Ash House Rehabilitation Unit

Quality Report

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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	Requires improvement
Are services safe?	Good
Are services effective?	Requires improvement
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

We undertook this comprehensive, unannounced inspection to find out whether Ash House had made improvements to their service since our last comprehensive inspection of November 2016.

When we inspected Ash House in November 2016, we rated the hospital as inadequate overall. We rated safe, effective, responsive and well-led as inadequate and caring as requires improvement. We placed Ash House into special measures.

At this comprehensive inspection in April 2017, we saw substantial improvement and it has been agreed that Ash House can exit special measures.

We have now rated Ash House as requires improvement because:

- We saw that there were no associate hospital managers to the service, so if a patient decided to appeal against their section, there was no hospital manager to hear their appeal. This was in breach of the Mental Health Act Code of Practice.
- Mental Capacity Act training had been attended by only 25% of staff, and Mental Health Act Awareness training had been attended by only 25% of staff.
- Although policies and procedures had been drafted for the service, many of the policies had yet to be made available to staff at the time of the inspection.
- At the time of the inspection, there was no registered manager at the service.

However:

- The service had met requirements with regard to the breaches of regulation found in the November 2016 inspection.
- The building had blind spots that were adequately mitigated to reduce the risk of harm to staff and patients. Patient risk assessments accurately identified patients' risk to self and others. Safeguarding referrals were being made when necessary to the local authority. Medication management was in place and audited. A full ligature risk assessment had been carried out on the building, and was maintained. Patients could access their rooms during the day, and electronic door access was available to bedroom areas so patients could access the area without needing staff assistance.
- We found care plans to be updated, personalised, and holistic. Patients were being given a copy of their care plan, or offered a copy. Physical health care needs were documented and recommendations made regarding actions. There was evidence that psychological interventions were available to patients, if required. The Mental Health Act administrator had developed and maintained a system to monitor and alert staff when actions were required under the Act.
- The service had a regular patient meeting that was attended by patients, and minutes were taken and shared. Patients were treated with kindness and respect. We saw positive interactions between patients and staff. There was regular access to an independent mental health advocate for patients. We were told by a patient that he was hoping to leave the service soon, and was involved in sessions preparing him for return to the community.
- There was provision of structured activities within the service to aid patient recovery and rehabilitation. The operational framework for the service gave clear admission criteria. Cultural and religious differences were recognised and given consideration. Activities within the service had improved since the inspection in November 2016. The use of an occupational therapy assistant meant planning and provision of activities was much more prevalent. The sessions provided were meaningful.
- During the inspection in November 2016, there was no evidence of any vision or values in place at the service. At this inspection, the new chief executive officer for the service had helped develop visions and values and had incorporated them into the new operational framework. A risk register had been introduced and was up to date and comprehensive. The governance structure that was in place appeared sound, although the limited number of patients in the service meant that the governance systems introduced had not been fully tested due to the lack of admissions.

Summary of findings

Contents

Requires improvement

Ash House

Services we looked at
Long stay/rehabilitation mental health wards for working-age adults

Summary of this inspection

Background to Ash House Rehabilitation Unit

This high dependency rehabilitation hospital houses adults with complex mental health diagnoses. It provides accommodation with 24 single occupancy rooms, all with en-suite washing and lavatory facilities. However, the provider has decided that they will take in a maximum of 18 patients. The building operates on three floors. At the time of the inspection, only the ground floor and the first floor were in use by patients. The second floor was not in use.

At the time of the inspection, there were five patients resident at the unit.

The service had a nominated individual in place at the time of the inspection. A nominated individual is a senior person who acts as the main contact with CQC. However, there was no registered manager in place. The intended registered manager had not yet submitted an application.

The regulated activities for Ash House are assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

CQC has carried out two previous inspections of this service. We conducted a comprehensive inspection in November 2016, We rated the hospital as inadequate with breaches of six regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014:

- Regulation 9 Person centred care
- Regulation 12 Safe care and treatment
- Regulation 16 Receiving and acting on complaints
- Regulation 17 Good governance
- Regulation 18 Staffing
- Regulation 19 Fit and proper persons employed.

We served a notice of proposal for breaches of two regulations and issued requirement notices for breaches of four regulations. We also placed the hospital into special measures.

The provider worked with us and with commissioners to improve. We monitored progress through regular telephone calls and engagement meetings.

We withdrew the notice of proposal following our responsive inspection of 10 March 2017.

At this inspection, we found that the requirement notices had been met.

Our inspection team

Team Leader: Richard O'Hara, inspector, Care Quality Commission.

The team comprised one inspection manager, two inspectors, a Mental Health Act reviewer, and a specialist advisor (pharmacist).

Why we carried out this inspection

The service was placed into special measures following a comprehensive inspection in November 2016. Services placed in special measures are followed up within six months of the publication of the decision to assess progress and determine whether special measures can be lifted.

This inspection was unannounced and comprehensive.

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?

Prior to the inspection visit, we reviewed information that we held about the location, spoke with commissioners, and asked a range of other organisations for information.

