Ash House Rehabilitation Unit

Quality Report

Norris Street
Warrington, WA2 7RP
Tel: 01925 240525
Website: www.krinvestcaregroup.co.uk

Date of inspection visit: 19 January 2018
Date of publication: 16/04/2018

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 undertook this focussed, unannounced inspection to find if Ash House had made improvements to their service since our last unannounced comprehensive inspection in July 2017.

When we last inspected Ash House, we found that two of the five key domains, effective and well-led, were deemed to require improvement, whilst the other three domains were rated as good. In completing this latest inspection, we considered that, based on information gathered during the period between inspections, caring and responsive domains remained rated as good. We reviewed three domains on this inspection: safe, effective and well-led.

We rated Ash House Rehabilitation Unit as good because:

- The service had met requirements with regard to breaches of regulation found in the inspection, report published in July 2017.
- The building had blind spots that were adequately mitigated by mirrors and equipment to reduce risk of harm to staff and patients. The service had an environmental ligature risk assessment in place, as well as individual risk assessments for each patient. Induction training was deemed appropriate and was completed across the service by all staff. Leave documentation for patients was audited. Patient risk assessments were holistic and up to date. Safeguarding was in place and audited. Medication management was in place and audited. All staff had a disclosure and barring service check that was electronically maintained and a copy kept in personnel files.
- Care plans were up to date, personalised and holistic. There was documented evidence that patients were being given a copy of their care plan, or offered a copy. Physical health monitoring was on-going at the service. There were comprehensive pre-admission criteria in place that was being followed. Patients were given time to access the internet by computer, as well as having access to their own mobile telephones after individual assessment. Mandatory training was taking place, and was audited by the service. Mental Health Act documentation was in order, and the new Mental Health Act administrator for the service was clearly knowledgeable about the subject. Ash House had five lay hospital managers who were involved with the service. Mental capacity of patients was being monitored and considered across the service.
- Policies and procedures that had not been tested on the previous inspection were embedded and seen to be working. Senior management oversight was present and noticeable at the service. There was a full and comprehensive risk register at Ash House. Policies at Ash House were in place and were relevant to the service. Key performance indicators were in place, and we saw evidence in minutes of meetings that these were used to gauge and enhance performance. Staff felt that morale was much higher, and felt that they had a voice in the service.

However:

- while staff told us supervision was regularly taking place, data supplied by the service was not up to date.
- Proactive referral to the independent mental health advocate was not being recorded when patients did not understand their rights.

Summary of findings

Contents

Summary of this inspection

Page

Background to Ash House Rehabilitation Unit 5

Our inspection team 5

Why we carried out this inspection 5

How we carried out this inspection 6

What people who use the service say 6

The five questions we ask about services and what we found 7

Detailed findings from this inspection

Mental Health Act responsibilities 9

Mental Capacity Act and Deprivation of Liberty Safeguards 9

Overview of ratings 9

Outstanding practice 19

Areas for improvement 19

Good

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 and personality disorders. It provides accommodation with24 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 for patients, although the rooms were being used as offices.

At the time of the inspection, there were seven 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 as the registered manager had recently resigned from post. The service had submitted relevant notices and documentation regarding the situation, and the recruitment of a new registered manager was in hand. Subsequent to the inspection, the service had recruited a new registered manager, and all relevant applications and notices were submitted to the Care Quality Commission in a timely manner. We were told that the nominated individual for the service was the controlled drugs accountability officer.

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 three 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:

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 engagement meetings and liaison between the service and other commissioning bodies.

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

At the most recent inspection reported in July 2017, we noted an improvement in the service. However, we rated the service as requires improvement, with requirement notices for the following breaches:

- Regulation 8 HSCA 2008 (Regulated Activities) Regulations 2014 General
- Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014 Good governance.
- Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2014 Staffing
- Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Consent to treatment

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

Our inspection team

Team leader: Richard O'Hara

The team that inspected the service comprised three CQC inspectors and a specialist advisor in the field of occupational therapy.

Why we carried out this inspection

We inspected this service as it had previously been placed in special measures in 2016, and rated as requires

Summary of this inspection

improvement in a report published in July 2017. We followed up within six months of the publication of the report to assess progress and determine if improvements had been made. The inspection was unannounced and focused on the safe, effective and well-led domains.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following three questions of the service and provider:

- Is it safe?
- Is it effective?
- Is it well-led?

