Making Space

Ashwood Court Nursing Unit

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inadequate
Are services safe?	Inadequate
Are services effective?	Requires Improvement
Are services caring?	Requires Improvement
Are services responsive to people's needs?	Requires Improvement
Are services well-led?	Inadequate

Summary of findings

Overall summary

Following this inspection, we took urgent action and served a Notice of Decision which placed conditions on the service's registration. The Notice of Decision prevented the provider from admitting any further patients to Ashwood Court Nursing Unit. In addition to the Notice of Decision we served two Warning Notices under Section 29 of the Health and Social Care Act, due to concerns about the safe care and treatment of the patients and the lack of good governance.

Our rating of this location went down. We rated it as inadequate because:

Safety systems, processes and standard operating procedures were not fit for purpose and did not keep people safe. Resuscitation equipment was out of date or missing and had been for several months at the time of inspection.

There was no evidence of learning from events or action taken to improve safety. There was no incident management policy for staff to follow and no evidence of learning from incidents.

The information needed to plan and deliver effective care, treatment and support was not available at the right time. The service did not have an environmental ligature risk assessment. Staff did not have access to Mental Health Act and Ministry of Justice paperwork to inform the care they provided.

Staff did not assess, monitor or manage the risks to people who used the service. Staff did not complete a risk assessment or crisis plan for all patients and did not review patient risk following incidents. Opportunities to prevent or minimise harm were missed.

Information about people's care and treatment was not appropriately shared between staff or with partner agencies. Staff did not notify the Care Quality Commission of all incidents that met the threshold for reporting.

There was insufficient attention given to safeguarding. Staff did not follow the provider's own safeguarding policy. Staff did not report all safeguarding concerns to the local authority that met the threshold for reporting.

Staff did not have the knowledge and skills needed to keep people safe. Staff did not have adequate training to safely manage incidents of violence and aggression that occurred on the unit. Staff were not up to date with mandatory training and did not have training in basic life support. There was not enough medical input to ensure the safe care and treatment of patients.

The service did not involve patients, families and carers in their care and treatment. Discharge planning was not well managed and not all patients had a discharge plan in place.

The service did not protect the privacy and dignity of patients. Male patients could see into female patients' bedrooms from the garden.

Leaders did not have enough oversight of the service to ensure patients were receiving safe care and treatment. At the time of inspection, the service did not have a risk register in place. The provider was not aware of the concerns found at this location until the inspection. The registered manager had responsibility for two locations and there was no deputy manager in place at Ashwood Court Nursing Unit.

Summary of findings

The governance arrangements were unclear and there was no clear audit system in place to assess, monitor and improve the quality and safety of the service. The medicines audit was out of date, equipment checks were not completed in line with manufacturers requirements and managers did not audit care records.

However:

Staff demonstrated a caring attitude towards the patients and patients spoke positively about the unit. Patients also stated they had a good relationship with bank and agency staff.

Patients described the unit as clean and comfortable.

Staff supported patients to take up volunteering opportunities within the local community.

The service had a good physical health pathway in place for patients.

Page Break

Letter from the Chief Inspector of Hospitals

I am placing the service into special measures.

Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate overall or for any key question or core service, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

The service will be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary another inspection will be conducted within a further six months, and if there is not enough improvement, we will move to close the service by adopting our proposal to vary the provider's registration to remove this location or cancel the provider's registration.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay or rehabilitation mental health wards for working age adults	Inadequate 	

Summary of findings

Contents

Summary of this inspection

Background to Ashwood Court Nursing Unit

Ashwood Court Nursing Unit is an independent hospital for people aged from 18 to 65. It is a community rehabilitation unit for people who need support with a severe and enduring mental illness. It has 10 beds and can admit up to five men and five women. Patients may be admitted informally or detained under the Mental Health Act.

Ashwood Court Nursing Unit is provided by Making Space. Making Space is a registered charity that provides services across the country. Ashwood Court Nursing Unit is adjacent to Ashwood Court – Unit 1 which is a residential home. Both units have the same registered manager and share facilities such as catering and cleaning.

