed regular audits of patients' anti-psychotic medicines. Staff monitored side effects and reported them to the appropriate psychiatrist at patients' reviews to ensure appropriate action was taken.
- The service used a range of evidence based interventions and initiatives for patients who had a diagnosis of dementia. The service was a member of the National Dementia Action Alliance (DAA), and on a local

level, a member of the Warrington Dementia Action Alliance (WDAA). Part of the DAA and WDAA strategy was to assist providers in assessing the quality of their services in delivering better outcomes for people with dementia and their carer's. Alternative Futures Group had co- designed a baseline tool kit to enable providers to assess the quality of their service provision.

- The hospital, in partnership with the WDAA, delivered a 'footsteps' training programme to all staff working at the hospital. The footsteps program was designed to support staff to deliver creative, person-centred dementia care that values a patient's individuality and to see beyond their diagnosis. The next footsteps training programme for staff was due to commence in February 2016.
- The hospital was also part of the evidence based 'dementia care matters' initiative, developed by David Sheard, that develops person-centred dementia care within organisations. David Sheard is the chief executive and founder of the dementia care matters initiative, and is a qualified mental health professional. As a leading consultant in dementia care, he has provided training globally to services that support patients with a diagnosis of dementia. This has included the Alzheimer's Society. Staff training involved encouraging staff to connect with patients on an emotional level and to develop an empathetic understanding of what it is like to live with dementia.
- Staff regularly monitored and assessed patients' nutritional and hydration needs. Individual staff were allocated a specific group of patients daily and were responsible for monitoring and recording their nutritional intake in a daily record folder. Where a patient was identified to be at risk of choking, prompt referrals were made to a speech and language therapist via the local GP service. Dietician support was also sought via the local GP service for individual patients where appropriate, and dietary supplements were available to improve patients' nutritional status where needed.
- We reviewed the provider's scheduled timetable of clinical audits. Audits are a tool used to continually monitor and assess the quality of care provided to patients. This included a wide range of clinical audits that benchmarked practice against National Institute of Care and Excellence guidance, for example, care plan approach reviews (CPA's), infection control, record keeping, service user reviews, clinical reviews and

Wards for older people with mental health problems

manager's audit of medication management. The hospital had a designated quality partner who was part of Alternative Futures Group's quality assurance and development team. They were responsible for supporting the registered manager in reviewing the hospital's clinical audit schedule and identifying any issues that may arise from this.

Skilled staff to deliver care

- The commissioning arrangements for Abbey Court meant that the service had good access to a range of professionals from the local mental health trust and primary care services. This included three consultant psychiatrists, a mental health act administrator and a GP service.
- The hospital's full time occupational therapist had left the service in the summer of 2015. The service had not appointed a new occupational therapist since this time. The service had a senior occupational therapist that was responsible for ordering specialist equipment and completing physiotherapy referrals. However, they were not always available because they had regional responsibilities supporting other parts of the organisation. Two senior occupational therapists within the organisation were also due to leave Alternative Futures Group in the next few months. This would leave Abbey Court with a further lack of occupational therapy provision. Senior management assured us that funds had been secured to recruit an occupational therapist in March 2016.
- The service also lacked an occupational therapist who specialised in dementia care. Therefore, there was limited resources to complete specialist occupational therapy dementia assessments, such as 'the functional behaviour profile'. This assesses how a person with impaired cognitive function performs in their daily activities and is used to form part of a patient's care plan.
- Senior occupational therapists (employed by Alternative Future's Group, but not based at Abbey Court) had also trained four support workers, one nurse and one senior nurse for the role of activity lead. This meant that patients with a diagnosis of dementia had access to a wide range of activities that were evidence based, person-centred and effective in optimising their

well-being. We saw that the activity leads displayed a good understanding of the importance of their role and had acquired the necessary skills to lead occupational activities for patients successfully.

- All staff had received a timely and appropriate induction to the hospital. Senior management provided us with the hospital's staff supervision records. We saw that all staff received clinical supervision every six to eight weeks. Clinical lead nurses were responsible for supervising qualified nursing staff, whilst nursing staff supervised support workers. Senior management completed all employees appraisals. All staff, excluding agency and staff who were currently on long-term absence, had received an appraisal of their performance.