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

During the inspection visit, the inspection team:

- visited all three wards at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients;
- spoke with four patients who were using the service;
- spoke with the unit manager and chief executive officer for the service;
- spoke with five other staff members; including nurses, an occupational therapist assistant, and health care assistants;
- reviewed three personnel files;
- spoke with the Mental Health Act administrator and reviewed Mental Health Act procedures;
- looked at five care and treatment records of patients;
- carried out a specific check of the medication management on all wards, including a review of five sets of medication records; and
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

We spoke with staff and patients at Ash House Rehabilitation Unit. Patients told us the service was always clean and tidy, staff were always available and ensured the patients had leave when it was scheduled. Patients told us that they were regularly monitored for physical health needs, offered copies of their care plans, and knew how to make a complaint if deemed necessary. A patient told us they were fully involved in their care planning. Staff told us that they felt supported by senior management, morale was good, and they felt that the service had improved with new staff and changes to the service.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Good

We rated safe as good because:

- The building had blind spots that were adequately mitigated by mirrors and equipment to reduce risk of harm to staff and patients.
- The service had an environmental ligature risk assessment in place, as well as individual risk assessments for each patient.
- Induction training was deemed appropriate and was completed across the service by all staff.
- Leave documentation for patients was audited.
- Patient risk assessments were holistic and up to date.
- Safeguarding was in place and audited.
- Medication management was in place and audited.
- All staff had a disclosure and barring service check that was electronically maintained and a copy kept in personnel files.

Are services effective?

Good

We rated effective as good because:

- Care plans were up to date, personalised and holistic. There was documented evidence that patients were being given a copy of their care plan, or offered a copy.
- Physical health monitoring was on-going at the service.
- There were comprehensive pre-admission criteria in place that was being followed.
- Patients were given time to access the internet by computer, and had access to their own telephones after individual assessment.
- Mandatory training was taking place, and was audited by the service.
- Mental Health Act documentation was in order, and the Mental Health Act administrator for the service was clearly knowledgeable about the subject.
- Ash House had five lay hospital managers who were involved with the service.
- Mental capacity of patients was being monitored and considered across the service.

However,

- Whilst staff told us supervision was regularly taking place, data supplied by the service was not updated.

Summary of this inspection

- Proactive referral to the independent mental health advocate was not being recorded when patients did not understand their rights.

Are services caring?

Good

This domain was not inspected as it had been rated as good in the previous inspection in July 2017.

Are services responsive?

Good

This domain was not inspected as it had been rated as good in the previous inspection in July 2017.

Are services well-led?

Good

We rated well-led as good because:

- Policies and procedures that had not been tested on the previous inspection were embedded and seen to be working.
- Senior management oversight was present and noticeable at the service.
- There was a full and comprehensive risk register at Ash House.
- Policies at Ash House were in place and were relevant to the service.
- Key performance indicators were in place, and we saw evidence in minutes of meetings that these were used to gauge and enhance performance.
- Staff felt that morale was much higher, and felt that they had a voice in the service.

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.

- When we inspected Ash House in April 2017, we found that the hospital did not have sufficient numbers of associate lay hospital managers.
- On this inspection, we found that the hospital had recruited five hospital managers and there were now sufficient numbers of experienced associate lay hospital managers to ensure the hospital could meet its responsibilities.
- We carried out a routine Mental Health Act monitoring visit in November 2017. On that visit, we found overall adherence to the Mental Health Act and the Mental Health Act Code of Practice.
- We identified some shortfalls on that visit. On this inspection, we saw that the issues raised were addressed or had improved.
- The hospital had appointed a new Mental Health Act administrator who had developed an improved system for storing Mental Health Act documentation.
- We looked at five sets of Mental Health Act records relating to detained patients at Ash House on this inspection. The records we saw were well kept with the required Mental Health Act paperwork available.

However, on this inspection, we found that where patients did not understand their rights, records did not provide assurance that staff were referring patients proactively to the independent mental health advocacy service as required by the Mental Health Act Code of Practice.

Mental Capacity Act and Deprivation of Liberty Safeguards

Ash House mandatory training included training in the Mental Capacity Act. At the time of the inspection, 75% of staff had completed Mental Capacity Act training. Staff we spoke to had a good understanding of the Mental Capacity Act. We saw evidence of consideration of capacity in the five care records we reviewed. We saw no evidence of best interest meetings for the patient care records reviewed; however, there was no evidence in the records to suggest that a best interest meeting had been required for any patient.