During the inspection visit, the inspection team:

- visited and reviewed all three wards, although only one ward was being used
- looked at the quality of the environment and observed how staff were caring for patients
- spoke with two patients
- spoke with the nominated individual, as there was no registered manager, and the nurse in charge of the unit at the time of the inspection
- spoke with six other members of staff, including an occupational therapist and the Mental Health Act administrator
- looked at all five patient care and treatment records
- observed a relaxation session for a patient
- observed a full medicine round
- observed an education session on post-discharge considerations.
- carried out a specific check of medication management
- carried out a specific check of Mental Health Act policy and management
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

There were only two patients out of five present at the time of inspection. They told us that building was always clean, and that patients were encouraged to clean up after themselves. They told us that patients felt safe, and that staff always had time to take patients out on leave.

A patient told us that he did not feel as aggressive since moving to Ash House, and that staff looked after his physical health care as well as his mental health. Both patients told us that care plans were given to patients, and they were written with input from the patients.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The building had blind spots that were adequately mitigated to reduce the risk of harm to staff and patients.
- Staff knew the location of emergency equipment and were trained in its use.
- The service had an environmental ligature risk assessment in place.
- Staff received appropriate induction training.
- Patient risk assessments accurately identified patients' risk to self and others.
- Safeguarding referrals were being made when necessary to the local authority.
- Medication management was in place and audited.
- Disclosure and barring service checks were completed on staff before they began employment within the service.

However,

- Patients did not have free access to outside space, which was overly restrictive for a mental health rehabilitation service.

Are services effective?

Requires improvement

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

- We saw that there were no associate hospital managers to the service, so if a patient decided to appeal against their section, there was no hospital manager to hear their appeal. This was in breach of the Mental Health Act Code of Practice.
- Mental Capacity Act training had been attended by only 25% of staff, and Mental Health Act Awareness training had been attended by only 25% of staff.

However,

- Care plans were found to be updated, personalised, and holistic. There was evidence that patients were being given a copy of their care plan, or offered a copy.
- Physical health care needs were documented and recommendations made regarding actions.
- The service had recruited a psychotherapist who gave two morning sessions per week, and we saw evidence that psychological input had been included in care plans.

Summary of this inspection

- The service had introduced a rating scale to measure the outcomes and progress of the patients from admission to discharge.
- Staff supervision was taking place; this was monitored by a staff member.
- Handovers were seen to be effective and carried relevant information to staff.
- Multi-disciplinary team meetings were held at appropriate times with relevant staff in attendance.
- Mental Health Act documentation was being monitored by an administrator, although the inspection team felt that further support was required.
- Staff were able to discuss the Mental Capacity Act, and there was evidence of capacity being considered within care records.

Are services caring?

Good

We rated caring as **good** because:

- The service had a regular patient meeting that was attended by patients, and minutes were taken and shared. Patients were treated with kindness and respect.
- We saw positive interactions between patients and staff.
- There was regular access to an independent mental health advocate for patients
- Patients told us that staff were always caring and considerate of their needs.
- We saw evidence that patients were involved in decisions and considerations for discharge.
- Patients had access to leaflets regarding treatments and their rights as detained patients.

Are services responsive?

Good

We rated responsive as **good** because:

- There was provision of structured activities within the service to aid patient recovery and rehabilitation.
- Patients could access their rooms at all times of the day, and had electronic fobs to access corridors allowing access to their rooms.
- The operational framework for the service gave clear admission criteria.
- Cultural and religious differences were recognised and given consideration.
- We observed a 'moving on' meeting involving staff and patients, where discussion took place regarding what to expect on discharge from the service.

Summary of this inspection

- We saw notices informing patients of the complaint process, along with complaint forms attached. The system was very easy to use.
- A patient complaint file, as well as a staff complaint file, was maintained at the service. We reviewed complaints from both files and found letters of response to complainants, evidence of investigation, and relevant actions.

Are services well-led?

Requires improvement

We rated well-led as **requires improvement** because:

- Although policies and procedures had been drafted for the service, many of the policies had yet to be made available to staff at the time of the inspection.
- At the time of the inspection, there was no registered manager at the service.

However,

- During the inspection in November 2016, there was no evidence of any vision or values in place at the service. At this inspection, the new chief executive officer for the service had helped develop visions and values and had incorporated them into the new operational framework.
- There was evidence of senior management oversight at the service.
- We saw that a risk register had been put in place, and was up to date and comprehensive.

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.

Mental Health Act training was mandatory at the service. Mental Health Act documentation was being maintained and was up to date and correctly completed. Detention paperwork was stored appropriately, with copies of relevant documents attached to medication cards.

There was a Mental Health Act administrator for the service. The administrator had a system that allowed them to monitor relevant dates and actions required under the Mental Health Act for patients.

There were no associate hospital managers for the service, as required under the Mental Health Act Code of Practice.

However, at the time of the inspection documents showed that only 25% of staff had received Mental Health Act training.