Multi-disciplinary and inter-agency work

- Regular multi-disciplinary team meetings took place to review patient care. Alternative Futures Group employed three consultant psychiatrists who all attended the hospital once a week to review patients with the wider multi-disciplinary team. We attended two ward rounds to observe how multi-disciplinary team reviews were conducted. Staff demonstrated respect for one another's professional input and they worked collaboratively to identify how they could improve care provision for individual patients.
- Effective handovers took place between each shift. Staff used a handover book to record patient progress throughout the day and night. This information was then used to form part of the formal handover at the end of each shift.
- The service had established a monthly team meeting for qualified nursing staff. This was a forum where qualified nurses could share best practice and discuss any ideas or concerns they may have regarding the service. However, there was no established team meeting for unqualified members of staff. Unqualified staff told us that senior management had recently facilitated an away day for all staff to build team morale and discuss their ideas and concerns relating to the hospital. They said they felt valued as they were able to express their views to senior management and see service delivery improve as a consequence. Unqualified staff said they thought it would be beneficial for them to have regular access to a team meeting, and senior management were currently developing an agenda to introduce this.

Wards for older people with mental health problems

- The service maintained regular contact with other teams in the organisation. Patients' care co-ordinators, from the relevant NHS community psychiatric team, regularly attended six weekly multi-disciplinary reviews to discuss patient progress.
- The new senior management team had established an effective working relationship with the local clinical commissioning group (CCG) and local authority to address any issues within the service. We attended and observed a quality assurance meeting, led by senior management, that was attended by three members of the local CCG. The hospital provided the CCG with an annual performance report to monitor service development.
- We spoke with the clinical commissioners, and they said they had a good relationship with senior management at Abbey Court. They praised the hospital for its ability to accept supportive challenge, and said that the service is responsive to feedback regarding its performance and take active steps to improve. For example, the CCG had raised concerns that safeguarding issues were not being adequately monitored or addressed. In response, the hospital had appointed a safeguarding lead nurse to effectively monitor and address these concerns.
- Abbey Court had developed an effective working relationship with the local NHS Trust to provide specialist training in dementia care to five local care homes. This was established in July 2015 as part of a combined commissioning for quality and innovation network target (CQUIN) for local care homes within the Warrington area. A CQUIN is a payment framework, awarded by CCG's, to reward excellence in health care through the achievement of local quality improvement goals. Abbey Court and the local NHS Trust both had a dedicated senior nurse practitioner that worked together to attend the five care homes once a week. They supported care home staff, patients and their families in the transition from hospital discharge to the care home setting. This included improving care home staff's skills and knowledge of how to care for someone with a diagnosis of dementia.
- All eligible staff were up-to-date with MHA training, deemed essential for their roles. This did not include staff who were currently on long-term absence. Eligible staff received training in the MHA annually, and this was delivered by a MHA administrative team from the local NHS trust. This included training in the new MHA Code of Practice (2015).
- There had been a MHA monitoring visit in May 2015 (Crossfield ward) and in June 2015 (Wilderspool ward). The review identified issues relating to inconsistencies in recording patients' capacity to consent to treatment. The review also identified that patients were not always provided with the opportunity to access their leave under Section 17 of the MHA. By the time of our inspection, the provider had addressed these issues.
- MHA documentation, such as detention records and approved mental health professional reports, were in place and up to date. All patients who required them had certificates authorising the administration of medication had certificates of consent to treatment (T2) and certificates of second opinion (T3) in place.
- However, of the eight care records of patients we reviewed detained under the MHA, we found five patients who had not had their rights explained on admission or regularly thereafter. Furthermore, in the cases where the patient did not have the capacity to understand their rights, their nearest relative or carer had not been consulted. This issue was also highlighted during the MHA monitoring visits in May 2015 and June 2015, but had not been adequately addressed by the provider by the time of our inspection.
- The local NHS trust provided administrative support and legal advice on implementation of the MHA and its code of practice to the service. At the time of our inspection, there were two dedicated MHA administrators from 5 borough's NHS foundation trust providing the service with MHA administrative support. A senior nurse practitioner, based at Abbey Court independent hospital, also held a professional qualification in mental health act law. The senior nurse practitioner provided further administrative support regarding the proper use of the MHA to staff and patients daily.
- Patients had access to independent mental health advocates (IMHA). In the MHA monitoring visits in May 2015 and June 2015, it was identified that automatic referrals on detention for patients were not being consistently completed. However, by the time of our

Adherence to the MHA and the MHA Code of Practice

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

Wards for older people with mental health problems

inspection, staff were completing timely and regular referrals to the IMHA service on behalf of their patients. IMHA's also visited the wards regularly to offer patients independent support and advice. The IMHA service told us that the hospital provided appropriate support to patients who were detained under the MHA.

