

The Priory Highbank Centre







Quality Report

Robinson House
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BL95LX
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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

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

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

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

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

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

Summary of findings

Overall summary

We rated long stay/rehabilitation mental health wards for working age adults at the Priory Highbank Centre as good because:


- The building was clean, and safely maintained. Building and safety assessments including ligature risk assessments were regularly assessed.
- Compliance with mandatory training was high. Staff received regular clinical and managerial supervision and an annual appraisal.
- Patients were involved in decisions about their treatment and care and were regularly consulted with.
- Rehabilitation was embedded in the delivery and culture of the service. Patients played an active role in their care.
- Care and treatment was underpinned by best practice and national guidance.
- A spiritual, personal and cultural education group provided patients with opportunities to explore and discuss qualities, virtues and values needed in daily living.
- Patients had access to advocacy services.
- Patients we spoke to were positive about the service they received.
- There were clear processes for access and discharge from the service. The service worked with referral and partner agencies to ensure appropriate assessments and treatments were delivered.
- The service had a clear set of vision and values. Staff were aware of these and reflected them in their daily practice.
- Staff morale was very positive. Staff felt supported by senior managers within the service and the provider organisation. Senior managers were visible to staff and were considered approachable and available.
- There was a governance structure to support the delivery of care. The service monitored performance. Senior managers carried out regular quality checks at the service.
- The service had trialled the multiple errands test to evaluate whether it was a valid tool for the mental health population.

However;

- The hospital should ensure that all staff understand the principles of the Duty of candour.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults	Good 	Please see main body of the report

Summary of findings

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Good 

The Priory Highbank Centre

Services we looked at

Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to The Priory Highbank Centre

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 centre includes Robinson House, which provides a service for 10 male patients aged 18 and over who had a diagnosis of mental disorder. Robinson House provides a slow stream rehabilitation service using a recovery based model. They provide this service for individuals who suffer from chronic enduring complex mental illness. The unit is part of the Priory group and is located within the main building of Priory Highbank Centre in Bury. Robinson House 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 could be entered from the lounge or conservatory. There is a sensory room and an activities room. The first floor provided bedrooms for patients.

The Priory Highbank Centre was last inspected by CQC on 17 February 2014 where they met the essential standards they were inspected against.

A CQC Mental Health Act monitoring visit took place on 28 September 2016.

At this review, we found that consideration was being given to installing SKYPE in order for families who did not find it easy to visit in person to keep in touch.

Patients had internet access via the corporate service user network located on the computer within the activities room on Robinson House. The provider told us they would continue to work with the corporate information technology department about SKYPE being installed.

In the notes, which we examined at this review, we found that capacity assessments were completed regularly for specific situations; however, we could not find evidence that the responsible clinician had assessed patient's capacity to consent to treatment at the most recent authorisation.

We asked what measures would be put in place to show that the responsible clinician had assessed patients capacity to consent to treatment at the most recent authorisation.

The provider told us the responsible clinician had provided guidance to the speciality doctor, who would discuss any medication changes with the responsible clinician to ensure all relevant paperwork was completed. They also told us that the Mental Health Act administrator would complete a spot check audit. We checked the above at this inspection and the unit had implemented the actions above.

There is a registered manager at Robinson House.

Our inspection team

The team that inspected the service comprised two CQC inspectors and a pharmacist specialist.

Why we carried out this inspection

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

Summary of this inspection

How we carried out this inspection

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

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

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

During the inspection visit, the inspection team:

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

- spoke with six other staff members; including doctors, a nurse, an occupational therapist, a support worker and a Mental Health Act administrator
- attended and observed two hand-over meetings and two multidisciplinary meetings
- observed two group work sessions
- collected feedback from three patients and one staff member using comment cards
- looked at two care and treatment records of patients
- carried out a specific check of the medication management arrangements
- looked at a range of policies, procedures and other documents relating to the running of the service.

On the same day as we inspected Robinson House, a team of CQC inspectors inspected the Priory Highbank Centre's specialist services for patients of all ages with brain injuries or a neuro-disability. The hospital provides two distinct services for patients with long-term neuro-disability conditions. A separate report has been produced.

What people who use the service say

We spoke with two patients who were using the service and collected feedback from three patients and one staff member using comment cards.

Patients we spoke to were positive about the care and treatment they received. They stated that staff were interested in their wellbeing and confident their needs would be addressed.

Patients told us that they were involved in decisions about their care and were encouraged in their rehabilitation.

The three comment cards completed by patients were all positive with comments made stating staff that were caring and treated patients well.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We rated long stay/rehabilitation mental health wards for working age adults for safe as good because:

- The ward was clean and well maintained and had environmental risk assessments and ligature audits in place.
- The service was proactive in managing staff resources to provide care. Staffing levels were reviewed daily and adjusted in line with acuity, observations, and daily activities on the wards. The service was actively recruiting to vacancies at the hospital.
- The service had experienced and appropriately qualified staff.
- There was safe medication management on the ward. Pharmacists attended the ward weekly and reviewed prescribing. Medication stock levels were monitored and medication was stored appropriately.
- Assessments and management of risks had been completed for all patients. The hospital had implemented the 'safe wards' initiative at Robinson House. This was to keep staff and patients as safe as possible.
- Incidents were reported and investigated. There was a process to report and learn from adverse incidents. Incidents and lessons learnt were discussed with staff at team meetings and disseminated to staff by news bulletins.
- The staff had received mandatory training to support them in their role. Staff received an induction when employed by the organisation.
- Staff had received training in safeguarding children and adults. All staff had a good understanding of the local alert process.

However;

- Not all staff had an understanding the principles of the Duty of candour.

Good



Are services effective?

We rated long stay/rehabilitation mental health wards for working age adults for effective as good because:

- Staff had received an annual appraisal of their work performance and received regular managerial supervision.
- Patient records were complete and accurate.
- There were care plans in place to support staff to care for patients and a full timetable of recovery-based therapies was in place.