Mental Capacity Act and Deprivation of Liberty Safeguards

Mental Capacity Act training was mandatory at the service, however only 25% of staff had completed the training. Staff we spoke to had an understanding of the principles of the Act, and how to apply them.

We saw evidence that capacity was being considered in the care records of the five patients at the service. There was no evidence of best interest meetings; however, the care records of the five patients at the service gave no indication that this was required for them.

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	Requires improvement	Good	Good	Requires improvement	Requires improvement
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

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

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

Good

Safe and clean environment

The hospital had three wards that were based over three floors. Chaucer ward was based on the ground floor and could accommodate up to eight patients in single en-suite bedrooms. However, this was not in use at the time of the inspection. Blake ward was based on the first floor and could accommodate up to eight patients in single en-suite bedrooms, and was in use at the time of our inspection to accommodate the five patients admitted to Ash House. Tennyson ward was based on the second floor and could accommodate up to eight patients in single en-suite bedrooms. Some of the rooms were being used as office space.

The lighting throughout the location was controlled by a motion detection system, meaning that if there was no movement within an area within a specified period the lights would automatically go off. The system had been adjusted since our last inspection for lights to remain lit longer, thereby limiting the chance that patients or staff would be left in an unlit part of the building.

Patient bedroom doors were left unlocked, and patients could access their rooms as they were issued with fobs that allowed limited access to sections of the building. There was a nurse call system in place, so nurses could be summoned for assistance in each room.

Access to door keys was available to all staff, so the doors of the unit could be opened by any member of staff. We noted the fence around the garden of the location had been increased in height to prevent patients from easily climbing over. The fence had a locked gate built in, secured with a combination padlock. During the inspection, staff were able to tell us the combination code and open the padlock.

Blind spots had been adequately mitigated by the use of shaped mirrors. The number of doors on corridors meant visibility was limited.

Some key rooms within the building were not identified with clear signage (such as bathrooms, kitchens, clinics and nursing stations). This could make it difficult for new staff, including bank and agency workers, and patients to navigate the building.

Ligature risks had been considered when the unit was built. A ligature point is something a person intent on self-harm may use to strangle themselves. There were three bedrooms on Tennyson ward with anti-ligature fittings, although we noted that the taps in two of the rooms were not anti-ligature. We were told these rooms would be used for patients assessed as being at risk of self-harm. They were not in use at the time of our inspection as none of the patients had been assessed as being at risk of serious self-harm.

A full ligature risk assessment had been carried out for the building. We would not necessarily expect a rehabilitation service to remove all ligature points, as patients will be preparing for discharge to the community. However, it is important that ligature points are identified to staff so that they can be considered as part of individual risk assessments. Patients were only able to access rooms with identified ligature risks under staff supervision.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Telephone access on each of the wards was in place, which meant that staff could access outside help in an emergency. Staff also had the use of hand-held radios for contact, due to the size and design of the location.

At the time of the inspection, the service only had male patients, so facilities provided were not measured against current Department of Health guidance regarding mixed-sex accommodation.

We saw evidence of infection control practice, with the use of hand gels, and the clinic rooms were clean. There was an infection control policy in place.

All three floors had a separate clinic room. Since the last inspection, wash basins were fitted in each room, with elbow taps fitted to improve infection control. Flooring in the clinic rooms had been changed to meet with required standards, also for easy cleaning and infection control. Only one clinic room was active at the time of the inspection, the clinic room on Blake ward.

The active clinic room was equipped with an electronic baseline physical observation machine and thermometer. Clinic rooms had fridges to store medications that required temperature controlled storage. Fridge temperatures were monitored regularly. Clinic rooms had air conditioning to ensure that room temperatures were maintained, and these temperatures were recorded regularly. First aid bags were available in clinic rooms, their contents up to date. Ligature cutters were kept in clinic rooms. As well as a clinic room, the ground floor had a bedroom converted into a GP examination office, fitted with examination couch and examination equipment for eyes and ears. The provider had a service level agreement in place with a local GP for patients to be seen weekly by the GP, or as required.

There was access to a defibrillator machine, a suction machine, and emergency oxygen that was easily accessible to staff. The oxygen was in date, as was the relevant attached equipment. Staff knew where the equipment was and how to access it. A defibrillator sign showing that a defibrillator was now available on both ground and second floors had been placed by the main door to the building.

Induction training was in place for all staff at the service. Data from the provider showed that staff were given appropriate induction training for the service.

A legionella risk assessment had been completed, and we saw evidence that room water temperatures were being monitored in accordance with national guidelines.

There were no controlled drugs kept at the service. Medication was blister packed for each patient and was colour coordinated for morning, afternoon and evening medication. A new contract had been agreed with a national pharmaceutical provider, and the pharmacy provided support to the service, should it be required.

All ward areas were clean and tidy. Furniture was new and well maintained. The kitchen was clean and fridge temperatures were recorded and noted to be within the acceptable range, however there had been no update to temperatures on the recording chart for the two days prior to the inspection. A cook had been brought in to prepare food for patients. There was a separate fridge for patients who might require halal food.