Good practice in applying the MCA

- Following the Mental Health Act (MHA) monitoring visits in May 2015 and June 2015, it was reported that the hospital had experienced difficulties establishing the appropriate legal status for some of its patients. This was because the hospital and local authority had differences in opinion regarding when to use the Mental Capacity Act, Deprivation of Liberty Safeguards (DoLS) or the MHA for patients at the hospital. This had resulted in an increase in the number of informal patients on both wards who lacked capacity and were deprived of their liberty. If there were delays in authorising patients' DoLS applications, the hospital would assess patients under the MCA to ensure they were being kept at the hospital under an appropriate legal authority. At the time of our inspection, 19 patients were detained under the MHA, and no patients were subject to DoLS. One patient on Crossfield's ward had agreed to stay at the hospital as an informal patient.
- All staff were up to date with training in the Mental Capacity Act (MCA). This did not include staff who were currently on long-term absence. The provider delivered MCA training to all eligible staff on induction to the service. A refresher course was then delivered on a two yearly basis.
- Staff demonstrated a good understanding of the principles of the Mental Capacity Act (MCA), in particular, the assumption that people have the capacity to make decisions, and that the consideration of capacity is specific to the decision being made.
- In the patient care records we reviewed, we found good examples of thorough capacity assessments associated with patients' 'do not attempt resuscitation' request. We also found good examples of thorough capacity assessments associated with patients' covert medication plans, (where medicines are disguised and given to a patient in food and drink because they would otherwise refuse to take them).
- Patients had access to independent mental capacity advocates who visited the hospital on a weekly basis.

Are wards for older people with mental health problems caring?

Good 

Kindness, dignity, respect and support

- We observed excellent interaction between staff and patients. We attended and observed a patients' lunch on Crossfields ward. Staff were responsive to patients' individual needs, providing assistance to patients who needed support to eat and drink. Staff were also mindful to maintain patients' independence as much as possible. Patients were encouraged to choose their favourite music to listen to during meal times, and choose where they wanted to sit.
- Whilst touring both wards, we observed some patients who were emotionally distressed. Staff demonstrated skill and kindness in supporting these individual patients. They used de-escalation techniques, such as verbal reassurance and appropriate distraction techniques, to effectively reduce patients' distress.
- We spoke with four patients on Crossfields ward. All patients commented that they felt safe and there was enough staff to meet their individual needs. One patient said staff had "assessed what specialist equipment I need and have ordered it for me". Another patient said staff "understand what I need and let me do things in my own time".
- We spoke with nine carers of patients at the hospital. One carer commented on staff's "attentiveness to patients' needs". Another relative described the staff as "very skilled to do their job". Another carer said that their relative had "come on leaps and bounds since being here", whilst another described the level of care delivered by staff as "outstanding". We spoke with staff from the local clinical commissioning group. They said that carers always gave positive feedback regarding the service at Abbey Court.

The involvement of people in the care they receive

- The hospital sometimes invited patients to have settling in days on the wards before they accepted a place. This gave patients and their carers the opportunity to see if they liked the hospital before committing to stay long-term.

