The Priory Highbank Centre

Quality Report

Walmersley House
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Date of inspection visit: 5 December to 6 December and 13 December 2018
Date of publication: 24/05/2019

This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Requires improvement

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

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

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

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

Summary of findings

Overall summary

Priory Highbank Centre is operated by Priory Rehabilitation Services Limited and provides in-patient mental health services for adults and specialist neurological rehabilitation for adults and children.

The hospital has a total of 34 beds comprising of 24 rehabilitation beds for patients of all ages with a brain injury or a neuro-disability and along term high dependency rehabilitation unit for 10 male patients aged 18 and over who have a diagnosis of mental disorder.

Facilities include designated therapy areas, dining and outside areas, a family sitting room and a self-contained flat which can be used for patients and their families.

The Priory Highbank Centre was last inspected by the CQC in December 2016 and was rated 'good' overall. We inspected this service using our next phase inspection methodology and carried out an unannounced inspection on 5 ,6 and 13 December 2018.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led? Where we have a legal duty to do so we rate services' performance against each key question as outstanding, good, requires improvement or inadequate.

Throughout the inspection, we took account of what people told us and how the provider understood and complied with the Mental Capacity Act 2005.

Our rating of this hospital stayed the same.

We rated this hospital as requires Good overall because:

- The service provided a safe and clean environment with enough staff to keep patients safe.
- Staff cared for patients with compassion and provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- Managers across the hospital promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.

However, we found that:

- The service did not consistently notify the Care Quality Commission of reportable incidents, which occurred whilst services were being provided in the carrying out of a regulated activity.
- Care plans were not fully holistic and recovery orientated in relation to discharge planning.
- Following this inspection, we told the provider that it must take some actions to comply with the regulations and that it should make other improvements, even though a regulation had not been breached, to help the service improve. We also issued the provider with one requirement notice that affected long-term conditions. Details are at the end of the report.

Ellen Armistead

Deputy Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long term conditions	Good 	The service had enough staff with the right skills, qualifications and experience. Staff continued to work together to support each other and provide good care. Staff kept patients safe from harm and abuse. They understood and followed procedures to protect vulnerable adults or children. Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They knew how to support patients who lacked the capacity to make decisions about their care. Patients were treated with compassion, dignity and respect. Staff involved patients and those close to them in decisions about their care and treatment. They made sure patients were aware of their goals and plan of care. Managers monitored performance and used the results to help improve care. The serviced promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. However, incidents were not consistently reported the CQC as per their registration requirement.
Long stay or rehabilitation mental health wards for working-age adults	Good 	The unit was safe, clean, well equipped and furnished. There were skilled staff able to deliver care and the multidisciplinary team worked well and was well established. Patients were provided with physical health checks and best practice guidance was followed. All patients had regular risk assessments updated by the multidisciplinary team. Patients individual preferences were central to planning the care they received and involvement in the local community was integral to the care they received. Discharge planning was discussed and documented at multidisciplinary team meetings and with commissioners and during Mental Health Act tribunals and managers hearing meetings. The leadership and governance on the unit promoted the delivery of high quality person centred care with recovery and optimisation of patients' independent living skills.

Summary of findings

However:
Care plans were not holistic and recovery orientated in relation to planning for discharge.

Summary of findings

Contents

Good

The Priory Highbank Centre

Services we looked at

Long term conditions; Long stay or rehabilitation mental health wards for working-age adults;

Summary of this inspection

Background to The Priory Highbank Centre

Priory Highbank Centre is a private hospital in Bury, Greater Manchester and is operated by Priory Rehabilitation Services Limited.

The Priory Highbank Centre is registered to carry out the following regulated activities:

- accommodation for persons who require nursing or personal care
- treatment of disease, disorder or injury
- assessment of medical treatment for persons detained under the 1983 Mental Health Act
- diagnostic and screening procedures

The service was last inspected by the CQC on 5,6 December 2016 where they were rated as good.

A CQC Mental Health Act monitoring visit took place on 23 July 2018. This identified that patients still did not have access to the intranet, patients had not been consulted about advance statements and a bathroom door was kept locked. During this visit we saw that these issues had been rectified.

The registered manager at the hospital is Helen Powell who has been in post since 4 March 2004.

Our inspection team

The team which inspected The Walmersley Unit and Lynne House comprised a CQC lead inspector, CQC inspector and a specialist advisor with expertise in neurology. The team which inspected Robinson House comprised two CQC inspectors and an assistant inspector.

The inspection team was overseen by Nicholas Smith, Head of Inspection (Hospitals) and Brian Cranna, Head of Inspection (Mental Health).

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

During the inspection and the Mental Health Act monitoring visit we:

- observed care and looked at a range of policies, procedures and other documents relating to the running of the service;
- looked at the quality of the ward environments and observed how staff were caring for patients;

Summary of this inspection

- spoke with five patients who were using the service and five patients when the Mental Health Act reviewer visited;
- spoke with six family members;
- spoke with 24 members of staff including; registered nurses, health care assistants, therapy staff, a cleaner and an activities co-ordinator, training co-ordinator, family liaison officer, medical staff, and senior managers;
- looked at seven care and treatment records of patients and five records when the Mental Health Act reviewer visited;
- carried out a specific check of the medication management;
- attended and observed one multidisciplinary meetings;
- received feedback about the service from six commissioners.

Information about The Priory Highbank Centre

The Priory Highbank Centre is a 34-bedded private hospital located in Bury, Greater Manchester and accepts patient referrals from around the country and can be NHS or 'other 'funded.

Within the hospital there are three units: Robinson House, Walmersley unit (upper Walmersley and lower Walmersley) and Lynne House.

Robinson House provides a service for 10 male patients aged 18 and over who have a diagnosis of mental disorder. They provide a long term high dependency rehabilitation unit. The unit is part of the Priory Rehabilitation services group and is located within the main building of The Priory Highbank Centre in Bury.

There were six male patients in Robinson House at the time of the inspection and all six patients were detained under the Mental Health Act.

The unit is set over two floors. The ground floor provides an open kitchen, dining room and lounge area. There is a conservatory and a spacious garden which can be entered from the lounge or conservatory. There was a multifunction room, a laundry/arts and craft room, a further lounge, a relaxation room and a snug. The first floor provided bedrooms for patients.

Robinson House was last inspected by the CQC on 5, 6 December 2016 where they were rated as good.

A CQC Mental Health Act monitoring visit took place on 23 July 2018. This identified that patients still did not have access to the intranet, patients had not been consulted about advance statements and a bathroom door was kept locked. During this visit we saw that these issues had been rectified.

The Walmersley unit (upper and lower Walmersley) provides interdisciplinary team assessment and slow stream rehabilitation to patients over the age of 16 years. The units facilitate rehabilitation for a range of patients, from low awareness to the more independent. Rehabilitation programmes are tailor made to suit the assessed needs of the individual and can be delivered on a short term or longer term basis. Specialist areas include the management of patients who require assessment and those who have complex respiratory needs including tracheostomy and mechanical ventilation management. All patients are under the care of a consultant in rehabilitation medicine.

Upper and Lower Walmersley wards are each located on separate floors and all patients have their own individual room with communal dining, therapy and gym areas and have access to a large garden and a self-contained apartment.

At the time of our inspection Lower Walmersley was closed to in-patients and was being utilised for children who were staying on Lynne House to access day time and communal activities.

Lynne House is a complex care and slow stream rehabilitation ward, with five inpatient beds. It provides care for children with acquired brain injury and complex neurological impairment from birth to age 17 years. Services provided include care and management of children with tracheostomies and / or ventilator dependent children under the supervision of a consultant in long term ventilation. Care is also provided for children with a range of disabilities, such as cerebral palsy and epilepsy.

Summary of this inspection

Walmersley unit (upper Walmersley and lower Walmersley) and Lynne House was last inspected by the CQC on 5, 6 December 2016 where they were rated as good.

At the hospital there was one full time and two part time doctors in addition to a part time doctor who worked under practising privileges. There were 17 registered nurses, 80 health care assistants, 18 therapists including therapy assistants, family liaison officer, training co ordinator and a psychologist.

The accountable officer for controlled drugs (CDs) was the director of clinical services who was also the lead for the safe and secure handling of medicines.

Track record on safety across the hospital from August 2017 and July 2018:

- No Never events
- Five serious incidents
- No incidences of hospital acquired Meticillin-resistant Staphylococcus aureus (MRSA)
- No incidences of hospital acquired Meticillin-sensitive Staphylococcus aureus (MSSA)
- Two incidences of hospital acquired Clostridium difficile (c.diff)
- No incidences of hospital acquired E-Coli
- Five complaints.

Services provided under a service level agreement:

- Pharmacy
- Pathology and histology
- On call GP out of hours service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

Our rating of safe stayed the same. We rated it as **Good** because:

- The units provided a safe and clean environment with enough staff to keep patients safe.
- Staff completed risk assessments for every patient and updated them regularly.
- Staff were safeguarding patients and knew how to identify and report.
- Staff completed physical health checks and followed best practice when prescribing and monitoring medication side effects.

However,

- We found that on occasions where the medicines fridge temperature was out of range on the Walmersley unit and Lynne House, it was not clear within the ward documentation what actions were taken.

Are services effective?