Safe staffing

Staffing levels at the time of inspection were adequate for the number of patients admitted to Ash House.

Data provided by the director of business development showed there were three permanent registered mental health nurses employed, with a vacancy for another qualified nurse. There was one senior support worker, eight full time permanent support workers, five permanent part time support workers, and two bank support workers who were waiting to take on a full time role. There was one domestic assistant employed for 25 hours a week, with one permanent cook in place and another waiting to start. Food was prepared at weekends by an agency cook until the new staff member started. The unit worked with one registered mental health nurse to cover the day shift with three support workers, and one qualified nurse and three support workers for the night shift. At the time of the inspection, night shifts were being covered by an agency nurse, as the nurse who normally covered nights had left the service. Agency nurses were regularly used, and the same staff were normally requested to work on the unit.

We saw evidence that handovers were occurring, with relevant information relating to patients being communicated between staff.

One to one time with patients was regularly available and recorded, due to the small number of patients admitted to the unit. We saw evidence of activities that patients had

taken part in. We were told that leave for patients was not cancelled due to the staff numbers; at the time of the inspection there were three patients off the ward on leave with staff. The provider could cover for staff should they ring in sick, as staff from other locations owned by the provider could cover if necessary.

The responsible clinician supplied psychiatric cover out of hours for the service. The responsible clinician did part time sessional working of five sessions each week; this was due to the limited number of patients at the service. This would increase as patient numbers increased. If there was a medical emergency, the patient would be taken to the accident and emergency department.

Mandatory training figures supplied by the service showed that almost every member of staff had an induction, however, there were no dates to show when the induction took place; the data just indicated training was undertaken. The service had placed emphasis on training, and on the noticeboard in the foyer we saw a training notice for staff that showed anaphylaxis first aid training and Mental Health Act Awareness training scheduled, as well as a restrictive physical intervention course and breakaway training.

Assessing and managing risk to patients and staff

We reviewed five patient risk assessments. Risk assessments were up to date for all five patients, although the risk assessment for one patient did not adequately reflect an increase in self-harming ideation noted in a multi-disciplinary team meeting. Management plans were clear and comprehensive. Leave forms were being completed and were noted to reflect risks to staff and actions to be taken. There was evidence that speech and language therapy recommendations for patients at risk of choking were being followed. There was a clinical risk assessment and management policy in place that had recently been updated.

There was an observation policy in place. The nurse in charge of the ward at the time of the inspection was aware of the policy and could talk through it. Observation levels were rated from level one general observation up to level four one to one observations, level four being observed within arms' length. Data showed that 70% of staff had 'pat-down' search training in relation to patients, with new members of staff awaiting training. We were told that searches would only be conducted where staff had 'intelligence' suggesting it was necessary. We saw evidence in care records of patients being searched for drugs after leave. The search was based on an individual risk assessment and fully recorded.

There was a policy regarding managing violence and aggression from patients. We saw evidence that staff were undertaking restrictive physical intervention course training, and that a number of staff were due to complete the training the week following the inspection. We saw that breakaway training had also been arranged for staff. At the time of the inspection, there had been no incidents requiring restraint, and we were told that verbal de-escalation was used to good effect with patients.

There was a safeguarding policy in place at the unit. Staff noticeboards and offices had copies of safeguarding routes to be followed in the event of an incident. The nurse in charge at the time of the inspection was aware of the policy and could discuss it knowledgeably. We saw that safeguarding authorities were aware of any problems at Ash House. There had been no safeguarding alerts raised by the staff of Ash House since the previous inspection.

The action plan dated 24 March 2017 regarding breaches from the previous inspection stated that there would be no use of rapid tranquilisation in the service. Patients who may require rapid tranquilisation as part of their care would not be accepted in to the service.

Medication was provided by agreement with a new local pharmacy. We saw that medication audits were carried out both daytime and evening by a trained nurse. Audit sheets were maintained in medication files in the clinic. We saw evidence that prescribing of medication was following best practice, with improvements in the monitoring, recording, and maintenance of records. The administration of clozapine and the monitoring of physical health was being carried out.

There was a comprehensive list of prohibited items on a notice near the front door to the unit, aimed at visitors to the unit. Most restrictions for patients were individually considered and noted in care records. However, there was no free access to an outdoor space. Access to the garden area was through a door from the main ground floor lounge area, and this door was secured and required staff to open the door to go out and to come in. Access to the outdoor area was allowed with support from staff. Care

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

plans considered whether a patient could go in the outdoor area on their own. The restriction on access to outdoor space did not promote recovery, and was contrary to the ethos of a mental health rehabilitation hospital.

Pre-employment checks had been carried out in regards to staff, and disclosure and barring service checks were all in place.

Track record on safety

At the time of the inspection, there had been no notifications of serious incidents at Ash House since the inspection in November 2016. There was one on-going police investigation into an incident that occurred prior to the November 2016 inspection.