Wards for older people with mental health problems

- We looked at nine patients' care plans. On Wilderspool ward, two patients had copies of their care plan. However, seven of the care plans were for patients that had a diagnosis of dementia who did not have the capacity to understand what their care plan was for. For these seven patients, we did not find any evidence that carers had been given a copy of the care plan. However, all the carers we spoke with said they understood what their relative's plan of care was. They said that they received regular updates regarding their relatives care when visiting the unit or by telephone. One carer said staff were "very respectful to their ideas" and another said they felt "massively involved in the care of (their) relative".
- For patients who had limited to capacity to provide input into their care plan, staff used documents such as 'this is me', completed by the patients' carer, to make the care plan personalised and relevant to their needs. The 'this is me' patient profile included information such as what their hobbies were, what they liked to eat and drink and special people in their life.
- Staff regularly encouraged patients to attend the weekly review of their individual care. Patients could also talk to their psychiatrist on a 1:1 basis if they did not feel comfortable attending the meeting. Carers were invited to attend a multi-disciplinary meeting every six weeks to review their relatives care.
- Independent mental health advocates attended the hospital at least once a week to support patients who were detained under the Mental Health Act. Independent mental capacity advocates also attended the hospital weekly to support patients who had limited capacity to understand their care and treatment.
- The hospital ran family engagement days to increase carer involvement in the running of the hospital. Recently this had included hosting a sports day and carnival. The senior management team were currently looking at introducing a carer's committee group so that carers could regularly share their ideas and concerns regarding the running of the hospital.

Are wards for older people with mental health problems responsive to people's needs?

(for example, to feedback?)

Good 

Access and discharge

- Between 01 April 2015 and 01 October 2015, the average bed occupancy at Abbey Court was 84%. Beds were available when needed for people living within the local area.
- Abbey Court had an agreement with the local clinical commissioning group (CCG) to attend any referrals within two weeks of receipt. Senior management at Abbey Court discussed referrals with the CCG to prioritise admissions based on individual patients' risk and needs.
- There was a clear pathway into Abbey Court for patients diagnosed with dementia. Patients were admitted from an acute assessment ward, based at a local NHS Trust. The purpose of admission to Abbey Court was to provide patients with additional support to manage and stabilise challenging behaviour.
- Two of the consultant psychiatrists that worked at Abbey Court also worked on the NHS acute assessment ward. They had a license, formally known as a practicing privilege, to treat patients at Abbey Court. This meant that the consultant psychiatrists already knew the patients well, and were able to monitor their health and well-being closely during the transition from one ward to another. Following treatment, patients were regularly discharged to a local care home, or in some cases, their own home.
- Discharges from the hospital were planned in advance, and therefore patients were transferred at an appropriate time of day to suit their individual needs. Occasionally a patient was moved between the two wards. However, this only happened where a clinical need had been identified and following a discussion between hospital staff, the patient and their carer's.
- At Abbey Court, a delayed discharge is a patient that had spent more than 18 months at the hospital but no longer required treatment there. Between 18 April 2015 and 18 October 2015, Abbey Court had 13 delayed discharges. At the time of our inspection, the hospital had four delayed discharges. These were patients who did not have a diagnosis of dementia and were awaiting discharge from Crossfield's ward. Due to their complex mental and physical health needs, Abbey Court were

Wards for older people with mental health problems

struggling to find suitable, alternative accommodation. However, we saw that hospital staff, carers and community mental health workers were working together to find other appropriate placements. This included researching and attending alternative placements outside the local area. Patients' discharge plans were also discussed as a standing agenda item during their weekly review. In many cases, community mental health workers and the local CCG would attend to discuss patients' discharge plans.

- Abbey Court also worked in partnership with a local NHS Trust to deliver specialist training to care home staff. Training involved increasing care home staff's knowledge and skills of how to care for patients with a diagnosis of dementia. This had the positive effect of preventing patients being re-admitted to Abbey Court because care home staff could not manage their needs.

The facilities promote recovery, comfort, dignity and confidentiality

- There was a large activity room located on the corridor that connected both wards. This was accessible to all patients and contained board games, arts and crafts, sports equipment and a hair -dressing salon. We saw patients using these facilities during our inspection.
- There were quiet rooms available on both wards where patients could meet visitors or talk to a member of staff in private. Both wards had direct access to outside space that some patients were able to use freely during the day. Some patients required staff supervision to access the outdoor area. However, this was risk assessed according to individual patients' needs.
- In 2015, Warrington Borough Council awarded Abbey Court a rating of five stars for food hygiene (the highest rating). Patients and carers commented that the food was of good quality and that they could request food and drink to meet their dietary and cultural preferences. A communal kitchen was located on both wards for patients to store food and drink and make snacks where possible. For patients who had difficulty expressing what they would like to eat and drink, picture cards and menus were available to help them communicate their choice.
- Hot drinks and snacks were available to patients throughout the day and night. Due to their dementia,

some patients had a disturbed sleep pattern and were therefore awake more in the night than in the day. Staff respected individual patients' needs and made food and drink available to them when they were hungry.