Good



Summary of this inspection

- There was a strong recovery focused ethos and holistic assessments took place.
- A spiritual, personal and cultural education group provided patients with opportunities to explore and discuss qualities, virtues and values needed in daily living.
- Staff were skilled to deliver care to patients.
- There was good evidence of ongoing physical health monitoring for patients and implementation of best practice in the treatment and care of patients.
- Staff proactively provided flu vaccinations to patients.
- There were good links with other organisations. These included commissioners, health care providers such as GPs, pharmacists and safeguarding authorities.
- Staff were trained in the Mental Capacity Act and staff had working knowledge of the Mental Health Act.
- There was a spiritual, personal and cultural education group, called Your SPACE, that provided patients with opportunities to explore and discuss qualities, virtues and values needed in daily living.

Are services caring?

We rated long stay/rehabilitation mental health wards for working age adults for caring as outstanding because:

- Staff interacted with patients in a relaxed, kind and respectful way. Staff showed positive engagement and willingness to support patients. Staff actively listened to patients.
- The service encouraged patient feedback and patients were actively involved in the care and treatment they received.
- Access to advocates was available on the ward weekly.
- Staff showed an understanding of patients' needs.
- We saw patients were actively involved in their care. We saw evidence of patient involvement in the care records that we reviewed.
- Patients we spoke with, and comment cards we received, were positive about the staff.
- The service had trialled the multiple errands test for use with the patient group. multiple errands test multiple errands test.

Good



Are services responsive?

We rated long stay/rehabilitation mental health wards for working age adults for responsive as good because:

- There was an admissions process to inform patients of ward routines and orientate patients onto the ward.
- Staff worked to ensure they planned for patients discharge. The service was responsive to patients' needs

Good



Summary of this inspection

- The facilities promoted recovery, comfort and dignity. Access to spiritual support was available to patients.
- The service met the needs of patients and there was access to disabled facilities on the ward area.
- The hospital staff actively listened to and learnt from complaints.

Are services well-led?

We rated long stay/rehabilitation mental health wards for working age adults for well led as good because:

- The service was very well led at ward level and by the hospital manager.
- The service was very responsive to feedback from patients, staff and external agencies.
- There was clear learning from incidents.
- Staff were aware of the vision and values and reflected them in the delivery of care.
- There were a range of policies and procedures to support the delivery of safe care and good governance arrangements in place.
- Managers monitored performance and this was supported by a series of internal audits and quality monitoring tools.
- Staff morale was very positive. Staff told us that that they enjoyed working at Robinson House.
- Staff told us they could raise concerns without fear of victimisation and that senior managers were supportive, open and approachable.
- There was an open and honest culture with staff and managers seeking to improve the service provided to their patients.
- There was a commitment towards continual improvement and innovation.
- The service had trialled the multiple errands test to evaluate whether it was a valid tool for the mental health population.

Good



Detailed findings from this inspection

Mental Health Act responsibilities

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

All staff had received Mental Health Act training. Staff demonstrated a good knowledge of the Act. Care and treatment was delivered in line with the Mental Health Act and Mental Health Act Code of Practice. A Mental Health

Act administrator supported staff daily. They provided daily updates on patients legal status, renewal dates for their sections and reminders when patients were due to have their rights read to them.

Patients had access to independent mental health advocacy services. Patients we spoke with were aware of their legal status under the Mental Health Act and understood their rights.

Mental Capacity Act and Deprivation of Liberty Safeguards

All staff received Mental Capacity Act training.

Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act 2005 and the five statutory principles. Staff were able to seek guidance and there was a Mental Capacity Act policy in place.

Patients had their capacity assessed when this was in question and this was recorded in care records. Patients were supported to make their own decisions in line with the principles of the Mental Capacity Act.

There was a policy around Deprivation of Liberty Safeguards. Staff we spoke with demonstrated a good knowledge of Deprivation of Liberty Safeguards and were able to explain when they would be made. There were no patients subject to Deprivation of Liberty Safeguards.






Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay/ rehabilitation mental health wards for working age adults	Good	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Long stay/rehabilitation mental health wards for working age adults

Good 

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

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

Good 

Safe and clean environment

The ward layout did not fully allow staff to observe all parts of ward. There was a blind spots audit tool, which had been completed for the external gate entrance and areas throughout the ward.

There were current and up-to-date ligature risk assessments. The ligature risk assessments were completed for individual rooms including all patient accessible areas and outside spaces. Where ligature risks were identified these had been assessed. The blind spot and ligature risks were adequately mitigated as staff regularly assessed and observed patients throughout the day. Where a patients' risk increased throughout the day, the levels of observations was discussed and increased if necessary.

The ward complied with guidance on same-sex accommodation, as it was a male only ward. All patients were asked if they wanted a key to their own bedrooms.

There was no seclusion or de-escalation room on site.

There was a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. These were checked nightly.

All ward areas were clean and had good furnishings that were well maintained. The ward had a dedicated cleaner

throughout the week. Cleaning records were in place and up to date and demonstrated that the environment was regularly cleaned. Some patients were encouraged to clean and keep their bedroom area tidy.

Staff adhered to infection control principles including handwashing prior to providing direct care. Hand sanitisers and signs reminding patients, staff and visitors to regularly use hand sanitiser and wash wands were in place throughout the hospital and ward area.

Environmental risk assessments were undertaken regularly and the hospital had a risk management strategy and risk register in place as well as a health and safety policy statement. Personal emergency evacuation plans were produced when patients were assessed as requiring assistance in an emergency.

Nurse call systems were in place throughout the ward area if staff or patients needed to summon assistance.