Reporting incidents and learning from when things go wrong

An incident report file was maintained by the service. When an incident occurred, the report book had an entry made and verbal information passed to management. Incident reporting was an agenda item for the senior management team. Feedback would be given to staff through team meetings, multi-disciplinary team meetings, and through training and development. Any member of staff could report an incident. Policy stated that incidents should be investigated within 14 days, and feedback to be given to relevant parties.

We reviewed the incident report file for 2017. We compared incidents against care records and there were incident forms completed for each incident. The file did not contain actions decided at the senior management team meetings. However, we saw senior management team minutes for 3 March 2017 that outlined incidents and actions to be taken.

We saw that a member of staff had been suspended over an incident, this had been investigated and learning passed on.

Duty of Candour

There was a duty of candour policy in place that had been recently updated at the time of inspection. We saw no evidence of duty of candour being implemented; there were no reported incidents that required its use. Senior staff were aware of the duty of candour.

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

(for example, treatment is effective)

Requires improvement

Assessment of needs and planning of care

We reviewed care records for all five patients at Ash House. Care plans were found to be updated, personalised, and holistic. There was evidence that patients were being given a copy of their care plan, or offered a copy. We saw written evidence that a patient had refused his copy of the care plan. Physical health care needs were documented and recommendations made regarding actions, however, it was not always clear that this was being acted on. Four of the five records did show evidence of on-going physical health care, but the care plan for a patient with epilepsy did not contain the level of detail required to meet National Institute for Health and Care Excellence guidelines for epilepsies: diagnosis and management. This meant that staff might not be fully aware of how to manage the risk of seizures.

As there had been no new admissions since the previous inspection, we could not assess how the assessment criteria for new patients worked in practice. The new operational framework for the service showed that on referral there would be a pre-admission assessment meeting, with all referrals being discussed in a multi-disciplinary team meeting within 72 hours (three working days). A decision would be provided within 24 hours of the meeting. This could include a visit by the clinical assessment team before a final decision was made to decline or accept a referral. The operational framework outlined the process from referral to discharge. The framework was clear and manageable.

Care plans had a patient hospital passport at the front of each care record, an easily accessible summary of patient details. However, the passports were not signed, nor did it identify an author. Care plans had clearly improved since the previous inspection in November 2016, with evidence of patient involvement in goals. Three care plans were

signed by patients, one had refused, and one was not signed. Therapeutic plans were in place in all records, patients who were not really engaging had clearly been offered input.

Current patient care records were stored securely, with access for staff should it be required. Copies of Mental Health Act paperwork were now attached to care records. Archived records were kept in the office of the occupational therapist, and could be accessed by staff if required.

Records were stored on paper, although we were told that a computer system was being considered. Files were kept secured in a nursing station.

Best practice in treatment and care

The service's new operational framework referred to guidance from Royal College of Psychiatrists and the National Institute for Health and Clinical Excellence. We saw that guidance relating to medication management, schizophrenia and depression was available and considered during the inspection.

We had recently checked pharmacy records in a focused inspection on 10 March 2017, and they were found to be in order. We checked records again on this inspection, as well as observing a medicine round for administration of medication. We checked stock audits and they were in good order. Copies of capacity to treatment and consent to treatment forms were attached to folders for each patient. Medication errors were being recorded, reported and acted upon.

The service had recruited a psychotherapist who gave two morning sessions per week, and we saw evidence that psychological input had been included in care plans. Care plans included activity sessions, with a weekly session timetable outlining relaxation sessions, educational sessions, healthy lifestyle groups and other activities to promote independence and preparation for return to the community. We saw more input from the occupational therapist in care records. We observed a relaxation session designed for one of the patients.

There was a service level agreement in place with a general practitioner, to visit the service weekly to look after patients' physical health needs. The operational framework stated that within 10 days of admission, a physical healthcare check would be carried out by the GP. As the service had taken no new admissions since the November inspection, this had not yet been put into practice. A room had been specifically adapted and equipped for this action to take place.

The service was using the Model of Human Occupation Screening Tool as a means to measure outcomes. We saw evidence of discharge planning in care records, with activity sessions aimed at preparing patients for eventual discharge back into the community.

A clinical audit tool had been put in place for the occupational therapist. A nurse told us that they had been asked to undertake medicine audits, and we saw evidence in the clinic of audits being undertaken. We were told that delegation of further clinical audits was being considered for staff.

Skilled staff to deliver care

The service employed a range of mental health disciplines, including psychiatry, occupational therapy, psychotherapy, nursing and support workers. The psychiatrist still only visited the service two days a week, but in view of the limited patient numbers, the service considered this adequate. As patient numbers increased, the psychiatrist would increase his time at the service until full-time hours were needed. The occupational therapist was offering significantly more therapeutic time to patients compared to what we observed in our inspection of November 2016. The psychotherapist did two mornings of work a week, again in view of patient numbers.

At the time of the inspection, Mental Capacity Act training was poorly attended, with only 25% of staff having attended the training, and 26% attending Mental Health Act Awareness training Only 26% of staff had completed basic first aid training, and compliance with advanced first aid was 28% (with training scheduled for six more staff in May 2017). Other mandatory training subjects were over 75% complete, or had dates in place to complete the training.