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 unit had three wards, each situated on its own floor. Chaucer ward was based on the ground floor and could accommodate up to eight patients in single en-suite bedrooms. At the time of the inspection, one patient was using this ward, as he had been assessed by the responsible clinician as being best treated away from the other patients at that time, due to behavioural issues: he was allowed to be in other areas with other patients. Blake ward was based on the first floor and could accommodate up to eight patients in single en-suite bedrooms. At the time of the inspection, the six remaining patients were being accommodated on Blake ward. Tennyson ward was based on the second floor, and could accommodate up to eight patients in single en-suite bedrooms. A number of the rooms were being used as office space. There was also discussion of some of the rooms on Tennyson ward being refurbished as self-contained flats for patients deemed close to a return to the community.

The unit had parabolic mirrors (convex) situated around the wards to assist in visibility in potential blind spots. The design of the building and the number of doors on each corridor meant visibility was limited. Bedroom doors had windows fitted that could be used for observation purposes, but with the ability to be shaded for privacy.

The lighting throughout the location was being controlled by a motion detector system, meaning that if there was no movement within a specified period in a particular area, the lighting would automatically go off. Lights remained on for an extended period, ensuring that neither patients nor staff would find themselves in an unlit part of the building.

Each patient had their own room, with access to that room throughout the day. Patients were issued with an electronic fob that allowed limited access to parts of the building, negating the need to ask staff to open doors. There was a nurse call system in place in each room, allowing the patient to summon assistance if needed. 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.

There was an environmental risk assessment completed for the unit, this included ligature risks. A ligature point is something a person intent on self-harm may use to assist in choking themselves. We would not expect a rehabilitation unit to remove all ligature risks from a building, due to the necessity of preparation of patients for a return to the community. However, we would expect a full ligature risk assessment to be completed in order for staff (regular, agency or bank) to be aware of ligature risks, for consideration if a patient should have a relapse in their mental state.

The full ligature risk assessment for the building had been updated in January 2018, and was divided into single occupancy and multiple occupancy areas. Individual ligature risk assessments had been completed for all patients, and were all up to date.

Long stay/rehabilitation mental health wards for working age adults

Good

Ash House was clean and tidy throughout, with a weekly cleaning roster that was issued and recorded digitally. The roster was being regularly audited. The furniture was in good condition and appropriate in style and functionality. We saw evidence of infection control, including the use of hand gel dispensers, and a monthly audit was completed to monitor the effectiveness of infection control management. We saw that a deep-clean of the service had been organised later in 2018.

The service was admitting only male patients, so facilities provided were not measured against current Department of Health guidance regarding mixed-sex accommodation.

Patients at Ash House had access to a large, well-kept garden area that patients could access via the ground floor. The area was fenced with an emergency exit (a gate) secured by a combination lock (staff knew the combination).

Each floor had a functioning clinic room, although only the ground floor and first floor clinic rooms were in operation, due to patient numbers and patient accommodation spread. The clinic rooms were clean, and fridge and room temperatures were monitored and recorded. A room had been converted into an examination room on the ground floor. There was an examination couch for patient use, and examination equipment for eyes and ears. We were told that the GP registered for the patients would bring his own equipment, depending on the reason for visiting; there was a service level agreement for the GP to visit once a week or when requested.

Resuscitation equipment was checked and found to be in order, with evidence of regular checking noted. Medication was routinely checked by the pharmacy who supplied the medication to the service. Controlled drugs were checked, and the medication matched the record. Medication was all in date. Oxygen was in date, as was the equipment used in conjunction with the oxygen. Defibrillators were available, with signage directing towards storage locations. Legionella tests and water-related tests had all been carried out.

We saw evidence that all staff had completed an induction programme, with the dates recorded and audited.

Safe staffing

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

We were informed by the acting manager of Ash House that, at the time of inspection, there were four permanent registered mental health nurses employed at the unit, with a new nurse due to start, as well as a bank nurse who was employed by the service. Shortfalls in staffing were covered by bank and agency nurses. We were told that there were 15 health care assistants employed, with three new staff to start in the near future. There was one registered mental health nurse vacancy, and no health care assistant vacancies. The service allowed its staff to choose if they wanted to work night shifts or day shifts, allowing staff to choose their own shift pattern. The system allowed for two outstanding shifts a month to be covered by agency staff.

We were supplied with figures by the director of business development, which showed that, in the fourth quarter of the 2017/2018 financial year, bank and agency staff had accounted for 3% and 14% respectively of the total number of care hours at the service. We were told that any agency staff or bank staff utilised were known to the service, and saw evidence that staff had undergone a temporary worker induction process that was kept on file.