Good

Our rating of effective stayed the same. We rated it as **Good** because:

- Staff assessed patients' mental and physical health on admission and throughout their stay. Care plans addressed the individual patients' goals and how to reach them. Records were personalised.
- Staff provided care and treatment for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and staff supported them to live healthier lives.
- Staff supported patients to make decisions about their care for themselves.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff received an annual appraisal of their work and regular supervision.
- Staff had the skills, knowledge and experience needed to provide high-quality care. Staff from different disciplines worked together to benefit patients and make sure they had no gaps in their care.

Summary of this inspection

- Staff had a good understanding of the Mental Health Act and the Mental Health Act Code of Practice and they made sure that patients understood their rights. There were regular audits to ensure that the Mental Health Act was being applied correctly.

Are services caring?

Good

Our rating of caring stayed the same. We rated it as **Good** because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Managers told us that staff were very dedicated and were always caring. Staff on the children's unit visited patients in their own time to take them to social activities.
- Staff involved patients and those close to them in decisions about their care and treatment. The service employed a family liaison officer to help communicate with families and ensure they were fully involved in patient care.
- Staff provided emotional support to patients to minimise their distress and the service was supported by psychology.
- Staff responded to patients' cultural and spiritual needs.
- Staff involved patients and their carer's and or family members in decisions about their care and facilitated family contact where possible. Patients were empowered to make decisions about their own care.

Are services responsive?

Good

Our rating of responsive stayed the same. We rated it as **Good** because:

- Commissioners and care coordinators were kept updated about patients' progress, and care.
- The layout of the units supported patient's treatment, privacy and dignity.
- Patients individual needs were central to the planning and delivery of care and treatment and patients received person centred care.
- Staff fully supported patients to access a wide range of activities outside the service with a varied choice of activities, seven days a week.

However;

- Care plans on Robinson House were not fully holistic and recovery orientated in relation to discharge planning.

Are services well-led?

Requires improvement

Our rating of well-led went down. We rated it as **Requires improvement** because:

Summary of this inspection

- The service did not consistently report notifications as per their regulatory registration requirement.

However:

- Managers at all levels at the hospital had the right skills and abilities to run a service providing high-quality sustainable care.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- Managers monitored performance and used the results to help improve care. All staff identified risks to good care.
- The service had been proactive in capturing and responding to patients concerns and complaints. There were creative attempts to involve patients in all aspects of the service.
- The service proactively engaged and involved all staff and they ensured the voices of all staff were heard and acted upon.

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.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff explained patients' rights to them in a way that they could understand, repeated these as required and recorded that they had done it.

All six patients were detained under the Mental Health Act.

The Mental Health Act administrator provided training and there was additional ward based training that staff had developed themselves. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had easy access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had easy access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had easy access to information about independent mental health advocacy. They understood the role of the advocacy service. Contact details were displayed clearly. An advocate attended the ward every week and supported patients in their ward round if they wished. The advocates provided training for the staff so that they understood the role and its responsibilities.

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this has been granted.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The Mental Health Act administrator carried out monthly audits to monitor adherence to the Act, such as ensuring consent forms were renewed, patients received information about their rights and the time limits were met for renewing sections and section 17 leave or making referrals to tribunals.

Mental Capacity Act and Deprivation of Liberty Safeguards

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 which included deprivation of liberty safeguards and they assessed and recorded capacity clearly.

The majority of staff had had training in the Mental Capacity Act. The Mental Health Act administrator provided training and there was additional ward based training that staff had developed themselves.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.

There had been one deprivation of liberty safeguards application made in the last 12 months which protect people without capacity to make decisions about their own care.

Staff knew where to get advice within the service regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent

Detailed findings from this inspection

appropriately. They did this on a decision-specific basis regarding significant decisions. Care records contained mental capacity assessments for decisions such as flu vaccinations and financial decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long term conditions	Good	Good	Good	Good	Requires improvement	Good
Long stay or rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Requires improvement	Good

Good

Long term conditions

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

Are long term conditions services safe?

Good

We rated safe as **good.**

Mandatory training

The service provided mandatory training in key skills to all staff and made sure all staff completed it. The service maintained electronic records of mandatory training to assure managers of compliance rates. The site learning administrator reminded staff electronically when they were due to complete updates to mandatory training. Staff could easily log on to the electronic system.

The service required staff to complete several courses including basic life support with defibrillator, infection control and moving and handling. However, data provided showed the 90% target was not met in all training modules.

Upper Walmersley:

- Trained staff met the 90% target in 12 out of the 14 modules. However, they did not meet the 90% target in two modules; immediate life support (67%) and prevention management of violence and aggression breakaway training (75%).
- Untrained staff did not meet the 90% target in eight of the 13 modules including prevention management of violence and aggression breakaway training (79%) and Mental Capacity Act (86%). However, they met the target in five other modules.

We were told trained nurses complete annual immediate life support training, which also covered basic life support and defibrillator training.

The hospital director told us that compliance for immediate life support was 67%. There was one member of staff on long term sick at the time of our inspection: the outstanding four members were due to complete this training on 11 January 2019.

Lynne House:

- Trained staff did not meet the 90% target in nine out of 14 modules including immediate life support (25%). However, they met the target in five other modules.
- Untrained staff did not meet the provider target of 90% in seven of 13 modules including prevention management of violence and aggression breakaway training (33%). However, the target was met in six other modules.

The hospital director told us that two of the four members of trained staff were unable to complete the immediate life support training as planned in December, due to unforeseen circumstances. However, they were due to complete the training in January 2019.

The compliance rate of 33% for 'prevention management of violence and aggression breakaway training' although low, was appropriate for the service user group living at Lynne House.

Therapy staff :

- Therapy staff across the hospital met the provider target of 90% in ten out of the 13 modules. However, the target was not met in three modules including prevention management of violence and aggression breakaway training (62%).

The hospital director told us they had taken action to increase compliance by providing additional training at weekends. The service were offering staff the opportunity to train up and provide the training. The service provided a plan of training to be delivered to staff from January 2019 to March 2019.

We queried whether staff providing care to children had paediatric life support training. Senior managers told us that this was referred to in basic life support training and within the providers policy in cardiopulmonary resuscitation. The hospital director confirmed the service was currently seeking practical paediatric life support training for staff.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. Staff at all levels could describe what they would do if they had any concerns regarding safeguarding adults and children.

The service trained several members of staff to be designated safeguarding officers. The unit had information on noticeboards to inform staff, patients and relatives about who were the designated safeguarding offers, and safeguarding policies and procedures. The designated safeguarding officer delivered safeguarding training to all staff.

All staff received safeguarding awareness training on the first day of induction to the service.

The service delivered a combination of e-Learning and classroom training. The classroom training was level three safeguarding children.

Data from September 2018 showed compliance rates for safeguarding training via e-learning ranged from 94% to 100% and from 20% to 67% for classroom training:

E-learning (children):

Nurses Walmersley 100%

Nurses Lynne House 100%

HCAs Walmersley 100%

HCAs Lynne House 94%

Qualified therapists 94%

Classroom– children and adults combined :

Nurses Walmersley 20%

Nurses Lynne House 33%

HCAs Walmersley 33%

HCAs Lynne House 39%

Qualified therapists 67 %

Classroom training was reset to zero in September 2018.

Data prior to September 2018 showed overall compliance above 95 % for training in both childrens and adults safeguarding.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

The service employed an infection control lead and each unit had an infection control champion. The service undertook audits monthly and feedback was provided by the infection control lead or from managers during the handovers.

We saw completed audits of handwashing and personal protective equipment for the period September to November 2018 and compliance was generally good, for example compliance for handwashing ranged between 70 and 80%.

We saw that all areas had good access to personal protective equipment. There were gloves, aprons, alcohol spray and hand gel available in all areas and we witnessed staff using this at regular intervals.

The unit managed waste to control the spread of infection. There were yellow bags in each room and yellow waste bins.

We found signed cleaning rotas in patient bedrooms to indicate rooms had been cleaned daily and observed this taking place during the inspection.

During the inspection one patient had carbapenemase-producing enterobacteriaceae (a type of infection) and staff knew to keep the patient's laundry in a red plastic bag which was then put into a red cloth bag. Sporicidal wipes were used to clean any equipment such

as the hoist, which was witnessed during the inspection. Staff wore aprons and gloves at all times when providing care and treatment. All equipment used by the patient was cleaned after use.

The service provided the following infection rates for the period December 2017 to November 2018:

- C. difficile (2)
- MRSA (0)
- MSSA (0)
- Other bacteraemia (0)
- Surgical Site infection (0)

Environment and equipment

The service had suitable premises and equipment and looked after them well.

Staff completed daily checklists which included the ventilator and tracheostomy bag. Staff signed to say they had completed the checklist during every shift which we witnessed during the inspection. Staff completed a weekly checklist which reflected, for example, that staff had changed tubes for the ventilation equipment.

We observed a copy of daily bed checks.

We observed a range of equipment including a defibrillator, resuscitation bag and 'nippy junior', which showed evidence of servicing and electronic testing being in date.

Each patient had their own equipment and a spare tracheostomy bag which remained with the patient at all times including if they moved to a different area within the unit which we observed. We checked the contents of a tracheostomy bag which contained a list of equipment in the bag.

Assessing and monitoring risks to people who use services

Staff completed and updated risk assessments for each patient. They kept clear records and asked for support when necessary.

When the service received referrals one nurse and one therapist visited the patient to complete a pre-admission assessment and determined whether the service could safely meet the patient's needs. We saw evidence of the pre-admission assessment which contained all necessary information including need for religious support and specialist equipment.

The service had a policy for undertaking waterlow assessments within six hours of admission and we saw evidence this was completed in the four patient records checked. Staff ensured that patients received pressure relief according to their care plan and patients used airflow mattresses to help manage pressure relief.