The pharmacy that supplied medication had completed an audit of the service two weeks before the inspection. No significant problems were identified.

Leadership training had been made available, and the nurse in charge of the ward at the time of the inspection told us that she had attended two management courses since starting work at the service. We saw evidence that supervision and appraisals were taking place, and that

group supervision was taking place and recorded in minutes of team meetings. A nurse told us that in the short time she had been working at the service she had received supervision from a manager.

There were processes in place to deal with staff performance issues.

Multidisciplinary and inter-agency team work

Regular multidisciplinary team meetings were taking place and notes were placed in care records. There was evidence that all disciplines of the service were attending the meetings, however, there was little evidence of external care coordinators for patients attending the meetings. We saw evidence of relevant clinical commissioning group interaction. Staff told us that they had difficulty getting care coordinators to attend the meetings, but that the responsible clinician had stated he would ensure future attendance. Multidisciplinary team notes were comprehensive.

We saw that a new handover sheet had been introduced since the inspections in November 2016, and the information within was more suited to sharing information. The nurse in charge was able to give us a detailed account of patients' Mental Health Act status, risks and any issues that needed to be acted upon during that shift.

As a result of the inspections in November 2016, clinical commissioning groups and local authority safeguarding teams had actively encouraged better links with Ash House. We were aware from liaison with other stakeholders and regulators that liaison was being maintained.

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

Mental Health Act Awareness training was part of the mandatory training regime for Ash House. However, data provided by the service showed that only eight of thirty staff members, or 26% of staff, had completed the training. We saw further training had been arranged for the week of 19 April 2017 and 27 April 2017 for another eight staff. Staff we spoke to had a better understanding of the Mental Health Act than during the inspections in November 2016.

Mental Health Act documentation was being monitored and was present in each care record we viewed. The correct documentation was also attached to medication files in the clinic.

A full review of the adherence to the Mental Health Act was carried out on this inspection. We found that the Mental Health Act Administrator for the service had recently attended a two-day course that stressed Mental Health Act law and application. The administrator had also signed on to the Mental Health Law Online group. Additional support from a local mental health trust was available to the administrator, but only at his request.

The administrator had set up a process whereby they were able to track when sections were due for renewal, consent to treatment was due, as well as referrals to Mental Health Act tribunals. This included weekly reminders to the responsible clinician for actions that needed to be taken under the Mental Health Act.

The five patients' legal files were reviewed and a number of small errors were noted, but dealt with at the time of inspection. We saw that there were no associate hospital managers to the service, so if a patient decided to appeal against their section, there was no hospital manager to hear their appeal. This was against the Code of Practice, section 38.12. However, in discussion with the chief executive officer, we were told that the associate hospital manager for the service had resigned after the inspections in November 2016. We were told that the responsible clinician was hoping to arrange for associate managers attached to a local mental health trust to accept the role by the end of April 2017. After the inspection we noted that associate managers had been identified and were in agreement to link to the service.

We saw notices that informed patients of how to access advocacy, and the service had entered into a contract with a regional advocacy service to provide a service. An advocate attended the service on a weekly basis. The advocate would attend the weekly patient forum, and be available to patients for questions and advice.

Good practice in applying the Mental Capacity Act

Mental Capacity Act training was included in the mandatory training for the service. The training matrix provided by the service showed that only 25% of staff had completed the training. The staff numbers had increased since the inspections in November 2016, but training in the Mental Capacity Act seemed to have stopped. Staff we spoke to did have knowledge of the principles of the Act.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

We saw evidence of consideration of mental capacity in the five care records reviewed. Where capacity was limited, there was evidence of recording and consideration by the responsible clinician.

We saw no evidence of best interest meetings for patients at the service. However, on review of care records of the small patient base, there was no evidence that the patients at the service required a best interest meeting prior to the inspection. There were no patients being detained under a Deprivation of Liberty Safeguarding decision.

We were not able to discern if there was a central point of contact if advice was required. Staff told us they would go to the Mental Health Act administrator for advice. The operational framework for the service stated that a "social worker" would take the lead on capacity issues, but we are not aware of a social worker employed by the service in that role.

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

Good

Kindness, dignity, respect and support

We observed positive interactions between staff and patients. Staff treated patients with dignity and respect.

We spoke to two patients who told us that staff were caring and genuinely took an interest in the individual needs. A patient told us that he never felt staff put him under any pressure to take part in groups or sessions, but he knew about them and could attend or leave the session if he wanted.

Patients said they were happy that they could lock their doors and go in and out of their rooms when they wanted. We were told by one patient that he felt that he would be ready to leave the service soon, and was participating in sessions to make sure he was ready when he went back to the community.

A patient told us that the location was always clean, and that they were encouraged to take care in maintaining their own bedrooms. Patients told us they felt safe in the location, and there was always a staff member to talk to. We were told that staff always knocked and asked if they could come into a room, and patients felt respected.

There were no carers available to speak with us during this inspection.