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

We were told that staff numbers had been calculated relative to patient numbers, with a view to increasing staff as patient numbers increased: at the time of the inspection there were only seven patients admitted. There were two registered mental health nurses and five health care assistants per shift normally; on the day of inspection there were eight health care assistants on duty due to a patient requiring a high level of observations. The usual staff numbers included one extra member of staff per shift. Should staff levels be adjusted due to patient needs, the acting unit manager would be included in the numbers, as would the occupational therapy assistant. We were told that the wards were never understaffed due to the process in place, and this was borne out by the rota system. There was always an experienced nurse on each ward. The acting manager was authorised to bring in extra staff should the need arise.

Care records showed that one to one meetings between a named nurse and patients were taking place. We saw an audit that showed managers were checking section 17 authorised leave for detained patients was taking place, and that escorted leave was not being cancelled due to

lack of staff. We saw evidence that leave times had been changed due to circumstances, but not cancelled. Ward activities were seen to be regularly taking place, and only shortened if patients did not want an active role in a particular activity.

We saw that mandatory training was taking place, and was regularly audited. The service undertook a particular full day mandatory training course that included all relevant subjects for the service. The course was run by an accredited company. All staff had taken this course, as well as refresher courses in other aspects of training, such as Mental Health Act training, Mental Capacity Act, dysphagia training and immediate life support training.

The inclusive mandatory training day supplied by an accredited company ensured that all staff who had attended (100%) had coverage in training such as fire safety, health and safety, infection control, basic life support and moving and handling. Further training had been organised by the service, including Mental Health Act, Mental Capacity Act and restrictive physical intervention training. All training was over 75% attendance by staff if the inclusive mandatory training was taken into account. Further training was still available in a number of disciplines.

Assessing and managing risk to patients and staff

We reviewed five risk assessments during the inspection. Each risk assessment was up to date or due for review during the week of inspection. Each risk assessment was individualised and included a risk management plan. Risks categorised included verbal and physical aggression, self-harm, property destruction, absconding, diet, inappropriate sexual behaviour, and vulnerability. One risk assessment outlined a number of criminal offences that were used to formulate the plan, but we could not find any evidence on file of corroboration for the offences. This was raised with the acting unit manager, and we were assured that efforts would be made to confirm or corroborate the information. We saw that risk assessments had been completed prior to admission to the unit.

Staff updated risk assessments monthly, completion was audited. The risk assessment tool was a standardised format. Crisis plans were evident within care plans for each patient. We saw no evidence of advanced decisions. We were told that in the event of a crisis plan being followed, liaison with the clinical commissioning group and the care coordinator would be initiated to ensure the plan flowed effectively.

We saw observation charts for each patient, checking different physical health aspects. These were all up to date for each patient. If a patient showed deterioration in health, it was noted on the observation sheet, and an incident form would be completed. Any such deterioration would lead to a multi-disciplinary team meeting, or contact with the relevant GP or accident and emergency if deemed urgent treatment was necessary.

There were relevant policies in place. There was an observation policy, outlining the use of different levels of observation depending on the behaviour or need of the patient. A ligature risk policy was followed and with assessments for each patient and the service as a whole. There was a search policy for the searching of patients; this was in effect, and was only in use with one patient due to identified risks; this was clearly outlined in the care plan, and the patient was aware and had agreed to a pat-down search after leave. The service had a policy regarding police involvement when necessary, outlining actions to be taken. A leaflet entitled “Guide to Ash House” that was issued to all patients contained a ‘code of conduct’, behaviours expected of patients admitted to the service. All staff, including bank and agency staff, had been trained in the prevention and management of aggression. There was a policy in place for the service to go non-smoking soon after the inspection; this had recently been reviewed. There were no blanket restrictions in place, although each patient had been assessed for such restrictions as access to razor blades. There was a list of prohibited items displayed at the entrance to the location, this was primarily for visitors, although patients were also advised of what could and could not be taken into the unit.

The service was locked rehabilitation, and to this end, the entrances to the location were secured, requiring staff to open doors. The service only accepted patients who were detained under the Mental Health Act; as such, doors were kept locked to be secure.

We were told that staff used de-escalation techniques in order to minimise the need for physical restraint. This included verbal, diversion, and peer-involvement de-escalation techniques. Staff monitored possible abuse by being aware of care plans, watching and listening to

patients and visitors. There had been one use of physical restraint in August 2017, but none since that occasion. We were told that face-down restraint would never be used at the service. There was a rapid tranquilisation policy in place, but the service had never used rapid tranquilisation. The policy for rapid tranquilisation clearly stated that, unless admission criteria changed, patients who might require rapid tranquilisation would not be admitted The policy outlined the actions to be taken in the event of rapid tranquilisation, should admission criteria change. There was no seclusion room at Ash House.