The service arranged assessments for individually moulded chairs for children. This allowed further pressure relief and a change in position from the patients' bed and wheelchair.

The service undertook joint medical and nursing assessments for patients on the day of admission and this was clearly recorded in patient records.

Risk assessments were completed on admission and updated at regular intervals including pain, nutrition, tracheostomy care, moving and handling and personal emergency evacuation plans. The multidisciplinary team made decisions about how often patients should be monitored when patients were admitted. Some patients received continuous one to one care with observations recorded every half an hour. Staff monitored respiration, temperature, blood pressure and heart rate.

All patients vital signs were monitored according to the above list and the level of monitoring required was decided on an individual basis. At the time of inspection, the department was undertaking a trial of national early warning scores for three patients. National early warning scores is a method developed to alert staff to a deterioration in a patient's health.

Staff completed health action plans for all patients and we saw these in patient records. Health action plans included feed regime and weight charts, medication, sleep and resting, and family involvement. We saw that where possible patients and their relatives were involved in the completion of health action plans.

We saw evidence of regular medical input where this was required, in one record we checked we found evidence of doctor review every one to two weeks or more during a period of poor health.

Good

Long term conditions

Most patients in the adults' and childrens' unit did not communicate verbally. Staff were required to take account of non-verbal behaviour to monitor pain and discomfort. Staff told us they did so by being aware of patients' baseline levels and knowing the patients well to identify subtle changes. For example, staff told us that for a previous patient, they could recognise when the patient was about to develop a chest infection by noticing increased secretions and other changes. Staff also monitored behaviour such as how relaxed a patient seemed.

Two of the children had direct passports to admit them straight into hospital if required.

The service showed us a copy of their safety bulletin providing information on sepsis awareness and we saw sepsis awareness posters on noticeboards. However, staff told us they were not aware of a sepsis pathway for the service. We did not find that staff were trained in sepsis awareness or pathways.

Staff knew to use 999 in the event of an emergency. Patients were always escorted and all patients had a hospital passport containing details of medical history.

Staffing

The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

Due to the acuity of patients the service ensured that all shifts had staff with the correct level of training to maintain safety of patients. Health care assistants were trained to manage tracheostomies. Three out of five children at Lynne House required continuous one to one care, which was provided by health care assistants who were required to be ventilator trained. All children that attended school were accompanied by staff.

Lynne House ensured that six health care assistants were on duty for every shift and we saw from the rotas that shifts had been covered. Managers completed rotas six weeks in advance according to skill mix. Lynne House had eight health care assistants vacancies. However, six of the vacancies had been filled with staff going through the recruitment process. The service had active recruitment on-going to fill the remaining two.

Managers told us that shifts were always covered by either staff overtime or use of the same agency staff to ensure consistency. Agency staff completed an induction before working at the service.

The health care assistant establishment for Upper Walmersley was 53.8 whole time equivalents with 1.4 vacancies.

Nurse staffing

The service had enough nursing staff, with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.

The service completed work force planning on an annual basis. Staffing requirements were determined using national guidance for example the British Society for Rehabilitation Medicine and Northwick Park Dependency score. The service used the UK specialist rehabilitation outcomes collaborative staffing model to match patients and their clinical need with nursing staff to ensure the provision of safe and effective care. The service used a 'staffing ladder' to determine staffing requirements. The ladder informed the service of the minimum staff level required. The ladder was reviewed daily on each unit to ensure skill mix of staff met the needs of patients. The pre-assessment stage determined whether individual patients required additional staffing for example continuous one to one.

The nursing staffing establishment for Upper Walmersley was 9.7 and there were 2.7 vacancies. The nursing staffing establishment for Lynne House was 4.6 and there were 0.8 vacancies with recruitment in progress. Senior managers told us staff worked extra shifts to cover shifts not filled. Agency staff were not required.

Medical staffing

The service had enough medical staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.

The adult service was covered by a consultant in neuro-rehabilitation; they were on site one day per week and contactable at all times. The children's service was covered by a consultant in long term ventilation who was always available.

The service and the two consultants were supported by a speciality doctor from Monday to Friday 9am to 5pm. The

speciality doctor was being provided by a locum whilst a permanent doctor was currently going through the recruitment process. The service held a contract with a local on call GP service to provide out of hours medical support.

The medical staffing establishment was 1.5 doctors.

There was no formal cover in place for when the neurorehabilitation consultant was on leave. The consultant told us they were happy to be contacted at any time despite being on leave. Staff gave us examples of when this had been done.

The service was currently working with another NHS provider to arrange a formal arrangement for annual leave or sick cover and this was documented on the risk register.

Records

Staff kept detailed records of patients' care and treatment. Records were stored securely and were clear, up-to-date and easily available to all staff proving care. All records were documented on paper although plans were underway to move to electronic recording.

We checked two records at Upper Walmersley and two records at Lynne House. All records reflected clear care plans and risk assessments. The patient records contained an audit at the beginning of the record. The audit checked whether the record contained information such as do not attempt cardiopulmonary resuscitation documentation and personal evacuation plans.

All records checked contained necessary information including:

- patient alert records
- key information sheets
- medical records
- risk assessments
- health actions plan and care plans
- on-going documentation from medical and therapy staff.

Records showed continuity of care with clear information required for transfers of discharges. The patient alert record included information such as allergies, whether patients were nil by mouth, hearing and vision.

Records reflected on-going input of the multidisciplinary team including physiotherapy, occupational therapy and speech and language. We saw evidence of short and long-term SMART (specific, measurable, attainable, relevant and timely) goals, for example exercises set by physiotherapy then working towards making a simple meal in the therapy kitchen.

We saw that staff recorded consideration of consent during caring interventions and that they had ensured privacy and dignity.

In one record checked we found the patient had a period of poor health and could see regular updates provided by the doctor. However, we could not see from the record whether the patient's family had been contacted and informed.

Medicines

The service nearly always followed best practice when prescribing, giving, recording and storing medicines. Patients received the right medication at the right dose at the right time.

The service had a controlled drugs accountable officer and all staff were required to pass an assessment before administering medicines. The provider had a service level agreement with a national pharmacy and the pharmacist visited weekly.

We observed medicines audits for October and November 2018 which looked at a range of questions including whether medicine was locked away, stock within expiry date and kit sealed and labelled correctly. The audits reflected a high level of compliance. One 'no' answer was recorded for whether medication was labelled. We could see this had been noted by the pharmacist and corrected immediately.

We checked four prescription charts; they were all were signed and dated correctly and took account of allergies. Records indicated rationale for any medication missed, for example if a patient had been in hospital. The medication files contained staff signatures, staff competencies and photographs of patients at the front of the prescription chart.

We observed that all medicines including controlled drugs were stored securely. We completed checks on a selection of medicines in the medicines cupboard and controlled drugs in the fridge which were all within date. We checked opened medicines and saw date of opening

and expiry documented. The service maintained a short date stock list to show when medicines were near to expiry. The pharmacist attended weekly and signed with staff to indicate a controlled drug was denatured.

However, we noted on one set of medicines the date of opening and expiry were the same. This was escalated and corrected immediately.

The service monitored medicines that could be misused. We found one set of medicines was not in the designated cupboard. We found that the medicine had been put in the medicines bin ready for destruction. In response the service put measures in place and the pharmacist planned to include this in their weekly audit.

During the inspection we observed that the sharps bin was signed and dated correctly. However, we saw that it had been left open which was escalated and dealt with immediately.

We found that fridge temperature checks were performed and signed daily. We checked the period from September to December 2018 and found two occasions with no signatures. We found in upper Walmersley there were 15 occasions where the fridge temperature had exceeded the ideal range. In Lynne House we found the temperature exceeded the ideal range by one degree on two occasions. Staff signed to say they had re-set the fridge temperature. However, they did not consistently document they had reported to maintenance and we could not see what action had been taken by the maintenance department. We escalated this issue to managers who confirmed action taken was the fridge contents were stored in another area. They were looking at including this on the form which remained on the ward so ward staff were aware action had been taken.

Incidents and safety monitoring

The service managed patient safety incidents well. Staff recognised incidents and knew how to report them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All incidents were monitored using a dashboard and reviewed monthly by the quality, monitoring and learning meeting. Trends were monitored, for example falls, and actions created for improvement. Staff told us they were encouraged to raise concerns and report incidents. We found examples where the service had changed practice following an incident. For example, managers updated checklists and used visual aids to remind staff about the use of oxygen. Incidents were reviewed and investigated by managers.

Changes were also made to the information that was sent out to families when a patient was admitted. Learning from incidents and changes in practice were discussed during daily safety huddles for a designated period. Staff told us the issue could feature in the staff bulletin to further communicate lessons learned. Staff told us they were also informed of learning that occurred within the wider service. Managers told us they monitored changes in practice using walk rounds and discussions with staff.

Staff we spoke to were aware of their responsibilities regarding duty of candour. This is a legal duty on hospitals to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers.

Safety thermometer

The service monitored outcomes including falls and urinary tract infection rates however this was not displayed on noticeboards.

For the period December 2017 to November 2018 the provider recorded four occurrences of urinary tract infections.

There were no deep vein blood clots reported between December 2017 and November 2018.

There were four falls recorded for Upper Walmsley between December 2017 and November 2018 and no falls in Lynne House.

The service completed audits of pressure areas and we found that no patients had developed pressure sores in the period September to December 2018.

Are long term conditions services effective?