Safe staffing

The hospital used a staffing ladder to determine the staff numbers against the number of patients. This ladder was reviewed daily to ensure the skill mix met the needs of the patients. The ward manager was able to adjust staffing levels dependent on patient observations and planned activities outside of the unit. For every patient their specific requirements over and above the ladder were determined during the pre-assessment phase. For example: if they required special duty nursing this was agreed prior to the patient being admitted, or should their clinical presentation change during admission.

Long stay/rehabilitation mental health wards for working age adults

Good 

The ward usually worked with one qualified nurse and two healthcare assistants during the day and night. The staffing ladder formed the minimum staffing levels and informed recruitment.

The establishment levels were as follows:

- Establishment levels, qualified nurses (whole-time equivalent) - 1.9
- Establishment levels, healthcare assistants (whole time equivalent) - 13.7
- Number of vacancies, qualified nurses - 3.6
- The number of shifts that have not been filled by bank or agency – 0
- Number of shifts filled by bank or agency to cover sickness absence or vacancies – 132.

Total number of substantive staff - 23

Total number of substantive staff leaving in last 12 months -12.

At the time of the inspection, there were three qualified nurse vacancies at Robinson House. To mitigate these vacancies, the site was using consistent agency nurses obtained through corporate contracts. This was to ensure staff were adequately trained to maintain safety of the ward and ensure consistency for patients. In addition, the nurses were primarily only used on a night shift when the unit was at its most settled. There was an active recruitment plan to fill these vacancies.

A ward manager worked Monday to Friday. They had fifteen hours of their time incorporated into the staffing numbers. An occupational therapist covered the ward three days a week and an occupational therapy assistant five days a week. The ward had access to a psychologist for one day as well as an assistant psychologist. The ward also had a full time Mental Health Act administrator who was based on the ward.

The ward had access to adequate medical cover during the day provided by a speciality doctor and out of these hours, an on call doctor was available. A consultant psychiatrist attended one day per week although staff reported they were always accessible by telephone throughout the day.

Staff reported they sometimes needed another staff member to support community trips for patients and ensure ward was still safe when staff go out especially at weekends.

The service has a workforce-planning document in place where they have identified the vacancies. All vacancies are reviewed weekly in operational meetings and by the senior management team.

Staff had received up to date mandatory training and the average mandatory training for staff was above 75%.

Assessing and managing risk to patients and staff

The ward was locked and informal patients were informed of their rights to leave the ward at any time with notices attached next to the doors.

Staff at Robinson House received training in reducing restrictive interventions on the ward and the unit monitored this through the patients' 'your voice forum' and the staff bulletin, which shared information with staff. There was a reducing restrictive practice strategy and audit tool in place. This listed all current practices on the ward that may be deemed as restrictive practices on the ward and provided details of current practice on the ward. We did not find any restrictions in place and these were routinely monitored for their appropriateness in a rehabilitation service. There was a reducing restrictive audit tool in place.

There were no incidents of restraint reported between April 2016 to September 2016.

There was a clear culture of least restrictive practice and positive risk taking. Staff had made efforts to relax restrictions. For example, patients had access to their rooms at all times and had a key to lock the bedroom if they wished.

The hospital had implemented the 'safewards' initiative at Robinson House. This was to keep everyone as safe as possible. The 'safewards' model explains the factors that affect conflict and containment on wards and how staff can make a difference in the way they manage a ward. It includes 10 interventions to increase safety and decrease conflict and containment.

The provider had appropriate systems and processes to ensure that all patients had a comprehensive, individual risk assessment on admission. These were used by staff to develop risk management plans, which were regularly reviewed. Staff used an electronic system that flagged dates for review.

Patients were also assessed against their environment and risk assessments in care plans were in place to support this.

Long stay/rehabilitation mental health wards for working age adults

Good 

Staff used a standard tool for assessment of risk to assess and monitor risk. They completed this for each patient on admission. A detailed formulation identified risk factors, early warning signs and mitigation. Mitigation included such things as body language, rate of speech, tone of voice and level of eye contact.

We looked at the risk assessments for three patients. All were complete and up to date. They were comprehensive and captured all relevant information. For example they captured concerns relating to mental health, mental capacity, self-neglect, dietary concerns, alcohol and drug use as appropriate. Risk assessments were person-centred and proportionate. Staff categorised risks as low medium or high and highlighted these in green, amber or red. Staff recorded observation levels clearly. Each patient's level of risk was routinely reviewed every month by the patient's key worker and by the multidisciplinary team at ward rounds every three weeks, plus whenever clinically indicated and following incidents. The electronic system included an audit trail and staff recorded each review of risk.

Staff used the information from the risk assessment to develop an individual risk management plan for each patient. Staff had attempted to engage patients in writing risk management plans. We saw patients' views were recorded although were sometimes written in the third person. The risk management plans all contained a summary of the risk assessment and then went on to state each identified risk in detail. Staff had identified triggers to individual risks and mitigating action to take. The records contained the name of the staff responsible and a review date.

Staff also completed risk assessments prior to patients going out on leave. The files we reviewed also contained a formulation of risk for discharge and unplanned discharge.

Staff assessed, monitored and managed risks to patients on a day-to-day basis. These included signs of deteriorating health, medical emergencies or behaviour that challenged. Staff recognised and responded appropriately to changes to risks in patients.

Staff received safeguarding training as part of their induction and mandatory training. They understood how to identify potential abuse. There were established links with staff within the local safeguarding authority. Senior management were identified as safeguarding leads and

provided advice and support. The provider had good formal links with local safeguarding authorities, monthly meetings were held with a set agenda, and these were documented. There were policies for the safeguarding of both adults and children. The service had not raised any safeguarding alerts in the previous 12 months. We did not identify any incidents which required a safeguarding alert on inspection.

Each care record contained a personal emergency evacuation plan if this was needed. There was a visitor and child visiting policy in place to ensure children were safe and protected when visiting the hospital. There were separate areas off the ward that could be accessed to facilitate child visiting.

Track record on safety

There was a serious incident reporting template/ notification form. This identified the situation, background, assessment and recommendations. An incident management, reporting and investigation policy was in place.