The involvement of people in the care they receive

The service had a regular patient meeting that was attended by patients, and minutes were taken and shared. The minutes were signed by patients, and attended by an independent mental health advocate. We saw minutes on noticeboards. We saw evidence of patient input into care plans and their opinions recorded in multi-disciplinary meetings.

There were leaflets and noticeboards holding information regarding treatment or patient rights. The noticeboards held information on how to complain about the service. Patients were not directly involved in decisions about the service, however their opinions about the service were noted in minutes of the patient meeting.

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 had been no new admissions to the service since the inspection in November 2016, as part of the mutual agreement with the service and commissioners. Since then, the new operational framework for the service stated that a multidisciplinary team meeting would be held within 72 hours of receipt of a referral. A verbal response to the referring body would be made within 24 hours of the team meeting, followed by a visit to the service for the patient should they be accepted. On admission, a welcome pack that assessed medication and detention paperwork would be completed within eight hours, and a full review of admission paperwork including care plans would be completed within 24 hours of admission. The patient would be booked in to see a GP for a full physical examination within 10 days of admission.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

The new operational framework described a minimum stay of nine months and a maximum of four years, three months. There were three 'phases' of the journey from referral to discharge: 'assessment and stabilisation', 'core treatment and social learning' and 'resocialisation and transition' back into the community. There was a clear focus on recovery throughout.

There was a specific inclusion and exclusion criteria in place. The framework clearly stated that each case would be individually considered before a decision would be made. The criteria were considered appropriate for a rehabilitation service. However, as the service has not admitted any new patients since our last inspection, we were unable to see whether these criteria were being applied in practice.

There was adequate space in the location to move a patient from one ward to another, should it be required. Discharges prior to the inspection had taken place during working hours. There was no evidence that any discharge from the service had been delayed at the time of the inspection.

We observed a 'moving on' meeting involving staff and patients, where discussion took place regarding what to expect on discharge from the service.

The facilities promote recovery, comfort, dignity and confidentiality

Patients could access their bedrooms during the day. Patients had access to electronic fobs that allowed limited corridor access, allowing patients to move about in a particular area without staff involvement. There were nurse call buttons in each bedroom.

Mobile phone access was assessed for each patient on admission. Care plans showed consideration for mobile phone access, and outlined when and where phones could be used by the patient. Patients were allowed to personalise their bedrooms, if they chose to.

Activities within the service had improved since the inspection in November 2016. The use of an occupational therapy assistant had meant planning and provision of activities was much more prevalent. The sessions provided were meaningful. Even though there was a limited number of patients, the activities were seen to be promoted and would occur even if only one patient was interested.

Patients could make their own hot drinks during the day. Patients could also access a kitchen to make drinks and snacks during the day, the kitchen being locked to patient access between midnight and six in the morning. If drinks were required during the night, staff would provide them for the patients.

Meeting the needs of all people who use the service

There was a lift in place, to assist in reaching all floors in the building, but this required access by staff. Toilets and bathrooms had equipment such as handrails to assist patients with limited mobility, as well as adapted baths. The new exclusion criteria for the service stated that people with significant physical health co-morbidities would not be admitted to the service.

The service had noticeboards with information regarding services and treatments, with leaflet racks containing leaflets available.

Religious considerations were in place, with a prayer mat and a compass allowing the direction to Mecca to be noted for Muslim patients. We were aware that previous patients had been offered the chance to attend a mosque. There was a fridge in the kitchen that allowed halal food to be kept separately.

Listening to and learning from concerns and complaints

During the inspection in November 2016, we had no evidence of any complaint procedure or policy. During this inspection, we saw notices informing patients of the complaint process, along with complaint forms attached. The system was very easy to use. A patient complaint file, as well as a staff complaint file, was maintained at the service. We reviewed complaints from both files and found letters of response to complainants, evidence of investigation, and relevant actions. The aim of the service was to act on formal complaints within 14 days. Informal complaints were dealt with as and when made.

We tracked one complaint from December 2016, noted that the complaint had been acknowledged, there was an investigation, staff interviews, and a final decision. The process was complete and kept both staff and patient informed throughout.

Long stay/rehabilitation mental health wards for working age adults

Requires improvement

Minutes from the senior management team meeting on 3 March 2017 showed incidents, accidents and complaints were discussed with decisions regarding learning to be passed back to staff.

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

Requires improvement

Vision and values

During the inspection in November 2016, there was no evidence of any vision or values in place at the service. At this inspection, the new chief executive officer for the service had helped develop visions and values and had incorporated them into the new operational framework. The service values were based on the 'Enabling Environment' initiative, and the 'Psychologically Informed Planned Environments initiative. This involved creating a feeling of belonging, boundaries, communication, development, involvement, safety, structure, empowerment, leadership, and openness. The nurse in charge of the service on the day of the inspection said she was aware of these values, and could broadly discuss them.

Since the inspection in November 2016, the employment of a new chief executive officer and director of business development had led to senior management oversight at the service, with both of these staff members spending at least two days a week at the service. Staff we spoke to knew both of these senior staff members.