(for example, treatment is effective)

Good

Long term conditions

Good

Our rating of effective stayed the same.We rated it as **good.**

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.

The service had developed an integrated care pathway model based on the following national guidelines:

- British Society of Rehabilitation Medicine Standards for Rehabilitation Services mapped on to the National Service Framework for Long-Term Conditions, 2009
- The National Service Framework for Long Term Conditions. (2005)
- Competence Framework for Long Term Conditions – Neurological. Consultation document draft 3.0. "Skills for Health" (2005)
- British Society of Rehabilitation Medicine (2003) Rehabilitation Following Acquired Brain Injury National Clinical Guidelines
- British Society of Rehabilitation Medicine (2015) Specialised Neurorehabilitation Service Standards
- Independent Neurorehabilitation Providers Alliance Objectives and Standards

The model assured a co-ordinated pathway through the service, for example setting out standards for a safe admission, family involvement, health action plans and goal setting.

Staffing levels were established in line with guidance provided by the British Society of Rehabilitation Medicine; care was consultant led, trained and accredited within rehabilitation medicine and or neuropsychiatry.

Nutrition and hydration

We saw evidence of malnutrition universal screening tool in the patient records we checked. A dietician established feed regimes and monitored diet and nutrition of patients.

In response to recent British Medical Association guidance on the withdrawal of clinically -assisted nutrition and hydration, the service had produced draft guidelines which were due to be launched by the end of December 2018.

Pain relief

We saw evidence of pain management plans in patient records. staff gave patients pain relief in a timely manner and this was confirmed by the patients we spoke to. The service did not routinely record pain scores as most patients were nonverbal. Staff monitored the behaviour and wellbeing of patients to determine and monitor pain levels.

Patient outcomes

Managers monitored effectiveness of care and treatment.

In line with national guidance, at weekly team meetings staff discussed whether patient goals and actions had been achieved. Patients were assessed using functional independence measures on admission. This was repeated at different stages to monitor whether goals were achieved. Such goals could include making a drink or simple meal.

The service audited the integrated care pathway against agreed standards. Examples of standards set included 'all patients had a collaborative file for staff to record interventions', and 'all patients had a staff member with them until their required level of observation was determined'. The audit reflected that the service met both these standards in 2017.

For any standards not met the service recorded action points. For example, the service noted they did not record whether families felt informed about the service. The service arranged for the family liaison officer to ask and record this following the first family meeting.

The service assessed patients, using nationally validated outcome measures, on admission and during their time within the service. The service sent the outcome measures to the UK rehabilitation outcomes collaborative monthly. Staff we spoke to told us they did not receive any feedback from this outcome measure.

The service completed several audits including walk rounds. This took account of whether patients felt

welcome, did the ward look clean, and whether there were completed diet and fluid charts. Observations were recorded with a section for actions to be taken to improve.

The service was part of 'the independent neurorehabilitation providers alliance' who met regularly to discuss current issues and to share experiences, knowledge and best practice. In addition to this they would peer review each other every three years. The hospital director told us the Priory Highbank Centre had been reviewed in November 2018. We saw evidence that stated they were compliant with the criteria and the minimum standards set out for neurorehabilitation provided by members.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

The service provided a two-week induction to all staff. Health care assistants had a one-week induction. New staff were supernumerary for the first few weeks of employment. New staff were assigned a mentor. Managers signed off their competencies on an ongoing basis during the first few weeks of employment. The service provided new staff with a review after six months followed by annual appraisals. We saw that all staff had received their annual appraisal.

We saw evidence of competencies completed and signed off by senior staff. The service ensured that clinical staff completed competencies specific to the location during the induction period. These were repeated either annually or every three years. Records were held electronically. The system reminded managers and staff when refresher training was required. Competencies completed included: administering medication management, tracheostomy care and oral suctioning. Compliance was 100% for nurses, healthcare assistants and bank nurses for all competencies apart from deep suctioning (86% of health care assistants), full tracheostomy change (80% of health care assistants) and ventilation training (82% of nurses and 56% of health care assistants).

The service ensured that at every shift there were two members of staff on Lynne House who were trained in tracheostomy and ventilation care. Nursing staff were trained in immediate life support also.

Staff received monthly supervision. Therapy staff received clinical supervision monthly and staff told us they made use of informal peer supervision.

The service held a service level agreement with pathology, pharmacy and diagnostic services to support the medical and nursing staff.

Multidisciplinary working

Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.

The service worked with commissioners from the clinical commissioning groups and representatives from local authorities to plan admissions. Commissioners and social workers were involved in reviews of care and treatment for adults and children.

The service directly employed therapy staff including psychology, physiotherapy, occupational therapy, and speech and language therapy. The dietitian visited regularly, established and monitored feed plans for patients and the continence nurse attended team meetings to ensure joined up care.

The service arranged weekly team meetings which all members of the multidisciplinary team attended to discuss patients' medical status, goals and discharge planning. The service had a good working relationship with the local authority and involved social services for various reasons including discharge planning.

We saw in the records checked that a member of the nursing staff and therapy staff were involved in the pre-admission assessment and that risk assessments were completed on the day of admission, for example moving and handling assessments were completed by physiotherapists.

The service had developed effective links with the local hospitals and some patients had arrangements in place to facilitate direct admission. Two adult patients were insulin dependent diabetics. The service had good links with the diabetic nurse to support patient health and wellbeing.

Good

Long term conditions

Seven day service

Care was provided over seven days a week. However, qualified therapists were not accessible to patients seven days a week. Nursing, care and unqualified therapy staff were aware of patients plans and goals and would assist and prompt with this during the weekend.

Medical staff were available on the ward during the day Monday to Friday 9am – 5pm. Staff had access to the out of hours GP service at other times.

Health promotion

Staff told us that patients had access to podiatry monthly and the dentist visited patients at the unit.

Patients had the opportunity to have the flu vaccine during their stay at the hospital**.**

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the service policy and procedures when a patient could not give consent. Staff knew how to support patients who lacked the capacity to make decisions about their care.

We saw evidence of mental capacity assessments in the four records checked and staff we spoke to were aware of the principles of the Mental Capacity Act, 2005. Staff were aware of the importance of seeking consent for caring and therapy interventions and we saw consideration given to this in the records checked.

We saw that staff worked in line with the Mental Capacity Act code of practice and were aware of concepts such as 'least restrictive' and 'working in best interests'. We saw evidence of best interest assessments and minutes of meetings in patient records. We found that relatives were involved in the best interest decision making process. We found staff were aware of their responsibility to make decisions in a patient's best interest where patients lacked capacity.

Staff we spoke to were aware of the deprivation of liberty safeguards policy and we saw up to date deprivation of liberty safeguards authorisations contained in patient records.

Are long term conditions services caring?

Good

Our rating of caring stayed the same.We rated it as **good.**

Compassionate care

Staff cared for patients with compassion. The patients we spoke to confirmed that staff treated them well and with kindness. Managers told us that staff were caring on a daily basis. Staff visited patients in their own time to take them to social activities such as concerts, pantomime and the zoo. A further example was a member of staff purchasing school uniform for a patient in their own time.

Staff were described by managers as very dedicated and working to minimise the effects of patients' disability as much as possible.

Staff respected patients' privacy and dignity and we saw evidence of consideration of this in the patient records checked. For example, one patient had their physiotherapy delivered in their own room and we observed signs on the bedroom door to indicate therapy was in progress. Staff told us they made sure that patients' dignity was respected during caring interventions. They talked to patients during personal care routines to put them at ease, maintaining eye contact.

We found a range of examples where staff had gone out of their way to make the environment personalised to the child. An example of this was graffiti artwork of the child's name on their wall. We saw that all rooms were individualised and child friendly such as boy's duvet sets and toys. The tracheostomy equipment was stored in bags that were individualised to the child which minimised the clinical look of the equipment.

One patient we spoke told us they were very involved in their own care, staff were responsive and supportive. The patient told us they felt safe and had access to activities such as arts and crafts.

The majority of patients and relatives we talked to spoke highly of their service and told us that staff 'go above and beyond'.

Emotional support

Good

Long term conditions

Staff provided emotional support to patients to minimise their distress.

The family liaison officer was based at the unit Monday to Friday and provided emotional support to families. The service found this enabled relatives to better understand the circumstances of the patient and in turn support them.

Families were welcome to visit and we saw in the records we checked that families did visit patients regularly. Families could eat meals with patients.

The service was supported by psychology and we saw evidence of meeting emotional needs in patient records.

Understanding and involvement of patients and those close to them

Staff involved patients and those close to them in decisions about their care and treatment. The service employed a family liaison officer to help communicate with families and ensure they were fully involved in patient care.

The service arranged case conferences for all patients receiving rehabilitation across the units every two to three months. Families were invited to the meetings and asked to provide feedback about care and treatment, and goals prior to the meeting. The family liaison officer and the patient's key worker, facilitated any pre-meetings required to discuss the content of the case conference report and address their queries and concerns. We saw evidence of minutes of case conferences and case conference reports in the records we checked and found that families were involved in the process.

The family liaison officer worked with Headway (a charitable organisation for people who have experienced brain injury) to develop easy read information sheets for patients and their families. The family liaison service enabled families to understand what is happening to their loved one and a chance to ask questions and have things explained in a calm environment. The family liaison officer could liaise with the multidisciplinary team and arrange meetings between them and the patients and relatives. Staff were happy to make the time available to make this happen.

We saw from the records we checked that families were involved in completing the pre-admission assessment. Families were offered the opportunity to visit the unit and look round.