In the three months prior to the inspection, one staff member had been injured by a patient. The staff member had been given psychological support; the patient had also received counselling and appropriate actions taken.

Safeguarding was included in mandatory training, and safeguarding children and adults levels one and two had been completed by all staff. Each care plan at the service was individualised, recognising possible factors that could be exploited or lead to a safeguarding situation. The service had a safeguarding policy, due for review in March 2018, that outlined actions to be taken when and if required. In discussion, the acting unit manager clearly knew the safeguarding policy and relevant actions to be taken in a safeguarding situation. No safeguarding alerts had been raised in the six months prior to the inspection, as displayed in the key performance indicator audit.

We were told that the service had been heavily involved with local safeguarding structures in the past, and we were aware of the involvement of local safeguarding involvement due to CQC inclusion in the monitoring process. There was a safeguarding referral register maintained at the service. This showed the last referral to local safeguarding was in April 2017.

Children visiting patients at the service was planned, the policy not allowing for unannounced visits. Each visit was risk assessed, with a specific family meeting room allocated.

Medication at the service was provided by a local pharmacy. We saw that the pharmacy did regular weekly checks on medication and the administration of medication within the service. A monthly audit report was submitted by the pharmacy. The audit report outlined checks by the pharmacy in relation to general clinic room protocols, medication storage, fridge contents and temperatures, emergency drugs (including emergency bag and oxygen checks, as well as protocol for use of equipment), and all relevant documentation.

There were no nurse prescribers employed at the service. The responsible clinician, in conjunction with the pharmacy provider and a medication lead nurse, took overall lead for medication at the service. Possible use of excessive medication or inappropriate use of medication to control patient behaviour was monitored at multi-disciplinary team meetings, pharmacy audit, and medication reviews. We saw evidence of patient involvement in medication prescription and administration, where patients had described adverse effects that had been considered and led to a change in medication. We saw that patients on anti-psychotic medication had weekly physical health observations taken and blood monitoring.

Track record on safety

There was only one example of a recent adverse event; a patient physically assaulted a female member of staff. There was a full investigation into the incident, with an outcome that recognised that staff working at the time of the incident were all female. As a result of the investigation and a review, it was agreed that staffing should ensure that there was an adequate gender mix on each shift in order to mitigate risk. This was noted on work rotas.

Reporting incidents and learning from when things go wrong

An accident and incident-reporting log was maintained at the service; this was audited monthly. Incidents were reported electronically, and could be made by any member of staff with computer access.

Learning was fed back depending on whether it involved an individual or the team as a whole. We saw evidence of information being fed back in minutes from staff meetings. Staff meeting minutes from October 2017 showed information regarding concerns and complaints being discussed. Reflective practice was also encouraged at the service. Minutes from the combined mental health senior management team meeting showed that incidents were an agenda item each month.

Long stay/rehabilitation mental health wards for working age adults

Good

We were told that patients would be debriefed if there was an incident. Staff told us that they were kept informed of any problems that arose at the service.

Duty of Candour

There was a Duty of Candour policy at the service that outlined actions to be taken to inform patients and carers if anything untoward had occurred. Patients would be informed as per the policy, and this would be recorded in the case notes. We saw no direct evidence regarding Duty of Candour in the notes we reviewed, with no evidence seen of the Duty of Candour threshold being reached. However, staff were aware of the policy and how it would be used.

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

We reviewed five sets of case notes of patients at Ash House. They were up to date, personalised (including the views of the patient) and holistic. Care plans were recovery focused. There was evidence that patients were being given or offered a copy of their care plan. We saw evidence that each patient was having physical health care observations completed regularly and the results recorded. This included temperature, pulse, blood pressure, oxygen saturations and weight of the patient. Medication side effect rating scales were completed on each patient. Patients who were diagnosed with diabetes had blood sugars monitored as well as having "Guide to Diabetes Treatment" leaflets in their medication file.

A pre-admission assessment criterion was in place, as outlined in the operational framework for the service. This included the patient being assessed for current diagnosis, previous diagnosis, physical health, drug misuse, forensic history, current medication, mental health status and current and long-term needs. This would lead to a pre-admission multi-disciplinary team meeting where all aspects of care would be discussed and an initial care plan formulated.

The operational framework for the service stated that all referrals to the service had to be discussed in the multi-disciplinary team within 72 hours of receipt. A verbal response to the referring agency would be within 24 hours of the meeting. A clinical team would visit the patient within seven days of the decision to initiate the assessment. This would then lead to a section 117 aftercare meeting under the auspices of the Mental Health Act. We were told that a comprehensive assessment could take up to 12 weeks to complete. The operational framework for the service gave a minimum period of 12 weeks and up to nine months to achieve full assessment and stabilisation of a patient. All patients underwent a physical examination by the GP for the service, and we saw evidence of on-going physical health checks.