Good governance

During the previous inspections in November 2016, we found poor governance systems at the service, and this had an effect on the overall safety and quality of the service for both staff and patients. During this inspection, we saw that new governance systems were in place, but the small number of patients meant that the systems had not yet been fully implemented or tested.

However, at the time of the inspection, there was no registered manager at the service, and no application for a new manager put forward for registration. We were told that an application was in progress, but they were awaiting the result of a disclosure and barring service check for the applicant. There was no registered manager for the role since the inspection in November 2016. A new manager for the service had been recruited in January 2017 to take on the role of manager and registered manager, but they left the service within weeks of starting the post. We were told that, due to the special measures, it was difficult to recruit a new manager to be the registered manager.

There was no display of the ratings from the inspections in November 2016. We checked the website for the provider, and there was a link to the Care Quality Commission report showing the ratings. However, there was no indication of the ratings at the service. This was a clear breach of the regulation. We also noticed that the certificate of liability insurance that was displayed was out of date. On being informed, staff stated that the new certificate was available, and changed it immediately.

We saw that a risk register had been put in place, and was up to date and comprehensive. It was clear that there was a more knowledgeable and professional approach to the running of a mental health rehabilitation service. The senior management team told us that they planned to write or rewrite103 service policies. A number of new policies, while written, had yet to be ratified and put into place, so staff were unaware of them. We reviewed the medication policy, complaints policy, admission and discharge of patients from hospital policy, risk assessment register, and the ligature point risk assessment. The documents we reviewed showed that all aspects of the service were being considered with a view to improvement.

The chief executive officer stated that key performance indicators had just been developed for the service, which included audit of staff training, leave, incidents, safeguarding incidents, and financial and non-financial impact. However, these had yet to be introduced at the time of the inspection. We were told that these indicators would monitor and guide the service forward.

A clinical governance group had been set up, and we saw minutes from the meeting on 27 February 2017. The minutes outlined the route for ensuring better clinical governance within the service. This included the recommendation that a patient be invited to sit in the group in the future.

We saw minutes of health and safety meetings that considered risk assessments and safe systems at work; the minutes dated 20 March 2017 included discussion of a

health and safety audit that had been carried out. We saw evidence that the Mental Health Act and its application was being discussed at senior management team level, and passed on to staff at team meetings. Staff were told to actively encourage patients to use their authorised leave from the service. The senior support staff meeting minutes dated 16 January 2017 showed discussion about Mental Health Act updates.

Mandatory training was being monitored, and was to be included in the new key performance indicators. The occupational therapy assistant monitored supervision rates and ensured that supervision was up to date, as was noted in minutes of the senior management team meeting on 3 March 2017.

Medication was being audited within the service as well as by the pharmacy that was supplying the medication for patients.

The Mental Health Act was being adhered to and monitored by the Mental Health Act administrator for the service, although it was apparent that further support was necessary in order for the role to be carried out effectively.

Staff could submit items for consideration to be included in the risk register. Staff said that they felt more supported by senior management.

Leadership, morale and staff engagement

Staff told us they felt they could raise concerns to management, they felt their concerns were considered. Staff we spoke to said they felt good about their job, and that the working environment and atmosphere was much improved.

Staff morale was better than during the inspections in November 2016. They felt that they were better trained, with more opportunities. Staff did mention that the current patient numbers meant that they felt they could do more with patients.

Commitment to quality improvement and innovation

We were told that the service had contacted the quality network for the Royal College of Psychiatrists and were submitting an application with visits to be arranged in the second quarter of 2017.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that staff are sufficiently trained to fully understand their duties under the Mental Health Act and Mental Capacity Act.
- The provider must ensure that a registered manager is in place in adherence with requirements of the Regulations.
- The provider must ensure that policies and procedures necessary for good governance of a service are reviewed and in place.
- The provider must ensure that its managers consider exercising their power of discharge when receiving reports renewing the detention of patients.

Action the provider SHOULD take to improve

- The provider should ensure that it appoints a panel independent of people who are on the staff of the hospital or who have a financial interest in it for this purpose.
- The provider should ensure that care plans for patients with specific health conditions such as epilepsy are sufficiently detailed for staff to be able to deliver safe care.
- The provider should review the restriction on access to outdoor space and ensure they are able to meet individual patients' needs without impacting on those who are lower risk.

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
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 8 HSCA (RA) Regulations 2014 General **How the regulation was not being met:** **There was no registered manager at the service at the time of inspection, nor had an application been submitted at that time.** **This was a breach of regulation 8 (1).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **How the regulation was not being met:** **Policies and procedures had been prepared for the service but had not been assessed and made available to staff at the time of inspection.** **This was a breach of regulation 17(1).**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met:**

This section is primarily information for the provider

Requirement notices

The provider did not ensure that persons employed by the service provider received appropriate training in the Mental Capacity Act and the Mental Health Act to carry out the duties they are employed to perform.

This was a breach of regulation 18(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: The provider did not have any hospital managers, which meant that it could not fully meet the requirements of the Mental Health Act. This was a breach of regulation 11(4).