The service sent out information to families as soon as a decision was made to admit a patient. The service developed a document which showed relatives the pathway the patient would take during their admission and what steps to expect.

We spoke to a family member who told us that staff go out of their way to care for patients, and that staff always introduced themselves. We were told that the family member felt able to raise concerns and that they were always addressed. Families confirmed that they were involved and aware of patient's care plans; they were always kept up to date. We were told that staff were always sensitive to patient needs.

Are long term conditions services responsive to people's needs?

(for example, to feedback?)

Good

Our rating of responsive stayed the same.We rated it as **good.**

Services planned to meet needs of people

The service planned and provided services in a way that met the needs of people.

The paediatric patients had access to a communal lounge area. It was clean and bright with emergency call buttons which would also alarm in Lynne House. We observed that risk assessments had been completed for each patient.

Adult patients and their families had access to communal lounges and outside areas, with a separate children's area.

Families had their own waiting room, with access to hot drinks and biscuits, reading literature and a television. The hospital had an apartment which consisted of a small kitchen area, bedroom, lounge and dining area. Staff told us families who lived far away used the apartment and gave us examples of when patients and

their families had used the apartment for example to celebrate a patients birthday. During our inspection we observed a patient cooking breakfast under supervision for themselves and another patient.

The service had a 'suggestion box' at several places across the site to collect feedback of patients and their relatives. Families were regularly asked to provide feedback about care and treatment which was discussed at case conference meetings on a two to three-month basis. The service told us they organise satisfaction surveys, focus groups and patient involvement in governance meetings. Examples of changes made as a result included an outdoor gazebo and baby changing facilities for visitors.

For patients that became end of life, the service liaised with the palliative care team and arrangements made to transfer the patient to a more suitable environment, for example a hospice.

Meeting needs of different people

The service took account of patients' individual needs. The service considered individual needs at the point of admission. The admission paperwork included alerts about patients which was stored at the front of patient records for staff to be aware and allow them to meet the patient's needs accordingly.

Staff were keen to personalise care for patients including arranging activities according to patient preference. We saw a range of examples of this such as arranging for a band to visit the unit for a patient who liked music and drumming. All bedrooms were personalised according to patients' likes and dislikes; for example, decorated according to football team supported.

The communal dining room gave patients the opportunity for social interaction and stimulation. There was a selection of games and patients could watch television or listen to the radio. The room was clean and spacious and was decorated to feel welcoming, for example staff had put in a Christmas tree for patients.

The provider had established a communal area for the children to use in a separate part of the building (Lower Walmersley) which allowed children to benefit from social interaction and stimulation. There were private bedrooms available for children to use if they required rest or pressure relief. Staff brought all the equipment with the child such as spare tracheostomy each time they visited.

The service took account of cultural and dietary needs. All meals were prepared at the unit, which allowed flexibility in the menu. The chef was aware of patients' individual requirements such as patients who used halal foods and patients with diabetes. Patients could request individualised meals according to their preferences. Patients could use the kitchen in the flat if they enjoyed cooking.

The service had considered ways to communicate with patients who did not communicate verbally. Many adult patients and all the children were not able to communicate verbally due to their level of physical disability and the effects of brain injury. The occupational therapy service used light writers, and an eye gaze tablet. This was an electronic device which recognised where a patient looked and the patient could 'click' on an application using their eyes.

Staff worked with speech and language therapists to establish whether patients could communicate yes or no to enable patients to make choices.

Although staff accompanied children to access social activities, some staff told us that sometimes the children's unit was overlooked when organising formal activities.

The service accessed local translation services to assist patients and families for whom English was not their first language. Staff described the service as accessible, providing a quick response.

The service accepted both male and female patients to Lynne House and Upper Walmersley. We found that patient rooms did not have their own toilet or bathing facilities. The service had put measures in place to protect privacy and dignity of patients. Upper Walmersley was split into three areas with facilities in each area. This meant the distance between bedrooms and bathing facilities was minimised and dignity protected when patients were assisted to transfer. We spoke to one independently mobile patient who had no concerns with the current arrangements and felt their dignity and privacy was always respected.

Good

Long term conditions

The service was planning to set up a tea and chat group for those patients who can take part to find out how they felt about the service and ensure any learning actioned.

During the inspection we observed interaction between staff and a patient during a meal time. We saw that the staff gave sufficient time and space for the patient to make choices and was attentive to their needs.

Access and flow

There were 15 beds in Upper Walmersley which were all occupied during the inspection. The patients were a combination of patients with continuing health care needs and patients for neuro-rehabilitation. Both required a phased admission approach to assess and plan, ensuring the service could meet the needs of patients; the service did not facilitate emergency admissions. At the time of inspection there were two patients awaiting admission to the unit and one patient awaiting discharge.

Admissions were of a long-term nature. The admissions officer maintained contact with the clinical commissioning groups to advise of bed availability.

Lynne House (children's unit) was the children's home and most of the children had lived there for several years.

Lynne House did not maintain a waiting list as the children were long term patients and the unit was described as 'their home'. When children became 18 years old, arrangements were put in place to transfer to an appropriate adult unit.

The service had a patient transitional pathway for staff to follow, which started from the day of referral through to discharge and included pre admission assessment, goal planning, commissioner funding review and discharge planning.

When the service received referrals one nurse and one therapist visited the patient to complete a pre-admission assessment and determined whether the service could safely meet the patient's needs. We saw evidence of the pre-admission assessment which contained all necessary information including need for religious support and specialist equipment.

In the records we checked we saw a clear transfer and discharge checklist which included clinical records, current prescription and medicines supply. The key worker completed a discharge summary report which included the patient's health action plans and was sent to the accepting unit. Consideration of discharge was given as soon as patients were admitted. The pre-admission assessment had a section to record the long-term discharge plan. Staff told us they avoided discharging patients for example Friday afternoon.

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with staff. Representatives from the staff teams attended the monthly clinical governance meetings where complaints were discussed and then shared with staff.

The service had a complaints policy and actively encouraged patients and their relatives to provide feedback.

We reviewed four complaints and found they had been acknowledged and responded to in a timely manner and as per policy. We saw evidence of duty of candour. This is a legal duty on hospital to inform and apologise to patients if there have been mistakes in their care that have led to significant harm. The duty of candour aims to help patients receive accurate truthful information from health providers. We found that all four complaints had been investigated with explanation of actions taken. Responses to complaints contained contact details for patients to use if they were not happy with the outcome.

Families we spoke to told us they were encouraged to raise concerns and these were always addressed.

Are long term conditions services well-led?

Requires improvement

Our rating of well-led went down.We rated it as **requires improvement.**

Leadership

Managers at the hospital had the right skills and abilities to run a service providing high-quality sustainable care.

Good

Long term conditions

The service was led by the hospital director who had recently been appointed the professional lead for brain injury services for the provider. The hospital director was also the registered manager with the Care Quality Commission since 2004.

The management team consisted of a hospital director, medical director, a director of clinical services and a regional support services manager.

The director of clinical services had overall responsibility for qualified therapy, nursing staff qualified and non-qualified. The support services manager was responsible for unqualified therapy, maintenance, catering and housekeeping staff.

The medical director at the hospital also worked as a consultant on Robinson House which was located on the same site. Since concerns raised at our last inspection regarding the medical directors lack of regular oversight at the hospital, the provider had increased the medical director's allocated time on site to two days which allowed for them to now attend senior management meetings and chair the medical advisory committee meetings.

Staff could explain the leadership structure within the service and they told us the management team were both visible and accessible and that they made time for everyone including patients and their families.

During our inspection we observed positive working relationships within all teams.

Vision and strategy

Staff were aware of the corporate and healthcare division values and behaviours, which included putting safety first, putting patients at the centre of everything they do, striving for excellence and take pride in what we do and celebrate success.

We were told these were developed in discussion with staff across the provider and were included as part of staff induction.

The hospital director told us the strategy for the service was reviewed annually and documented within the business plan.

The business plan for 2018 had four key priorities; people, quality and safety, business development and profitability which were discussed at the monthly senior manager meetings. We observed the business plan highlighted strengths, weaknesses, opportunities and threats with documented relevant risks and actions taken.

Culture

Staff described the culture within the service as open and transparent. Staff could raise concerns and felt listened to.

Senior managers and ward managers told us they were proud of the staff and the care they provided to patients and their families. Staff acknowledged that at times the environment was emotionally challenging but they felt they supported each other well.

Staff were proud of the department they worked in, the service they provided patients and it was evident staff were proud of each other.

The service arranged training designed to help staff develop skills needed to manage difficult conversations and concerns of patients and families. Families we spoke to told us that staff were friendly and genuinely cared about their patients.

We observed good working relationships within the teams and it was evident that morale was good and staff felt respected and valued.

Governance

The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.

There was a clear governance reporting structure across the service and staff were aware of their responsibilities.

The senior management meeting and operational and clinical governance meetings were held monthly with each having set agendas. It was clear from the minutes of all meetings we reviewed discussion had taken regarding incidents, complaints, audit, risk and performance with evidence of sharing across other committees.

The roles and responsibilities of the medical advisory committee were documented within the medical advisory committee terms of reference and constitution policy. We observed the committee now met bi-annually with most meetings well attended.

Good

Long term conditions

The provider had policies and procedures for staff to follow. These were available electronically and we observed paper versions on the wards, which meant all staff had access to guidance when required.

We reviewed a selection of policies and procedures and observed these were in date and reflected current guidance.