- We viewed five patients' bedrooms during our inspection. Patients had personalised their bedrooms to meet their individual needs and preferences. Patients with a diagnosis of dementia had a memory box in place outside of their bedroom. A memory box helps people recall people and events from the past and helps lift a patient's mood by reminding them of good times. Staff placed one outside a patients' bedroom to help them identify it as theirs. Carers and staff had helped patients to make their own memory boxes, and the ones we saw contained personal items such as photographs, holiday souvenirs, post cards, and art-work completed by their grand-children.
- A senior occupational therapist from the Alternative Future's Group had recently trained seven clinical support workers as activity leads. Because they worked on a shift rota that covered weekends, activities were available to patients seven days a week. Patients had individual activity booklets. Staff used these to identify what activities patients liked, to timetable activities into their daily routine and record what activities they had engaged in.
- We attended and observed two activity groups that were designed for patients with dementia. One of the activities was based on the activating potential for communication programme. This is an evidenced based activity for older people who have difficulty expressing themselves, and it focuses on sensory stimulation (sound and touch) to improve communication. Staff used sensory aids such as musical instruments to engage the patients. We observed how patients' interaction with others improved and how their mood lifted as a result of participating in the group.
- However, two patients on Crossfields ward told us there were not many activities available and sometimes they were bored. Some carers of patients on Crossfield ward said that their relative was reluctant to engage in activities when encouraged by staff, and therefore they could not accurately comment on whether this was an issue. They raised concerns regarding the "lack of activities during the day". We looked at the activity plans

Wards for older people with mental health problems

for all four patients on Crossfields ward. We saw that all patients had an activity plan in place. However, patients were sometimes choosing not to engage with their activity plan when encouraged by staff.

Meeting the needs of all people who use the service

- As part of Abbey Court's induction programme, all staff completed training in equality, diversity and inclusion. The training involved raising staff awareness of the different needs of people using the service and how they could best support them.
- Abbey Court was part of the Warrington dementia action alliance group (WDAA). The WDAA ran meetings four times a year, and local members attended to identify improvements that they could make in dementia care for patients and carers in the local community.
- The hospital provided a range of information to patients and their carers regarding how to make a complaint or compliment, activities and support groups available in the local area and how to contact an independent mental health advocate. Posters explaining this information were available on both wards, and leaflets were provided to patients and their carer's on admission. The complaints information leaflet provided details of a central complaints co-ordinator for Alternative Future's Group. Patient and carers could contact the co-ordinator should they not feel able to address their concerns directly with staff at Abbey Court.
- Patients of the Christian faith were able to attend a local church service on a Sunday. Staff provided patients with an escort where required. Currently there were no patients who followed a different faith living at Abbey Court, but the hospital were able to access alternative religious support if required.

Listening to and learning from concerns and complaints

- Before our inspection, Abbey Court told us that they had received one formal complaint regarding the hospital between October 2014 and October 2015. During our inspection, we saw evidence that the complaint had been fully investigated by Alternative Future's Group. The hospital had a policy in place to deal with complaints and we saw that they followed this where appropriate.
- Senior management told us that where patients and families made a complaint regarding the hospital, these could mostly be resolved on an informal basis. As per

the hospital's complaints policy, this would involve the patient and/or carer meeting with a member of the senior management team to address any concerns within one working day. We spoke with four carers of patients receiving treatment at the hospital. They confirmed that where they had raised concerns regarding the care of their relative, senior management were approachable and had addressed their concerns immediately.

- The hospital had a whistle-blowing policy in place. This provided staff, carers and patients with a guide for how to raise complaints anonymously to a central quality assurance and practice development team at Alternative Future's Group. This team was responsible for investigating any whistle-blowing concerns and supporting local management to implement any changes that were required to improve the service.
- Nursing staff received feedback following the investigation of complaints. Senior management provided feedback during monthly nursing team meetings and within one to one clinical supervision. However, clinical support workers we spoke with raised concerns that they did not receive regular feedback regarding the outcome of investigation of complaints. This was because there was no regular team meeting for clinical support workers where these outcomes could be discussed with the wider senior management team.

Are wards for older people with mental health problems well-led?