Clinical notes were stored securely in locked nursing stations, in filing cabinets. These notes were available to staff when needed, and were all paper notes. Information was typed into a computer system onto a relevant template then printed and placed in the patient file. We saw that patient files were comprehensive and well organised. The acting unit manager said that they hoped to go electronic for note storage in the future.

Best practice in treatment and care

The service had a Medicines Management and Administration policy that outlined all aspects of medication monitoring and administration. Guidance from the Medicines Act, the Misuse of Drugs Act and the Nursing and Midwifery Council Standards for Medicine Management was used to ensure best practice at the service. We saw evidence that guidance from the National Institute for Health and Care Excellence was being considered in relation to the treatment of patients with schizophrenia. Patients were receiving appropriate drug and physical health monitoring in accordance with national guidance. We saw monthly check records relating to anti-psychotic medication administration.

Ash House had employed a psychotherapist and a psychologist, both of whom worked two days a week for the service, with a view to increased time as patient numbers increased. We saw evidence that patients were being offered therapies and treatment was being recorded in care notes. A wide range of activities were available for patients, including activities of daily living, educational sessions, budgeting, and community and health activities. These activities were available seven days a week.

Long stay/rehabilitation mental health wards for working age adults

Good

We saw evidence in care records that the GP for the service had visited the service when requested, and that physical health care was being considered and recorded within the notes. The service was actively trying to get patients to live healthier lives. Information boards at the service highlighted actions to beat smoking addiction and obesity, and with a "Step up To the Challenge" competition. All patients and staff had been given step counters, with the result that within a period of time the results showed increases in the distance each counter recorded. This technology helped to show improvements in fitness of patients and staff.

Patients could access computer and internet on the ward, dependent upon risk assessment. Each patient had a weekly planner that included using the computer for specific periods. Some patients had their own telephones that could access the internet. Support was available for those patients who were not technologically proficient.

The service used rating scales to record severity and outcomes of patient mental health. The service used the model of human occupation screening tool (MOHOST), whilst the psychologist at the service used the historical clinical risk-20, the Beck depression inventory, and the Beck anxiety inventory. We saw evidence of discharge planning in care records, aimed at returning patients to the community.

Staff were engaged in clinical audit. The audit for Ash House for January 2018 showed staff involvement including care plan audit, infection control audit and pharmacy audit.

Skilled staff to deliver care

The multi-disciplinary team at Ash House included a psychiatrist, a psychologist, an occupational therapist, registered mental health nurses, a psychotherapist, health care assistants, and patients and family where applicable. The skill mix allowed for a provision of suitable interventions for patients. The team was a mix of full time and part time staff; as patient numbers increase, part time staff will take up full time posts.

All staff were given a full induction programme for the service. There was a physical induction, aimed at making staff aware of their environment at Ash House. This included patient involvement, so new staff also met the patients. An induction checklist in a personnel file also included an introduction to the company, terms and conditions of service, equal opportunities policy and worker development, organisation rules, and health and safety (including first aid and incident reporting). Learning needs were identified through supervision and appraisals. Staff were encouraged to take part in relevant national vocational qualifications. Staff could access to specialist training: we saw certificates for staff who had trained in dysphagia treatment, the treatment of people with swallowing disorders. The acting unit manager had taken leadership training.

We saw minutes of regular team meetings, including two staff meetings in the first two weeks of January 2018. These were well attended by staff. Staff told us that the information sharing and communications at the service had improved greatly since the last inspection.

Supervision and appraisals were audited monthly. Figures supplied by the service showed that supervision was taking place, but not regularly, based on the data. Staff told us they were receiving regular supervision. Data indicated that five staff had not had supervision within policy requirements: one staff member showed no supervision since 9 January 2017, however the staff member below showed supervision on 9 January 2018.This could be an error in the data matrix. However, the service should ensure that supervision was being recorded properly.

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

Multi-disciplinary and inter-agency team work

Multi-disciplinary team meetings were regularly taking place and were being recorded in care records. The disciplines within the team meetings included a responsible clinician (consultant psychiatrist), psychology, occupational therapy, registered mental health nurses and health care assistants. Patients and family members were noted to regularly attend such meetings. We saw evidence of involvement of care coordinators and clinical commissioning group input. Notes from the meetings were comprehensive and holistic.