Information reviewed regarding incident data for October 2016 indicated there were 13 incidents reported on the ward. None of these indicated they required any physical intervention by staff.

Statutory notifications are appropriately submitted to the Care Quality Commission under the Care Quality Commission (Registration) Regulations 2009 (part 4).

Reporting incidents and learning from when things go wrong

All staff members could report incidents and these were captured on a written incident reporting form. Agency staff also had access to these forms. Staff we spoke to were aware of what incidents required reporting and how to report these. They received feedback about incidents via multidisciplinary meetings and through a weekly bulletin to staff. Any learning from incidents was shared with staff at team meetings. Incident review meetings were held and a health care team incident review report was completed. We reviewed two incident reports and this included a section on lessons learnt, processes to mitigate and prevent recurrence. Staff had access to these records, which they could discuss at the ward meetings and via supervision. Staff and patients received debriefs and were offered support after any serious incident.

Long stay/rehabilitation mental health wards for working age adults

Good 

Duty of Candour

The provider had a policy outlining the Duty of candour requirements that provided guidance for staff. The incident management, reporting and investigation policy also referenced the Duty of candour. The policy set out the provider's approach to Duty of candour and what action staff would take if an incident occurred that prompted the duty. It included a flow chart of actions needed.

The provider told us that during the two week induction programme, staff were alerted to the policy on Duty of candour and its content discussed. The Duty of candour was also covered in whistleblowing training.

There was a clear culture of transparency in the service. The provider encouraged staff at all levels to be open and honest if something went wrong.

We discussed the Duty of candour requirements with the staff on duty. They were clear that they would explain and apologise to patients and their families in the event of an incident. They explained how lessons were learned if things went wrong, such as through supervision, team meetings and a weekly staff bulletin. However, some staff said they had not heard of the duty of candour requirements. We did not find any evidence of any impact on patients or other relevant persons but we were not assured that all staff fully understood the principles of the Duty of candour. There were no incidents that met the Duty of candour at the time of the inspection.

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

(for example, treatment is effective)

Good 

Assessment of needs and planning of care

There was a strong recovery focused ethos and holistic, mutual approaches to planning care.

The model of care promoted a recovery and goals based approach to care planning. It focused on ensuring that each patient received the most appropriate care and

treatment within clearly agreed timeframes and in the least restrictive environment. The records we looked at contained comprehensive accounts of the reason for admission and goals for discharge.

We examined three patients' care records. We found them to be complete and inclusive. They showed evidence of patients' individual diverse needs and patient involvement in developing care plans, although some were written in the third person. Staff and patients together re-evaluated and updated care plans every month and following changes to care needs. Where patients found it difficult to engage, staff offered encouragement so they were able to contribute. Care plans showed that consideration had been given to minimum restrictions being placed on patients' liberty.

Staff carried out an initial assessment that incorporated mental and physical health assessments and further health investigations where necessary. It included a risk assessment and evaluation of patients' social, cultural, physical and psychological needs and preferences. The assessments focused on patients' strengths, self-awareness and support systems in line with the recovery model of care. Care records we looked at confirmed that staff assessed patients when they were admitted and made plans for their continuing support from the start of their treatment.

With each patient, staff developed a care plan. The records we reviewed were up to date. The care plans were centred on the patients' diverse needs as identified by them and clearly demonstrated patients involvement. They were recovery focused and contained goals for future discharge. There was evidence of good multidisciplinary team working based on the patients' needs. Staff understood the diverse care needs of the patients. Daily notes reflected the content of the patients' care plans. Staff provided a copy of their care plan for each patient. If the patient refused a copy, the reason was recorded.

We observed two ward review meetings. The meetings followed a clear structure. They included multidisciplinary discussion of all aspects of the patients' care and consideration of future plans.

The care records we reviewed contained evidence of ongoing physical health monitoring.

Care planning was progressive and goal-led. Patients had regular sessions with their key nurse to discuss and review

Long stay/rehabilitation mental health wards for working age adults

Good 

their care plans, and they had the opportunity to attend review meetings with the multidisciplinary team. Families and carers were encouraged to be involved in the care planning process.

Best practice in treatment and care

National Institute for Health and Care Excellence guidance was available for staff on the ward, such as national guidance 27 that addressed transition between inpatient hospital settings and community or care home settings for adults with social care needs. Other clinical guidance included service user experience in adult mental health settings and type one diabetes in adults: diagnosis and management.

A spreadsheet of all current National Institute for Health and Care Excellence guidelines and quality standards relevant to the service was maintained and accessible to all members of staff via the healthcare and quality section of the corporate intranet.

We reviewed all eight prescription charts on the ward. Prescribing was in line with National Institute for Health and Care Excellence guidance. Comprehensive multidisciplinary meeting discussions took place when prescribing medication above recommended British National Formulary levels. The British National Formulary was a reference book that contains authoritative information and advice on prescribing medicines including indications, contra-indications, side effects, and recommended doses. The pharmacist advised of any updates or changes in guidance.

Clozapine monitoring was in place and this was registered online, under the patient monitoring system and was overseen by the pharmacist. This meant that patients received regular checks of their white blood cell count to ensure they could continue to be prescribed Clozapine safely. Qualified staff also completed training online about dose titration and monitoring. Insulin alerts were in patients' medication charts and care notes to alert staff to any issues about diabetes.

Staff carried out monthly audits of care records that included checking risk assessments, care plans, physical health care, Mental Health Act documentation and whether service users had received copies of their care plans. All care records and audits were complete and up to date. The electronic system flagged up review dates and included an audit trail where reviews were recorded.

All patients had access to physical healthcare checks on admission and throughout their stay and access to specialists was facilitated when needed. Nutrition and hydration needs were monitored and the ward had access to a dietitian weekly. We saw that input from the dietitian had taken place for patients who were diagnosed with diabetes to provide advice and support to patients and staff around food and diet choices. The occupational therapist promoted an exercise group twice a week.