Good 

Vision and values

- Staff we spoke with were aware of Alternative Futures Group's (AFG) vision and values and demonstrated commitment to these in their professional practice. AFG's vision was to continually strive to put patients in control of their own care, to make a positive difference to the lives of others, and to be sustainable. This vision was underpinned by staff acting in way that was principled, reflective, dynamic, empowering and with integrity. Staff were mostly positive about Abbey Court's local vision to become a hospital that exclusively specialises in dementia care.

Wards for older people with mental health problems

- Staff were familiar with Abbey Court's senior management team. Staff we spoke with said that the new senior management team were approachable, and that some members worked weekends to provide consistent managerial support across the wards.

Good governance

- All staff, including agency, were up to date with mandatory training. This did not include staff who were on long-term sickness or had been suspended. All staff, excluding agency and staff on long-term absence, had received an appraisal of the work performance in the last year. Although shifts were covered by an adequate number of nursing and clinical support work staff, there was an over-reliance on agency staff to cover staffing short-falls. Although five agency staff were employed on a fixed-term temporary contract to ensure continuity of care delivery for patients, agency staff could not perform all the duties of a named nurse. The duties of named nurse commonly included regularly reviewing and updating patients' care records, including their care plan. Senior management were aware that some patients' care records were not being reviewed regularly because there were not enough nurses employed by the service to full-fill the role of named nurse. The hospital had advertised four nursing vacancies. Senior management were interviewing two candidates for these roles in March 2016.
- The hospital had a scheduled timetable of clinical audits. Audits are a tool used to continually monitor and assess the quality of care provided to patients. The hospital had a designated quality partner who was part of Alternative Futures Group's quality assurance and development team. They were responsible for supporting the registered manager in the review of the clinical audit schedule and identifying any issues that may arise from this.
- Senior management submitted items to Alternative Futures Group's (AFG) risk register. We reviewed the risk register during our inspection. Items that were currently active on the register included a reduced staff team due to long-term absence, and concerns regarding the hospital's track record on reporting incidents of abuse to the relevant local authority and clinical commissioning group (CCG). Both of these concerns were submitted to the risk register in July 2015. Since these concerns had been raised, we saw that AFG had made changes to their incident reporting system, CARISTA. The change ensured

that incidents recorded as a safeguarding concern automatically prompted staff to alert the local authority and CCG. Staffing short-falls were being addressed through advertisement of vacancies and the employment of five agency nurses on a temporary fixed-term contract.

Leadership, morale and staff engagement

- Before our inspection, the hospital submitted an employee opinion survey of results (2014). The survey had an employee response rate of 55%. The survey asked employees how they felt about their involvement in the hospital, including their ability to provide feedback into how it was run. The results indicated that staff felt that communication with senior management was poor, and therefore staff had little opportunity to raise concerns and ideas to improve care for patients. Since this time, senior management had taken steps to address these concerns. This included facilitating an away day for all staff to discuss their concerns and ideas for hospital's development. Staff we spoke with commented positively on this away day, and said they would like to have more opportunities to feel involved in how the service was delivered.
- The hospital had also employed a new management team in October 2015. Since this appointment, staff we spoke with said that the management team were more accessible and approachable. They therefore felt more valued and involved in the running of the service. The nursing team had access to a monthly team meeting where senior management attended to discuss their concerns and ideas for service improvement. However, there were no regular team meetings for clinical support work staff. We spoke with seven clinical support workers. They all identified that they would benefit from a regular team meeting where they could discuss their concerns and ideas with the senior management team.
- Alternative Future's Group offered additional, optional courses to staff to help improve their professional skills and knowledge. This included a diploma in dementia care.
- Between October 2014 and October 2015, the hospital had a high sickness and absence rate at 11%. This included staff who had been suspended from work. We saw that senior management were using a performance management plan to address any issues relating to individual staffs work performance. This included supporting staff members who had recently returned to

Wards for older people with mental health problems

work following suspension. Sickness and absence rates were decreasing since a new registered manner had been instated in October 2015. Staff said they felt more supported in their role by senior management, and therefore were less likely to be absent due to work-related stress.