Handover notes were seen to be effective and well considered. Staff were able to give detailed information on each patient regarding their detention status and ongoing treatment. We saw evidence in care records of discharge planning for patients.

Long stay/rehabilitation mental health wards for working age adults

Good

Ash House was still involved in liaison with national and local bodies with regard to the monitoring and regulation of their service. At the time of inspection, some of the organisations involved were limiting their involvement due to improvements within the service.

Adherence to the MHA and the MHA Code of Practice

When we last inspected Ash House, we found that the hospital did not have sufficient numbers of associate lay hospital managers. Associate lay hospital managers have a specific role in reviewing patients' detention when patients' detentions are renewed and when patients apply to challenge their compulsory hospitalization.

On this inspection, we found that the hospital had recruited five hospital managers, many of whom had carried out the role of associate lay hospital managers at other hospitals for many years. Records showed that associate lay hospital managers hearings were occurring in a timely manner on renewal of detention. The associate lay hospital managers had a standardized format to ensure they looked robustly at the detention criteria when hearing cases. This helped them to check whether patients still met the threshold for detention. We found there were now sufficient numbers of experienced associate lay hospital managers to ensure the hospital (as the detaining authority) could meet its responsibilities when reviewing detention as required by the Mental Health Act.

We carried out a routine Mental Health Act monitoring visit in November 2017. On that visit, we found overall adherence to the Mental Health Act and the Mental Health Act Code of Practice. We identified some shortfalls on that visit. These included staff not always recording that they had given patients information on their rights in patient records and there were no posters informing patients of the CQC's role in complaints about the Mental Health Act. At that time, the hospital also did not have a Mental Health Act administrator.

Managers provided an action statement telling us how they would improve adherence to the Mental Health Act and Mental Health Act Code of Practice. On this inspection we saw that the issues raised had been addressed or had improved, for example improved recording of patient's rights and posters informing patients of CQC's role.

The hospital had appointed a new Mental Health Act administrator who ensured that the responsibilities of the Mental Health Act were met. The administrator had developed an improved system for storing Mental Health Act documentation so the paperwork was stored systematically and was therefore more accessible. The Mental Health Act administrator had systems to ensure that any key deadlines or tasks required by the Mental Health Act were met. This meant there were good systems in place to support adherence to the Mental Health Act. The administrator had identified that there was no system of medical scrutiny of detention papers where the detention was initiated or renewed at the hospital through, for example, arrangements with clinicians in the local mental health NHS trust and was looking to address this.

We looked at five sets of Mental Health Act records relating to detained patients at Ash House. The records we saw were generally well kept:

- There was a full set of detention papers on each file.
- There was good evidence of patients regularly informed of their rights as detained patients.
- There were good records relating to the approval of section 17 leave with clear conditions of leave.
- There were good arrangements to seek informed consent for treatment for mental disorder for detained patients with all patients having appropriate legal authority to treat on the appropriate legal form (T2 or T3 certificate).
- There was evidence that patients had their case reviewed by mental health tribunals recently.
- Patients had access to an independent mental health advocate who visited the hospital regularly.

However, on this inspection, we found that where patients did not understand their rights, records did not provide assurance that staff were referring patients proactively to the independent mental health advocacy service as required by the Mental Health Act Code of Practice. There were notices around the service identifying the advocacy service, and how to contact the advocate.

Staff were aware of their duties under the Mental Health Act. Staff had received relevant training including training on the Mental Health Act Code of Practice. Staff had attended a bespoke training session on the Mental Health Act in independent hospital. Mandatory training for the Mental Health Act was included in the all-inclusive training package attended by 100% of staff at the service. 64% of

Long stay/rehabilitation mental health wards for working age adults

Good

staff had also attended the secondary training package for the Mental Health Act. Staff benefitted from the Mental Health Act coordinator working at the hospital three days a week and planned to undertake on-going training of staff.

Good practice in applying the MCA

Ash House mandatory training included training in the Mental Capacity Act. At the time of the inspection, 75% of staff had completed Mental Capacity Act training. Staff we spoke to had a good understanding of the Mental Capacity Act. We were told that patients detained under a Deprivation of Liberty Safeguard application would not be considered for admission to the service.

There was a Mental Capacity Act and Best Interest policy at Ash House, the policy was due for review in March 2018. The policy was available on the service intranet. We were told that staff could access information relating to the Mental Capacity Act from the policy or from the responsible clinician or the Mental Health Act administrator for the service.