The service offered psychological therapies in line with National Institute for Health and Care Excellence. The ward has access to psychology twice a week and this was timetabled. The psychology staff had been trained in cognitive behavioural therapy.

Health of the Nation Outcome Scores were completed on admission and periodically throughout the patients stay to assess and record severity and outcomes for patients. These scores were also completed prior to the patients care programme approach meetings and where any patient was discharged. Staff used the Health of the Nation Outcomes scale to measure the health and social functioning of people with severe mental illness with the aim to improve health and social functioning. These were completed at regular intervals and were recorded on the patients' care notes. These were reviewed at patients care programme approach meetings to consider how effective the service was on improving the patient's health and social functioning.

There was a spiritual, personal and cultural education group, called Your SPACE, that provided patients with opportunities to explore and discuss qualities, virtues and values needed in daily living. This included exploring the concepts of hope and strength, to develop trust and to provide an outlet for self-expression. The group was developed to address these concepts in a creative and engaging way. Staff developed a structured plan that included reflection, for example, the values of different groups helped patients identify their own values and consider their responsibilities in the community. This helped patients to work together and to recognise and address conflict.

Staff participated in regular clinical audits and quality walk round audits of the environment. Ligature and suicide audits had been completed twice yearly as well as a care plan audit, use of restraint, data protection audit, infection control and schizophrenia and safeguarding audit. The

Long stay/rehabilitation mental health wards for working age adults

Good 

pharmacist completed weekly audits on the ward and these all fed into the clinical governance meetings. Monthly Mental Health Act compliance was reviewed monthly by an audit and this fed into the clinical governance meetings. Corporate audits had been completed, examples of these included Mental Health Act compliance and Mental Capacity Act yearly audits. Action plans had been completed to address any issues raised and these had been signed off at the governance meetings.

Skilled staff to deliver care

A range of professionals provided care to patients at Robinson House. These included nurses, healthcare assistants, occupational therapists, psychologists, a speciality doctor, a consultant psychiatrist, and speech and language therapists. Appropriate checks were in place to ensure staff had a current registration and had been revalidated to enable them to practice in the professional body they were registered with. Pharmacy staff visited the ward weekly. There was a recovery assistant that inputted into the ward daily working alongside the occupational therapists to provide ward based and off-ward activities.

Staff were appropriately skilled for their role. The hospital had a corporate induction, which new staff attended. Staff also received a local induction when on the ward. Staff told us they had received an appropriate induction and had been supported to settle in on the ward. Staff had access to key policies and procedures and the main policies and procedures had been printed out for staff to refer to.

In addition to mandatory training staff were able to access additional specialist training to support the delivery of care. The occupational therapist had been trained in assessment of motor and processing skills. Some staff had been trained in cognitive behavioural therapy and psychosocial interventions.

Staff received supervision and appraisals. Between September 2015 and September 2016, all staff had received an appraisal and 95% of staff had received supervision.

Staff performance issues were being addressed and we saw that performance improvement plans had been produced and these were being monitored.

Multidisciplinary and inter-agency team work

There were structured weekly multidisciplinary meetings and these included health care assistants, occupational therapy, speech and language therapists, nursing staff,

doctors and psychology. The consultant psychiatrist also attended weekly to review patients care and treatment and liaised daily with the speciality doctor. We observed one of these meetings and patients were invited and encouraged to attend if they wanted to.

Psychological, physical health, risk, mental state and medication were discussed as well as capacity, financial and advocacy issues. Observation levels and care programme approach outcomes were also discussed and occupational therapy sessions and patient involvement were addressed.

Representatives from local safeguarding teams usually attended the designated safeguarding officers meeting monthly. Staff from clinical commissioning groups who funded the patients were provided with monthly progress reports and care programme approach meetings every three months. Care coordinators were also involved and updated about individual patients.

All patients were registered with local general practitioners and effective links were in place with their general practitioners. Quarterly medicines management meetings were held and pharmacists and general practitioners were invited to attend.

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

Staff received Mental Health Act training as part of their mandatory training programme. Compliance with Mental Health Act training was 95%. Staff we spoke with demonstrated a good understanding of the Mental Health Act and the code of practice and were aware of their responsibilities under it.

The ward had a dedicated Mental Health Act administrator and staff could access support and advice. The administrator scrutinised Mental Health Act documentation and completed regular audits. This included information on the patients legal status, renewal dates for sections and when their rights were due to be read again. Patient rights under section 132 of the Mental Health Act were revisited monthly. Care records we reviewed detailed patients detention under the Mental Health Act. Staff regularly reminded patients of their rights during their detention. The appropriate legal certificate (T2 and T3 forms) were in place when detained patients received treatment for a mental disorder and were attached to medication cards. Patients with capacity use a T2 form to consent to the

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Good 

medication they have been prescribed. Where a patient lacked capacity a T3 form was used to confirm that a second opinion appointed doctor had reviewed the patient's medication and had approved the treatment plan. Capacity assessments to consent to treatment had been completed. There were good systems in place to ensure patients had access to Mental Health tribunals and hospital managers' hearings and the Mental Health Act administrator was responsible for this.

Patients had direct access to fresh air and patients were granted section 17 leave to enable them to leave the ward and access local areas and hospital grounds. Where risk assessments had indicated the need for the patient to be escorted, staff would facilitate this. Patients had access to a ward cordless phone so that they could make calls in private and patients had access to their own mobile telephones.

Patients had access to Independent Mental Health Act advocacy services who proactively visited the ward weekly. Posters advertising the service were displayed on the ward. Staff knew how to refer patients to the service. Patients we spoke with were aware of the advocacy services available. Information on how to make a complaint or how to contact the Care Quality Commission was also on display.