- All staff had access to Alternative Futures Groups (AFG) intranet site, Bud-e. This could be accessed via work-based computers, or laptops and smart phones outside of work. Bud-e was a forum where staff could review policies and procedures and see what the latest service developments were across AFG. AFG also produced a staff newsletter that included information of latest service developments, success stories and contact details for additional staff support services.
- We spoke with 15 staff members working at Abbey Court. All staff praised the strong team ethic and said that staff worked well together across both wards. However, clinical support workers said that they would like more opportunities to provide feedback into the running of the service.
- Staff based on Crossfield ward also raised concerns that they may not have a job following the closure of admissions to patients who did not have a diagnosis of dementia. Senior management were able to provide a guarantee that staff would keep their job despite this closure. However, some staff on Crossfield ward wanted to carry on working with patients who had a functional mental health problem (for example depression, schizophrenia or bi-polar disorder), as opposed to patients with dementia. This meant that some staff may potentially look for alternative employment. Senior management were supporting Crossfield ward staff through this process. They encouraged Crossfield staff

to spend time working on Wilderspool ward. The aim was to increase staff's skills and knowledge in dementia care, and also to see if staff would like working with a different patient group.

Commitment to quality improvement and innovation

- An Alternative Future's Group staff member was a lecturer at a local university, and had recently published evidence-based research on person-centred dementia care. This research was used to inform part of the staff induction programme to Abbey Court.
- The hospital displayed a strong commitment to providing evidence based interventions and initiatives for patients who had a diagnosis of dementia. This included their active role in improving dementia care in the local community as part of the Warrington Dementia Alliance Association. The hospital had also worked in partnership with a local NHS Trust to provide specialist training in dementia care to five local nursing homes. The hospital were also providing staff training in the 'dementia care matters' initiative. This had been recognised as an innovative approach to supporting people with dementia. Training focuses on encouraging staff to engage with patient on an emotional level and to develop an empathetic understanding of what it is like to live with dementia.
- Staff used evidenced based tools to assess the occupational needs and abilities of patients with dementia, such as the pool activity level assessment tool. They also provided evidenced-based activities, such as the activating potential for communication group (founded by Sonas activating potential for communication Ltd).

Outstanding practice and areas for improvement

Outstanding practice

The service demonstrated a commitment to continuous improvement and innovation in the service they provided to patients with a diagnosis of dementia. This included:

- Being an active member of the Warrington dementia alliance association (WDAA). The WDAA met four times a year to identify how they could improve dementia care within the local community.
- Active participation in the dementia care matters initiative. This evidence-based initiative places emphasis on building empathy with patient's diagnosed with dementia, and encourages staff to see

the patient as an individual person beyond their diagnosis. The hospital had developed a 'foot-steps' training programme, based on this initiative, that was delivered to all staff as part of their induction programme.

- Using a variety of evidence-based practices. This included the pool activity level assessment tool and the activating potential for communication group, founded by Sonas activating potential for communication Ltd.

Areas for improvement

Action the provider **MUST** take to improve

- The hospital must ensure that patients receive a physical health assessment on admission.
- The hospital must ensure that patients' physical health assessments are accurately recorded to enable staff to make appropriate and timely interventions.
- The hospital must ensure that they are meeting the Department of Health guidance on same-sex accommodation.

Action the provider **SHOULD** take to improve

- The hospital should ensure that there are enough adequately trained nursing staff to meet the holistic care needs of all the patients using the service.

- The hospital should ensure that all patients' care plans and assessments are fully completed and routinely reviewed.
- The hospital should ensure that all patients detained under the Mental Health Act have their legal rights read on admission and routinely thereafter. This must be recorded in patients' care records. The hospital should ensure that, where appropriate, patients' relatives are informed of this.
- The hospital should ensure that there are a range of professionals in the multi-disciplinary team so that patients' holistic care needs are assessed and managed effectively.
- The hospital should ensure that all staff have the opportunity to provide feedback into how the service is delivered.

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

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

There were no day rooms/lounges designated as male and female.

This was a breach of regulation 10(2)(a).

Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

We reviewed nine patient care records. In five of these, patients' vital signs (i.e. blood pressure, temperature, respiration rate, oxygen saturation levels, pulse) had not been completed as clinically indicated. This put patients at risk, as staff did not have the information available to determine when a patients' physical health may be deteriorating, and therefore to take prompt intervention where required.

This was a breach of regulation 12 (1)(2)(a).