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Managing risks, issues and performance

Managers monitored performance and used the results to help improve care. All staff identified risks to good care and there was evidence that the service took action to eliminate or minimise risks on the risk register.

Risk, quality, trends and performance was monitored through audit, the quality framework and at key governance meetings including the quality monitoring and learning (QML) meeting.

Information in relation to risk and trends was shared with staff at handover and via the weekly Highbank incident trends (HIT) bulletin.

Staff told us staff meetings on the ward were held but these were not on a regular basis as the teams were small and day-to-day issues and information on complaints, incidents and audit results were shared at handover. We reviewed three team meetings from each ward and observed inconsistencies in the agenda, template and recording of actions with information basic on Lynne House minutes.

The operational and clinical governance meetings were well attended by senior managers, ward managers and medical staff. There was a set agenda for these meetings with standing items, including staffing, incidents, key risks and monitoring of performance and patient experience.

It was clear from the minutes we reviewed discussion had taken place of the risk register, incidents and performance. Actions from the meeting were documented and updated on an action log. Each action had an assigned person, target date and if required documented reason why not achieved.

There was a risk register which highlighted risks across the services and was reviewed monthly.

There were eight risks on the risk register with each risk documented the date the issue was added, the review date, the assigned person to deal with it along with the initial and current rating and actions taken to mitigate against each risk.

We observed one risk: difficulties recruiting trained nurses had been on the risk register since 2013. However, we saw actions had been taken including working with a new recruiter, use of consistent agency staff, changes to the induction process and complete risk assessments and the risk had reduced from 25 to six.

Senior managers and ward managers were able to tell us what the key risks were for their area of responsibility.

Managing information

There were clear service information and performance measures reported and monitored by managers including risk, incidents, deaths and complaints.

Access to information technology on the wards was limited. However, staff had the equipment needed to do their work. The service had plans to standardise and introduce electronic prescriptions and patient records.

Staff on the children's unit had access to a mobile phone, to take with them when escorting a patient to hospital.

In most instances, staff made notifications to external organisations as needed. However, we observed one serious incident, managed and actioned appropriately, had not been shared with Care Quality Commission in line with their regulatory requirements. We raised this at the time of inspection and the organisation took steps to prevent a recurrence of this situation.

Engagement and Involvement

The service engaged with local organisations to plan and manage appropriate services. It collaborated with partner organisations effectively.

Prior to our inspection, we contacted commissioners and received mostly positive feedback about the service provided.

Patients were not always able to participate in engagement processes due to their health condition. However, the service continued to engage with and seek

feedback through the six-monthly patient and relative focus groups, written feedback via 'suggestion boxes' and a recently introduced meeting 'voices for choices' specifically for patients.

We reviewed minutes from meetings and observed discussions were open with opportunities for everyone to provide both positive and negative feedback, with actions taken to address issues raised. We saw evidence of changes as a result of the service responding to patient and families feedback including a jigsaw table in the dining room, baking group and baby changing facilities.

The majority of patients and their families we spoke to felt the service had engaged with and involved them in decisions or changes that could affect them. A patient gave us an example of changes the service was making to assist them in achieving their recreational activities.

The senior management team completed quality walk rounds on the wards throughout the day and night and routinely sought feedback from staff, patients and their relatives or carers. During our inspection it was evident that senior managers were knowledgeable about the staff, the patients and their families on the wards.

A weekly bulletin with key messages from governance and operational meetings was emailed out to all staff at site. In addition, staff also had access to a company-wide newsletter that was issued weekly in a web based format. Staff had an opportunity to raise any issues or ideas at the 'your say forum' via elected representatives from each area.

The annual staff engagement survey from January 2018 showed an increase in the overall engagement score from 66% (February 2016) to 81%. We saw evidence that the service had responded to and taken action to improve some areas requiring improvement for example the thank you and suggestion board was moved to a visible place.

The service engaged with staff to improve their knowledge and understanding of what the key lines of enquiry (safe, effective, caring, responsive and well led) meant to them. Staff were invited to create posters and we observed these on display around the hospital. This process is now being rolled out across other sites.

Learning, continuous improvement and innovation

The service had responded to a fall in the retention of healthcare assistants over a six-month period and developed a recruitment assessment day. The assessment day included face to face interviews, group activity, literacy test and a discussion with a current health care assistant describing their role. Assessors throughout the process were clinical and non-clinical managers who then met and agreed suitable candidates to move forward through the safer recruitment process. Data provided showed from February 2018 to October 2018 a total of 37 healthcare assistants had been successfully recruited via this process. During our inspection we spoke with one member of staff who had been recruited. They felt the assessment day was informative about the role and what was expected of them.

The hospital director told us they had received accreditation for student nurses from a local university to work within the service. Senior managers told us this was the only neurorehabilitation site across the provider for this to happen.

The service had recently hosted a training day on the 'dilemmas in the management of complex brain injury' focusing on clinically-assisted nutrition and hydration (CAHN). The guidance covers decisions to start, re-start, continue or stop clinically assisted nutrition and hydration for adults in England and Wales who lack the capacity to make the decisions for themselves. The event included presentations from guest speakers from external organisations in addition to the consultant from the centre.

Following the launch of international dysphagia diet standardisation initiative, the service had created a training package which was to be rolled out across the provider from January 2019. In addition, a questionnaire had also been created to establish practice and monitor impact before and after training.

Staff across the hospital had the opportunity to vote for and recognise their colleagues who go above and beyond their role. Each month the votes were reviewed by the senior management team (who don't vote) to identify a winner, who received a voucher. At the end of the year there was another vote of all 12 previous winners to determine 'employee of the year' who received additional vouchers.

All members of staff who had been nominated, received the comments made about them by their colleagues.

Good

Long term conditions

Staff we spoke to felt this had a positive impact on staff morale. In addition, staff across the organisation had the opportunity to nominate a colleague for a 'star award'. The awards were each based on the five values, with two winners selected from each region. At the end of the year all regional winners were entered the division star awards.

The hospital director told us that the director of clinical services and the support services manager had been nominated by the operations director for a star award.

The hospital director told us there was a focus on 'staff health and well-being' and a budget had been allocated towards a staff wellbeing group. Staff had been invited to breakfast clubs and afternoon teas. We were told of plans for the '12 days of Christmas', where a payroll number would randomly be selected each day and the member of staff would win a prize.

Long stay or rehabilitation mental health wards for working age adults

Good

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

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

Good

Safe and clean environment

All ward areas were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Cleaning records were up to date and demonstrated that the ward areas were cleaned regularly. The ward had access to a cleaner seven days a week.

There was a clinic room and access to emergency equipment was available including ligature cutters. The emergency equipment was checked daily.

Staff adhered to infection control principles, including handwashing. There was an infection control lead within the hospital and an infection control champion on the unit. Hygienic hand gels were available on entry to the unit.

Staff did regular risk assessments of the care environment and patients were assessed against their environment with care plans in place where needed.

Staff knew about any ligature anchor points and actions to mitigate risks to patients who might try to harm themselves. A ligature point is anything which could be used to attach a cord, rope or material for the purpose of hanging or strangulation. The ward layout did not fully allow staff to observe all parts of ward and staff mitigated this risks by increasing the levels of observations throughout the day when required and removing the risks where possible. They completed a ligature audit twice a year on all areas inside and outside the unit along with a specific blind spot audit. Following each audit an action plan was completed where required and actions were addressed and monitored for completion through the operational governance meetings.

Staff and patients had easy access to a nurse call system throughout the unit.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and they received training to keep people safe from avoidable harm. They had eight whole time equivalent nurses and eight nursing assistants. Two wholetime equivalent nurses worked per day shift and one per night shift. They also had one health care assistant on duty during the day and two at night. Additional to this during the day they had an activity coordinator, an occupational therapist, a Mental Health Act administrator and a manager on the unit.

There was always a permanent member of staff on duty and when agency and bank nursing staff were used, those staff received an induction and were familiar with the ward. They were also provided with a local induction pack and orientated to the unit. They could bring in additional staff if they needed to increase the observation levels of patients. The ward manager was able to adjust the staffing levels when planned activities outside the unit required additional staff.

There was a locum doctor available Monday to Friday 9am -5pm. Staff had 24/7 access to an on-call psychiatrist and the responsible clinician attended the unit twice weekly. The hospital had a contracted agreement with an out of hours service that provided out of hours medical and dental care to the local communities within the area.

Long stay or rehabilitation mental health wards for working age adults

Good

Mandatory and statutory training

The service provided mandatory training in key skills to all staff. The training summaries confirmed that for nurses having completed their mandatory training this was 89% compliance and 94% compliance for nursing assistants. This was monitored on the ward by the manager and overseen by the Priory training department.

All qualified nurses had received immediate life support and all nursing assistants were up to date with their basic life support training.

Assessing and managing risk to patients and staff

Staff completed and updated risk assessments for each patient and used these to understand and manage risks individually. We reviewed three risk assessments and these were reviewed and updated following incidents as well as being reviewed at a multidisciplinary team meeting and at care programme approach meetings. They were updated weekly and fully reviewed monthly and more often if required. There was on-going risk assessment that involved the individual patients where appropriate.

They minimised their use of restrictive interventions and followed best practice guidance when considering or imposing any restrictions on a patient. There was no restraint or rapid tranquilisation used in the last 12 months.

Safeguarding

Staff knew how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it. There were designated safeguarding leads for adults and children.

Staff access to essential information

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Patients records were stored electronically and staff could access these when needed. Mental Health Act documentation was paper based with original documentation being maintained.