Good practice in applying the Mental Capacity Act

Staff received Mental Capacity Act training as part of their Mandatory training programme. Compliance with this training was 100%. Staff we spoke with demonstrated a good knowledge of the Mental Capacity Act and the five statutory principles. There was a policy on the Mental Capacity Act and staff were aware of the policy and how to access it.

There had been no applications to deprive individuals of their liberty and the hospital maintained a database to record where any applications had been made.

Staff we spoke with demonstrated a good knowledge of Deprivation of Liberty safeguards and were able to explain when they would be made.

We saw evidence that capacity to consent was being considered. We saw evidence of patients being supported to make decisions for themselves. This was on a decision specific basis and in line with the principles of the Act. Capacity of patients was assumed unless there was cause to doubt this for specific decisions.

Care records contained mental capacity assessments for specific decisions for example flu vaccines, blood tests and other such interventions. Decisions were accepted and recorded, for example where patients had decided they did not want to have a flu vaccination. Multidisciplinary team meetings also discussed these issues and then completed an assessment if needed.

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

Good 

Kindness, dignity, respect and support

Staff respected patients and valued them as individuals. The recovery model of care helped staff ensure patients were empowered as partners in their care.

Feedback from patients was positive about the way staff treated them. Patients told us that the care they received was superb and that staff were dedicated to providing high quality care.

There was effective engagement between staff and patients on the ward. Staff were warm and friendly. They treated patients with dignity, respect and kindness during their interactions and the relationships between them were positive. Patients told us they felt supported and said staff cared about them. They described staff as friendly, approachable and helpful.

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted patients' dignity. Relationships between patients, the people close to them and staff were caring and supportive. These relationships were highly valued by staff and promoted by leaders both at ward level and by the senior management team. The daily notes included a section for staff to make a positive statement about the patient.

Staff recognised and respected patients' needs. We saw evidence in care records that staff considered patients' personal, cultural, social and religious needs.

The staff ensured patients' dignity, privacy and confidentiality was always respected, for example, by

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Good 

providing private space for conversations and knocking on doors before entering patients' rooms. There was a confidentiality policy and we were assured through our discussions with staff that they understood it.

The involvement of people in the care they receive

We could see from the care records we reviewed that staff made efforts to ensure patients were involved in planning their treatment. Patients had developed their own goals and objectives.

Patients were involved in their own care. They were invited to their ward meetings, and were involved in planning their week's activities, both as a group and individually. Staff reviewed patients' needs and planned activities that would meet their interests and needs. The staff at the hospital listened to patients. An example of this was where a patient had advised that they did not want to receive a specific medication, the patients' views were discussed and alternative medication sought. Patients and families were encouraged and supported to attend ward reviews. If a patient did not wish to attend, the consultant psychiatrist met with them outside the multidisciplinary meeting. The key nurse fed the outcomes of the discussions and any decisions made back to the patient after the review.

Patients had several forums in which to share their experiences both formally and informally. These included the 'your voice' forum, their care programme approach meetings, their one to ones with their named nurse and their weekly advocacy service.

All patients were asked to complete a satisfaction survey every year. This gave patients an opportunity to give feedback on the service they had received. Questions covered issues such as privacy and dignity, whether the service met the patient's needs and how approachable they found staff. Senior management reviewed the survey responses. The most recent survey was carried out in March 2016. Four patients responded. Overall satisfaction was 77%, with scores ranging from 50% to 100%. Actions arising from the survey were agreed with the patients at the monthly 'your voice' meeting to ensure all areas were addressed. The 'Your voice' meeting also offered the patients a monthly informal meeting in which to share their experiences and ideas for the unit.

Examples of changes being made following feedback included change to the menu choices, décor ideas for refurbishment of the unit and the development of a gardening group.

Patient information sheets were available about their detention under the Mental Health Act and their rights.

There was an independent mental health advocate who supported patients. Patients had direct access to advocacy services and there was information displayed across the ward. The advocate also visited the ward each week to ensure that patients were aware of the support that the advocate could provide. The patients we spoke with said they had periodically used the advocacy service.

A pet therapist visited the ward monthly with a dog.

Are long stay/rehabilitation mental health wards for working-age adults responsive to people's needs? (for example, to feedback?)

Good 

Access and discharge

There an admission process to inform and orientate patients to the service. Patients could visit the ward prior to admission. All of the admissions were planned and the care records we looked at contained comprehensive accounts of the purpose of admission and goals for discharge.

A comprehensive pre-admission assessment was completed before admission to determine the suitability of the placement, especially to the rehabilitation services. An admission, transfer and discharge policy was in place to support and guide staff.

Discharge plans were in place for patients and records we looked at confirmed this.

The hospital managers and ward managers discussed access and discharges daily. We saw that patients' discharges were facilitated with appropriate involvement from the commissioners of the service and care coordinators to repatriate patients to their local area where possible.

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Good 

The average length of stay reported was 952 days and the bed occupancy was 83% for the period between April 2016 to September 2016. The service provided slow stream rehabilitation for patients who required ongoing rehabilitation and care.

The facilities promote recovery, comfort, dignity and confidentiality

The ward was spacious, well-furnished, and allowed patients to access quiet areas and a relaxation room. Patients had been consulted about the refurbishment of the kitchen area, which was bright and modern. Patients had access to two television areas and a large and comfortable conservatory area with zoned areas providing access to a television, quiet relaxation area. The large conservatory had a pool table, darts and access to a keyboard and many books and board games.

Patients were encouraged to do their own washing and were supported by staff. An activity room was also available and this allowed patients to access computers. A policy was being developed to address the use of technology for example Skype, to enable patients to keep in touch with their relatives whilst at the hospital. Patients had identified this and the hospital managers were addressing this.

Family visitors to the ward had access to quiet areas on and off the ward area. Family members were encouraged to visit and arrangements were made to meet relatives outside of the hospital if this was more appropriate. Arrangements had been made for a patient to return home overnight to be with their relative.