We saw evidence of consideration of capacity in the five care records we reviewed. We saw no evidence of best interest meetings for the patient care records reviewed, however, there was no evidence in the records to suggest that a best interest meeting had been required. We were told that, should it be necessary, an independent mental capacity advocate would be involved in such a meeting. This was reflected in the Mental Capacity Act policy.

There was no audit of capacity at the service, however, care records did reflect the consideration in an open manner on the record, making it easy to check.

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

Good

This domain was not inspected as it had been rated as good in the previous inspection, published in July 2017.

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

(for example, to feedback?)

Good

This domain was not inspected as it had been rated as good in the previous inspection, published in July 2017.

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

Good

Vision and values

There was a well-established set of values in place at Ash House, based on the "Enabling Environment" initiative. In discussion, staff were aware of the values. The unit manager told us that the nursing team and staff were involved in the development of these values, and they were tied in with service objectives.

Staff knew the names of senior staff in the organisation, and the chief executive officer and director of business development still spent two to three days a week at the service. We were told that the finance director had also visited the service. The ward manager was able to apply for leadership development if they felt it was required.

Good governance

Since the last inspection, it had been noted that governance at Ash House had been prioritised; this was evident from engagement meetings and from input from other organisations who were liaising with the service. The service had admitted only two patients since the last inspection, but this allowed the inspection team to view the governance process and admission criteria process.

At the time of inspection, there was no registered manager at the location, as the registered manager had recently resigned from the location. The correct submissions had been made to the Care Quality Commission regarding the absence of a registered manager. The service was actively

seeking a new registered manager. Subsequent to the inspection, the service had recruited a new registered manager, and all relevant applications were submitted to the Care Quality Commission in a timely manner.

Ratings from the previous Care Quality Commission inspection were displayed at the service and on the provider website. There was a risk register in place, and this was up to date and comprehensive. We requested and reviewed policies relating to Mental Capacity Act, completion of healthcare records, Duty of Candour, complaints, Mental Health Act administration, medicines management and administration, and safeguarding of vulnerable adults. The documents showed that the service was committed to improvement.

At the previous inspection, key performance indicators and their use to gauge performance had yet to be implemented. During this inspection, we saw evidence of 19 key performance indicators in place to monitor and utilise data. These included monitoring of Mental Health Act compliance, patient complaints, staff complaints, mandatory training, safeguarding alerts, care plans audited, patient care progression (patient mental health and behavioural improvement), patient discharge data, and patient and staff meetings achieved. The data from these indicators was discussed in meeting minutes for both staff and patients.

We reviewed minutes from a combined audit and compliance group meeting (October 2017) that discussed items such as safety and risk management, clinical and cost effectiveness, training and development, and patient focus. Senior management team minutes from December 2017 showed agenda items that included incidents, accidents, complaints, safeguarding, audit compliance and key performance indicator feedback. Staff meeting minutes from 18 January 2018 showed discussion around care plan and risk assessment review, staff survey results, complaints, staff patient boundaries and handover management (to prevent disturbing staff during handover).

Mandatory training was being monitored and was included in the key performance indicators. Medication was being monitored by both the service and the pharmacy that provided medication to the service.

Mental Health Act training and monitoring was audited to good effect.

Staff could submit items to the risk register, this would be done by informing the manager and then the risk would be considered and action taken.

Leadership, morale and staff engagement

Staff told us that they felt more supported by management. This was demonstrated in the most recent staff survey (January 2018) at the service, which showed a marked improvement over the 2017 survey. The survey comprised 10 questions, reflecting the results from the previous survey against the most recent survey. The questions covered topics including facilities, cleanliness, supervision, developmental opportunities, and an overall rating. 100% of staff rated the service at Ash House as good, very good or outstanding in the most recent survey; in the 2017 survey 16% of staff rated the service as poor.

Staff told us they felt respected and valued. Staff said they felt supported, with good relationships with senior multi-disciplinary team staff. There were no bullying or harassment cases reported at the service at the time of the inspection.

Commitment to quality improvement and innovation

We were told that after meetings with staff and patients, there was consideration for altering the layout of the second floor accommodation at Ash House. The plan was to make the second floor into self-contained flats, allowing patients who were close to a return to the community to be more self-proficient and prepared for discharge.

Since Ash House was rated as inadequate in the first service report, the service has worked well with stakeholders and other professional bodies to ensure that the service provided has moved forward. This should be considered as a commitment to quality improvement that is reflected in the rating for this report.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure that the recording of supervision accurately reflects the supervision that is taking place.
- The provider should ensure that, although patients have regular contact with the independent mental health advocate, a process is adhered to whereby patients are referred to the advocate when rights are not understood, in keeping with the Code of Practice.