Medicines management

Staff followed best practice when storing, administering and recording medication. Staff regularly reviewed the effects of medications on each patient's physical health.

A medicines management audit was completed monthly by the external pharmacist and reported to the unit. All patients were registered with a GP and they had access to physical health monitoring for example bowel screening, diabetes and access to the well man clinic at their GP surgery. A schizophrenia audit had been completed and comprehensive physical health checks were in place to ensure these patients received additional health checks. However, all patients received comprehensive physical health checks and this included patients that were in receipt of any high dose antipsychotic medication.

Track record on safety

The hospital reported one serious incident at the hospital in June 2018 where a patient did not return from authorised unescorted leave. The patient subsequently returned safely to the unit.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. Changes had been made following a patient not returning from leave. The hospital reviewed the incident and discussed this as a team. They implemented changes and provided the patient with a mobile phone when they went on leave. When things went wrong, staff apologised and gave patients honest information and appropriate support.

Staff understood the duty of candour. There were policies and procedures available to staff should they need to access as well as flash cards to remind staff.

Are long stay or rehabilitation mental health wards for working-age adults effective?

(for example, treatment is effective)

Good

Assessment of needs and planning of care

All admissions were arranged in advance and staff visited each patient following referral to carry out pre-admission assessments. Staff completed a comprehensive physical

and mental health assessment of all patients on admission in addition to a risk assessment. Staff used nationally recognised assessment tools to assess patient needs. No patients had been recently admitted to the unit.

Staff developed care plans that met the needs identified during assessment and they up-dated them when needed. Staff reviewed them routinely every three weeks during ward rounds, and at other times according to need.

We reviewed three care records. Care plans were personalised but were not fully recovery-oriented. They contained details of needs identified during assessment, patients' goals and the therapeutic interventions needed to reach those goals. The care plans focused on individual goals made in collaboration with patients around their strengths likes and dislikes to improve social and interpersonal functioning. Staff used the information from the recovery star clinical assessments with to develop care plans with patients. There was access to psychology and care plans reflected this if this was assessed as a need for the patients on the unit.

Best practice in treatment and care

Staff provided treatments and care for patients based on national guidance and best practice. Staff supported patients with their physical health and encouraged them to live healthier lives, for example, through participation in smoking cessation schemes and healthy eating advice. Physical health care included an annual health check, flu vaccination and managing cardiovascular risks.

Staff ensured that patients had good access to specialists when needed, such as a dietitian, speech and language therapist, dentist and optician. All patients were registered with a local GP and had access to bowel screening, a diabetes nurse and a 'well man' clinic.

Staff assessed and met patients' needs for food and drink as well as for specialist nutrition and hydration.

The care and treatment interventions staff provided included administering medication, psychological therapies and activities intended to help patients acquire and maintain living skills, such as shopping, cooking, and doing their own laundry. Other activities included gardening, cooking and woodwork. There was a weekly group that explored the values and qualities needed in daily life which provided a safe environment for self-expression. There was an occupational therapist and assistant occupational therapist who coordinated all of the weekly activities. Activities were planned for during the weekend as well. The occupational therapist confirmed they had not completed any occupational therapy care plans however, plans were in place to review the patient's meaningful activity goals. An example of this was where a patient stated they would like to go to a pub. Goal were set with this patient to plan and facilitate the patients goal. The occupational therapist has worked with patients to develop occupational therapy care pathways. They also support patients when planning for social and leisure events for example purchasing their own tickets for a cinema trip and assisting them in planning their week ahead.

Staff used recognised rating scales to assess and record severity and outcomes, for example, Health of the Nation Outcome Scales. They also used a recognised assessment tool such as the recovery star clinical assessment.

Staff participated in clinical audit, benchmarking and quality improvement initiatives. The care records contained an audit section. Staff carried out an audit for schizophrenia based on the national audit tool, but did not participate in the national audit as the service did not provide the whole pathway. The external pharmacist carried out weekly medications audits.

The service was taking part in the Royal College of Psychiatrists' Accreditation for Inpatient Mental Health Service Scheme.

Skilled staff to deliver care

Managers made sure staff had the skills needed to provide high-quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills.

The team included or had access to the full range of specialists required to meet the needs of patients on the ward, including doctors, registered nurses, healthcare assistants, occupational therapists, activities staff, psychologists, physiotherapists, social workers, pharmacists, speech and language therapists, dietitians, dentists and opticians. There was support from domestic staff and the Mental Health Act administrator. A pet therapy service visited every month.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff were experienced and qualified, and they had the right skills and knowledge to meet the needs of the patient group. They had access to specialist training, such as dysphagia and challenging behaviours, and could request training additional to that provided internally.

Managers provided new staff with appropriate induction using the care certificate standards as the benchmark for healthcare assistants.

Managers provided staff with supervision meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development and appraisal of their work performance. Managers ensured that staff had access to regular team meetings.

The percentage of staff that had had an appraisal in the last 12 months was 100%.

The percentage of staff that received regular supervision was 83%.

Managers identified the learning needs of staff and provided them with opportunities to develop their skills and knowledge. They ensured that staff received the necessary specialist training for their roles.

Managers dealt with poor staff performance promptly and effectively. There were no staff subject to suspension or supervised practice.

Multi-disciplinary and inter-agency team work

The multi-disciplinary team included the full range disciplines including a psychiatrist, mental health nurses, support workers occupational therapy, psychology, access to a speech and language therapist.

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The manager told us they had regular contact with commissioners and clinical teams. All disciplines involved in the patients' care were invited to their regular care review meetings.

They held regular and effective multidisciplinary meetings and reviewed every patient at least every three weeks.

Staff shared information about patients effectively at handover meetings at each shift change.

The ward team had effective working relationships, including good handovers, with other relevant teams, such as physiotherapists, psychologists, dietitian and speech and language therapists.

The ward team had effective working relationships with teams outside the organisation, such as care co-ordinators, commissioners, local authority social services and GPs.

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

A CQC Mental Health Act monitoring visit took place on 23 July 2018. This identified that patients still did not have access to the intranet, patients had not been consulted about advance statements and a bathroom door was kept locked. During this visit we saw that these issues had been rectified.

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice. Managers made sure that staff explained patients' rights to them in a way that they could understand, repeated these as required and recorded that they had done it.

The Mental Health Act administrator provided training and there was additional ward based training that staff had developed themselves. Staff had a good understanding of the Mental Health Act, the Code of Practice and the guiding principles.

Staff had access to administrative support and legal advice on implementation of the Mental Health Act and its Code of Practice. They knew who their Mental Health Act administrators were.

The provider had relevant policies and procedures that reflected the most recent guidance.

Staff had access to local Mental Health Act policies and procedures and to the Code of Practice.

Patients had access to information about independent mental health advocacy. They understood the role of the advocacy service. Contact details were displayed clearly. An advocate attended the ward every week and supported patients in their ward round if they wished. The advocates provided training for the staff so that they understood the role and its responsibilities.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff ensured that patients were able to take section 17 leave (permission for patients to leave hospital) when this has been granted.

Staff requested an opinion from a second opinion appointed doctor when necessary.

Staff stored copies of patients' detention papers and associated records (for example, section 17 leave forms) correctly and so that they were available to all staff that needed access to them.

Staff did regular audits to ensure that the Mental Health Act was being applied correctly and there was evidence of learning from those audits. The Mental Health Act administrator carried out monthly audits to monitor adherence to the Act, such as ensuring consent forms were renewed, patients received information about their rights and the time limits were met for renewing sections and section 17 leave or making referrals to tribunals.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the providers policy on the Mental Capacity Act 2005 which included deprivation of liberty safeguards and they assessed and recorded capacity clearly.

Ninety percent of staff had had training in the Mental Capacity Act. The Mental Health Act administrator provided training and there was additional ward based training that staff had developed themselves.

Staff had a good understanding of the Mental Capacity Act, in particular the five statutory principles.

There was no deprivation of liberty safeguards applications made in the last 12 months which protect people without capacity to make decisions about their own care.

Staff knew where to get advice within the service regarding the Mental Capacity Act, including deprivation of liberty safeguards.

Staff gave patients every possible assistance to make a specific decision for themselves before they assumed that the patient lacked the mental capacity to make it.

For patients who might have impaired mental capacity, staff assessed and recorded capacity to consent appropriately. They did this on a decision-specific basis regarding significant decisions. Care records contained mental capacity assessments for decisions such as flu vaccinations and financial decisions.

When patients lacked capacity, staff made decisions in their best interests, recognising the importance of the person's wishes, feelings, culture and history.

The service had arrangements to monitor adherence to the Mental Capacity Act. Staff audited the application of the Mental Capacity Act and acted on any learning that resulted from it.

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

Good

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity, and supported their individual needs.

Staff attitudes and behaviours when interacting with patients showed that they were discreet, respectful and responsive, providing patients with help, emotional support and advice at the time they needed it.

Staff supported patients to express their views and be actively involved in making decisions about their care, treatment and support as far as possible.

Staff supported patients to understand and manage their care, treatment or condition.

Staff directed patients to other services when appropriate and, if required, supported them to access those services.

The patients said staff treated them well and behaved appropriately towards them.

Staff understood the individual needs of patients, including their personal, cultural, social and religious needs.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff said they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients without fear of the consequences. Anonymous phone lines were available to staff to report any concerns.