The ward had access to a large garden area and patients accessed this freely through the day. The doors were locked at midnight to maintain safety in the building but patients were able to still access this during the night if needed. Patients had access to a smoking area outside that afforded cover if it was raining.

All patients had their own individual bedrooms and were able to personalise them with their belongings. Patients had their own keys to their bedrooms and had secure lockable storage to store their possessions. They were free to access them at any time.

Group work and activities were provided during the week and at weekends and patients were encouraged to attend. Patients went out into the local town accompanied by staff

and bought newspapers daily for the ward. Staff had access to a mini bus to transport patients if needed and local trips and outings were planned. Patients had access to a private area to make phone calls.

Patients had access to drinks and snacks throughout the day and night and an open kitchen area that allowed patients to make their own drinks. Patients were also encouraged to make their own snacks and meals and were supported to do this by the occupational therapist in an open kitchen area. When patients were assisted in making their own meals, they went out accompanied and shopped for the ingredients. This promoted their recovery through maintaining and developing their independent living skills.

The food was provided by a hospital kitchen and was brought onto the ward. A three week rolling menu choice was available, a dietitian worked alongside the kitchen staff to meet the needs of patients with specific dietary needs, for example, diabetes, and arrangements to ensure religious and ethnic dietary needs could be met where this had been identified. A healthy eating group was delivered monthly to patients and plans were in place to provide pictorial and photographs of the menu options to aid some patients in making a choice of their meals.

There were two clinic rooms and facilities were available to allow patients to be examined.

Meeting the needs of all people who use the service

Access into the ward area included ramps to allow access for people who had mobility difficulties. The bedrooms on the first floor had access from a lift or stairs. There was a hoist in the bathroom area and an accessible toilet available.

Information leaflets were available throughout the ward and an information board provided patients with information about access to advocacy, patient rights and who to contact to make a complaint. Information about the Care Quality Commission was also available and they provided contact information for patients on how to contact the Care Quality Commission should they have any complaint about their detention under the Mental Health Act. Local information about groups and places to visit were also available.

There was access to a multi faith room off the ward area if patients wanted to access space for private prayer. There was a spiritual lead identified at the hospital to arrange and

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Good 

facilitate access to spiritual support if required. A vicar visited the ward twice a month. Information leaflets were made available should these be needed for patients who spoke different languages.

Access to interpreters and signers could also be facilitated and accessed if needed.

All patient bedrooms and patient areas had access to nurse call facilities.

Listening to and learning from concerns and complaints

There was a current policy in place in relation to complaints. Staff were able to access this on their intranet. The hospital maintained a complaints log to monitor the actions taken and maintained a log of the responses and recommendations as well as dates of the outcome and closure of the complaint where necessary.

There had been one complaint received in May 2016 this had been investigated and the outcome of the complaint shared with the complainant. This had been partially upheld.

There were no complaints referred to the parliamentary health service ombudsman.

Information was available on the wards to inform patients on how to make a complaint. Information for detained patients about how to make a complaint to the Care Quality Commission about their detention under the Mental Health Act was available.

The staff and manager agreed that they would try to resolve the complaint at ward level but if not they would offer support to patients wishing to make a formal complaint if required. Patients felt they were listened to.

Complaints and any learning were shared at staff team meetings, supervision and by a news bulletin and in-house newsletter called 'top priority'.

Patients also had access to a monthly meeting called 'your voice' where they were able to voice their concerns and to look at any improvements that could be made to the unit. We saw minutes of these meetings and actions and dates of actions completed were recorded.

In December 2016, a compliment was made to the ward stating they were satisfied that appropriate medical treatment was available and that the patient was detained in a safe and secure environment where they received highly skilled and experienced nursing care and support.

Care notes contained an attached service user satisfaction survey. This was completed yearly initially on paper with help from staff if needed and was then transferred to the care notes.

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

Good 

Vision and values

The hospital's vision was 'to be a mainstream provider of high quality specialist neuro-rehabilitation and complex mental health service and to be totally committed to providing safe and effective care.'

Their aim was, 'to become a centre of excellence, where clinical effectiveness, best practice and service user involvement are at the centre of the care delivered.' Their purpose was to make a real and lasting difference to the everyone they support.

This was underpinned by a set of five values and behaviours that were based on:

- 'putting people first'
- 'being a family'
- 'acting with integrity'
- 'being positive'
- 'striving for excellence'

The strategy for the long-term conditions services had been incorporated into the hospitals' strategic plan for 2016. This listed specific objectives including:

- to provide safe and effective care
- to have a steady, well trained, competent work force
- to have policies, procedures and systems in place
- to achieve and exceed financial targets.

The hospital director and senior management team were in the process of developing the strategic plan for the

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Good 

forthcoming year. The vision, values and objectives had been cascaded to staff across the services and information was displayed throughout the hospital and was visible on the ward. Staff we spoke with had a good understanding of these.

Good governance

There were monthly clinical governance committee meetings, monthly departmental meetings and weekly operational management team meetings taking place. There was a clear governance structure in place with committees for medicines management, health and safety, safeguarding and quality monitoring. There was a set agenda for these meetings with standing items, including the review of incidents, key risks and monitoring of performance. Identified performance shortfalls were addressed by action planning and regular review. The hospital did not have a formal medical advisory committee. The hospital director confirmed a medical advisory committee meeting was scheduled to take place in January 2017 with a plan to conduct routine medical advisory committee meetings after the initial meeting. The hospital director confirmed a MAC meeting took place at the hospital in January 2017, with a plan to conduct routine MAC meetings after the initial meeting. The meeting minutes for the MAC meeting in January 2017 showed the meeting was chaired by the medical director (MD) and attended by the hospital's medical team and site management team. The meeting covered key topics such as doctor's working arrangements and new appointments / working arrangements.