Involvement in care

Staff involved patients and those close to them in decisions about their care, treatment and changes to the service. An example of this was where a decision had been made for the hospital to go no smoking in July 2019. This had been communicated to patients and smoking cessation was being encouraged with available support and access to nicotine patches.

Staff involved patients in care planning and risk assessments which was evidenced in care plans and participation in multidisciplinary team reviews. Patients could access a copy of their care plans if they needed.

Staff communicated with patients so that they understood their care and treatment. Staff enabled patients to give feedback on the service they received and fully involved patients. Carers were provided with an information sheet about Robinson house and were encouraged to use the suggestion boxes throughout the hospital to provide any feedback. They provided various meetings including monthly 'Your Voice' meetings where patients put forward suggestions of forthcoming activities and events they wanted to attend. Patients were active partners in their care and we saw that staff were fully committed to working in partnership with patients and empowering patients to have a voice.

Staff involved patients in occupational therapy groups, psychology groups, your space groups, a shop to cook group as well as gardening and woodwork groups. These were only some of the activities available on and off the unit and within the community.

Staff enabled and supported patients to make advance decisions (to refuse treatment, sometimes called a living will) when appropriate.

Staff ensured that patients could access advocacy.

Are long stay or rehabilitation mental health wards for working-age adults responsive to people's needs?

(for example, to feedback?)

Good

Access and discharge

The average bed occupancy over the past 12 months was 55% with an average length of stay being 1508 days.

Staff supported patients during referral, discharge and transfers between services – for example, if they required treatment into an acute hospital or temporary transfer to a psychiatric intensive care unit. An example of this was where a patient became acutely unwell whilst on the unit and required a transfer to a psychiatric intensive care bed.

The unit had discharged one patient to a specialist unit in the last 12 months. There were discharge plans and dates in place for all patients however; the dates in three records we looked in were the same. Staff told us that they were required to put a discharge date in each patients' record but that these dates were unrealistic and achieving the interventions within the plans did not result in the patients being discharged. Staff told us that for many of the patients there were barriers to discharging them as there were unsuitable placements and or homes to move these patients into to meet their long term chronic and co morbid health needs. The barriers to discharge were regularly discussed at multi disciplinary team meetings and Care Programme Approach meetings and were further challenged in managers hearings and at Mental Health Act tribunal's. Records we reviewed provided evidence that discharge plans were being reviewed on a regular basis with the multi disciplinary team, commissioners and family members.

The ethos of the unit for these patients was focussed on maintaining their current functioning and social skills rather than proactively providing rehabilitation to reintegrate them back into a less restrictive placement within the community. This was not in line with the ethos of the unit.

Facilities that promote comfort, dignity and privacy

Long stay or rehabilitation mental health wards for working age adults

Good

Patients had their own bedrooms where they could keep personal belongings safely. There were quiet areas for privacy and where patients could be independent of staff. Patients could personalise bedrooms, they had a safe in their rooms and were offered a key to lock their bedroom.

Patients were involved and encouraged to participate in activities of daily living for example preparing snacks with support and encouragement. Patients could make their own drinks throughout the day and night. Patients had access to occupational therapy with a therapy timetable in place to optimise therapeutic and meaningful activities.

Staff and patients had access to the full range of rooms and equipment to support treatment and care (clinic room to examine patients, activity and therapy rooms as well as a snug and kitchen and games area). There were a wide range of activities provided during the day, evenings and weekends. Activities were planned for in the community meetings and included visits to theatres, cinemas and concerts, fishing trips, canal boat rides and meals out as well as many other activities that were provided.

Patients attended group activities on the unit and planned themed nights and had access to a gym on site. Patients participated in 'working parties' on the unit where staff and maintenance worked together to make improvements to the environment. Patients had made an outside bench, helped to decorate the 'snug' and had also made the bar area. During our visit we saw patients going off the unit to attend a concert on one of the other units at the hospital.

However, we found there was minimal community preparation to enable patients to transition back into their local community within a rehabilitation pathway.

There were quiet areas on the ward and a room where patients could meet visitors.

Patients could make a phone call in private and some patients had their own mobile phones. Patients now had access to the internet and a computer.

Patients had access to outside space with a large garden area.

Patients could make hot drinks and snacks 24/7.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as leisure activities, holidays and educational visits. They also supported patients to maintain family relationships and assisted in the arrangements to facilitate a patient returning to his family home overnight. They also assisted patients to use skype to remain in contact with family members. Some patients also had access to their own mobile phones.

Meeting the needs of all people who use the service

The service was accessible to all who needed it and took account of patients' individual needs. Staff helped patients with communication, advocacy and cultural support when needed. Information was provided in easy read formats and this also included easy read leaflets in relation to their rights under the Mental Health Act.

Listening to and learning from concerns and complaints

The service provided opportunities for patients to make complaints through the use of comment boxes and access to the manager and or staff where complaints could be raised. There had been no complaints raised within the last 12 months and where complaints had previously been raised then these were treated seriously and they had investigated them and learned lessons from the results and shared these with all staff. Patients did get feedback from complaints they made. Complements were also logged and these included positive comments from a relative and a commissioner about the care, kindness and support staff gave toward a patient who was nursed at the end of their life.

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

Good

Leadership

The unit manager had a good understanding of the services they managed. They could explain clearly how the team were working to provide high quality care. The manager was visible in the service and approachable for patients and staff. Leadership development opportunities were available, including opportunities for staff below team manager level.

Vision and strategy

Long stay or rehabilitation mental health wards for working age adults

Good

The service had a vision for what it wanted to achieve and workable plans to turn it into action which had been developed with involvement from staff, patients, and key groups representing the local community.

Staff knew and understood the provider's vision and values and how they were applied in the work of their team. Their purpose was to make a real and lasting difference to everyone they support by putting people first, being a family, acting with integrity, being positive and striving for excellence.

Staff had the opportunity to contribute to discussions about their service and staff could explain how they were working to deliver high quality care.

The unit was meeting patient's individual needs however, they were not fully focussed on recovery and discharge to enable patients to transition on into community placements. They had not admitted any more patients to the unit as was not conducive to the patients on the unit at the time of the inspection.

Culture

Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff felt respected, supported and valued and they were positive about working for their team.

Staff felt able to raise concerns without fear of retribution.

Staff knew how to use the whistle-blowing process and managers dealt with poor staff performance when needed. Managers held a monthly 'Your say' forum for staff to attend and provided an opportunity for new staff to meet with managers.

Teams worked well together throughout the hospital and managers of the other wards met regularly.

Staff had access to a weekly staff development group. This was a solution focused group accessible to all staff on the unit. They looked at any development needs required and it was chaired by someone different each week.

Staff appraisals included conversations about career development and how it could be supported. The hospital had provided opportunities on the unit for students studying to become mental health nurses.

Staff reported that the provider promoted equality and diversity in its day to day work and in providing opportunities for career progression. One example of this was where a health care support worker had gone on to study for a mental health nursing qualification.

Staff had access to support for their own physical and emotional health needs through an occupational health service.

The provider recognised staff success within the service – for example, through staff awards.

Governance

The service used a systematic approach to continually improve the quality of its services and promote high standards of care. There were governance systems within the unit to ensure that the unit was safe and clean, there were enough staff, staff were trained and supervised, patients were assessed and treated well, and that the ward adhered to the Mental Health Act and Mental Capacity Act. Incidents were reported, investigated and learnt from on this unit.

There was a clear framework of what should be discussed at a ward and team level in team meetings to ensure that essential information, such as learning from incidents and complaints was shared and discussed. Staff had implemented recommendations from reviews of deaths, incidents, complaints and safeguarding alerts within the service.

Staff undertook or participated in local clinical audits. The audits were sufficient to provide assurance and staff acted on the results when needed.

Staff understood the arrangements for working with other teams, both within the provider and externally to meet the needs of the patients.

The unit manager had completed a self-review for the accreditation for inpatient mental health services in rehabilitation as an associate member and was working towards improvements against the self-review.

Management of risk, issues and performance

The service had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Staff maintained and had access to the risk register at ward and location level.

Long stay or rehabilitation mental health wards for working age adults

Good

Staff at ward level could escalate concerns when required. Staff concerns matched those on the risk register. The service had plans for emergencies – for example, adverse weather conditions or a flu outbreak.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems. The service used systems to collect data from wards and directorates that were not over-burdensome for frontline staff.

Staff had access to the equipment and information technology needed to do their work. The information technology infrastructure, including the telephone system, worked well and helped to improve the quality of care. Information governance systems included confidentiality of patient records. Team managers had access to information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Information was in an accessible format, and was timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed within this unit.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure notifiable incidents are reported to the Care Quality Commission (Regulation 18).

Action the provider SHOULD take to improve

- The provider should improve compliance rates for mandatory training.
- The provider should consider updating the medicines policy regarding actions taken when fridge temperatures go out of range.
- The provider should ensure that staff consistently record communication with patients' next of kin.
- The provider should consider including sepsis awareness training for staff.
- The provider should continue to mitigate the risks regarding mixed sex accommodation.
- The provider should make sure systems and processes in place for the dispensing of medicines are followed and audited for compliance.
- The provider should have cover arrangements in place for all medical staff.
- The provider should consider introducing a standardised template for minutes of all staff meetings.
- The provider should ensure the care plans on Robinson house are fully holistic and recovery orientated in relation to discharge planning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The registered person must notify the Commission without delay of incidents which occur whilst services are being provided in the carrying on of a regulated activity, or as a consequence of the carrying on of a regulated activity.** Regulation 18 (1) (2)(a) (b)