Risks were identified for the ward and were documented and escalated by the services appropriately. Key risks were reviewed during weekly operational management team meetings.

There were routine staff meetings on the ward areas to discuss day-to-day issues and to share information on complaints, incidents and audit results. There were quality walk round checks of the building, environment and paperwork completed monthly. These were submitted and reviewed at the governance meetings. Information was cascaded to the staff on the ward through a weekly performance bulletin.

The hospital had reviewed the staff retention and vacancies and as a result, they have implemented the following below to improve their retention and attract the right calibre of staff.

- Career development for nurses – grades defined with competencies for each level so nurses can progress
- Salary review to ensure the staff are in line with competitors and in house
- Nurse loyalty bonus
- Incentive to join payment on joining and at the end of probation
- 50%, National Midwifery Council registration fees paid for nurses
- Appointment of a central nurse recruiter to support site recruitment.

Staff had received mandatory training identified as well as receiving supervision and appraisals.

The ward manager had sufficient authority to do their job and had administrative support. The ward manager informed us they had the appropriate authority to submit items to the hospital risk register. Registered mental health nurse vacancies had been identified on the risk register and existing controls were in place to manage this risk.

Leadership, morale and staff engagement

There was effective team leadership at Robinson House and staff morale was good. A new ward manager had recently been appointed and staff reported there had been improvements made. Staff understood the roles of other staff on the ward and were positive about their work. Staff we spoke with indicated there was lots of support from senior managers within the hospital. Staff told us they could raise concerns without fear of victimisation and that senior managers were supportive, open and approachable.

Staff were actively involved and kept up to date about the ward and hospital they worked within. Staff had the opportunity to have their say at monthly staff forums. Staff also had opportunities to make suggestions for how daily life of staff and patients could be better and these were reviewed by the hospital managers and implemented. This initiative was named 'bright sparks' and staff could leave comments in suggestion boxes throughout the hospital. It was implemented following suggestions made at listening groups held as part of a staff engagement survey.

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Good 

The overall lead for the services was the hospital director, who was also the registered manager with the Care Quality Commission. The hospital director was supported by the medical director and the director of clinical services, who had overall responsibility for the therapist teams and the ward based nursing and support staff.

The support services manager was responsible for maintenance, housekeeping, catering operations and staff.

The medical director also worked as a consultant on the Robinson unit and visited the hospital one day a week. The hospital director told us that the medical director did not attend any meetings including the senior management team as this was allocated on a day when the neurological consultant attended; however, they received the minutes from the meetings.

The hospital director told us the medical director would meet weekly with the hospital director and information would be shared, although this was not a formalised process.

We found that the medical director (MD) had limited involvement or knowledge on risk and oversight of the hospital. Following our inspection, an action plan was implemented which included the increase of allocated time for the medical director to visit the hospital from one day to two days per week. The hospital director also confirmed that the medical director had attended the most recent weekly senior management team meeting.

We discussed the role of the MD with the hospital director, who put immediate actions in place to increase the involvement of the MD within the hospital's management systems.

This included the increase of allocated time for the MD to visit the hospital from one day to two days per week to enable the MD to attend SMT and medical advisory committee (MAC) meetings.

The hospital director confirmed the MD had attended the most recent weekly SMT meeting. We also saw evidence that the MD chaired the MAC meeting in January 2017.

Staff sickness rates was reported as 16% in September 2016 and this was above the hospital's target of 4.5%. The hospital had a business plan and there was a continuous recruitment programme to sustain safe staffing levels.

All the ward nursing, support and therapist staff we spoke with were highly motivated and positive and enjoyed their work. They told us the managers were approachable, visible and provided good support.

There was a confidential reporting (whistle blowing) policy in place and the staff we spoke with were aware of what steps to take if they wanted to raise concerns.

Commitment to quality improvement and innovation

The service had trialled the multiple errands test for use with the patient group.

The multiple errands test is typically used with patients with acquired brain injury. It measures the patients' ability to function in everyday situations through a number of real-world tasks (for example, purchasing specific items, collecting and writing down specific information, arriving at a stated location). The tasks are performed in a community setting and limited by specified rules. The participant is observed performing the test and the number and type of errors (for example, breaking rules, and omissions) are recorded.

The purpose of the trial was to review whether the multiple errands test was sensitive to functioning difficulties that may or may not be highlighted on the Addenbrooke's Cognitive Examination (3rd edition), which was part of the patient group's standard rehabilitation. It was anticipated that the results may influence future care plans and rehabilitation aims. Overall, the project aimed to evaluate whether the multiple errands test was a valid tool for the mental health population. The results were not known at the time we inspected.

The hospital achieved the 'investors in people' gold award in October 2015. They had received a food hygiene rating of five (very good) from the local metropolitan council in February 2015 and this was updated on 13 November 2016 where food hygiene and safety and structural compliance was very good and confidence in management was high.

Robinson House had used the 'safewards' training pack and drawn up a list of mutual expectations that included, for example, informing each other of concerns and offering opportunities to be involved in recovery. The 'safewards' model was developed through independent research

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Good 

funded by the National Institute for Health Research. It explains the factors influencing rates of conflict and containment on wards. It incorporates 10 interventions to increase safety and decrease conflict and containment.

Outstanding practice and areas for improvement

Outstanding practice

- The service had trialled the multiple errands test for use with the patient group. The purpose of the trial was to review whether the multiple errands test was sensitive to functioning difficulties. Overall, the project aimed to evaluate whether the multiple errands test was a valid tool for the mental health population.
- There was a spiritual, personal and cultural education group, called Your SPACE, that provided patients with opportunities to explore and discuss qualities, virtues and values needed in daily living. This included exploring the concepts of hope and strength, to develop trust and to provide an outlet for self-expression. The group was developed to address these concepts in a creative and engaging way.

Areas for improvement

Action the provider **SHOULD** take to improve

The provider should ensure that all staff understand the principles of the Duty of candour.