All 10 beds in the unit are commissioned on behalf of the NHS by NHS Wigan Borough Clinical Commissioning Group. The service is registered to provide the following regulated activities: assessment or medical treatment for persons detained under the Mental Health Act 1983; treatment of disease, disorder or injury; and diagnostic and screening procedures. At the time of this inspection the unit held seven patients, five male patients and two female patients. Four patients were subject to Ministry of Justice restrictions.

Ashwood Court Nursing Unit has been registered with the Care Quality Commission since 23 November 2010. There have been four inspections carried out at Ashwood Court Nursing Unit. The last inspection was carried out on 28 June 2018. The service was rated as good overall.

The issue of medical equipment not being routinely checked as well as disposable items being out of date had been raised at the last inspection. The service was still not compliant with this at this inspection.

What people who use the service say

We spoke to four out of the seven people who were patients using the service at the time of our inspection. They were generally positive about the care they received from staff. However, some patients expressed concern over staffing levels impacting on safe care at night. Two patients did not know what a care plan was and reported not having one to ones with their named nurse. Both patients and carers reported there were not enough trips and activities off the ward.

How we carried out this inspection

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

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

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

During the inspection the team:

Summary of this inspection

- toured the environment
- spoke with four patients and two carers
- spoke with eight staff including a student nurse, occupational therapist, registered mental health nurse, healthcare assistants, consultant psychiatrist, pharmacist and the registered manager
- looked at six care and treatment records for the patients
- reviewed six prescription charts
- reviewed a range of other documents, policies and procedures.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Following this inspection, we took urgent action and served a letter of intent to the provider to ask for some immediate actions to be taken to ensure the safety of patients. We reviewed the response of the provider to this letter of intent and found it did not provide enough assurance.

We therefore served a Notice of Decision under Section 31 of the Health and Social Care Act (2008), which prevented the service from admitting or re-admitting any patients. We also asked the service to urgently ensure lifesaving equipment was in place and fit for purpose and to complete risk assessments for all patients.

We also served the provider with two Warning Notices under Section 29 of the Health and Social Care Act (2008). The first notice was served in relation to Regulation 12: Safe Care and Treatment. The provider was asked to ensure action was taken within three months in relation to concerns about staff not being adequately trained to manage incidents of violence and aggression, staff not responding appropriately to patients' presentation and the lack of environmental risk assessment. The second notice was served in relation to Regulation 17: Good Governance. The provider was asked to ensure action was taken within three months in relation to concerns about the lack of robust audit systems, staff not reporting safeguarding incidents to the local authority, governance systems and processes not being in place and the lack of an incident management policy.

The service had not notified the Care Quality Commission of incidents that occurred, which met the threshold for reporting under the Health and Social Care Act (2008) Registration Regulation 18.

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

- The service must ensure that staff are adequately trained in basic life support. (Regulation 18)
- The service must ensure that all staff are up to date with the provider's mandatory training. (Regulation 18)
- The service must ensure that patients have access to enough medical cover to support with their safe care and treatment. (Regulation 18)
- The service must ensure that staff have access to formal clinical supervision and appraisals. (Regulation 18)
- The service must ensure that they have adequate management arrangements in place. (Regulation 18)

Summary of this inspection

- The service must ensure that staff understand their role and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and Mental Capacity Act 2005. (Regulation 18)
- The service must ensure that the privacy and dignity of all patients is protected. The service must ensure that male patients cannot see into female patient's bedrooms and that staff are able to observe patients whilst maintaining their privacy and dignity. (Regulation 10)
- The service must ensure that patients and their carers or families are involved in their care and treatment, where appropriate. (Regulation 9)

Action the service SHOULD take to improve:

- The service should ensure that staff are able to safely support patients and call for help in an emergency in all areas of the unit.
- The service should ensure that staff have easy access to all essential information in care records to support care and treatment.
- The service should ensure that patients have time with their named nurse.
- The service should ensure that 'as required' medication is appropriate for each patient, that the reason for use is clearly documented and that physical health checks are undertaken by staff in line with national guidance.
- The service should ensure the staffing establishment levels are sufficient to provide safe care and treatment both during the day and at night, and to support patients to engage in activities.
- The service should ensure that all patients have a full assessment of their needs on admission.
- The service should ensure that care plans are reviewed and updated as needed.
- The service should ensure that all patients have a discharge plan in place.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Long stay or rehabilitation mental health wards for working age adults	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate
Overall	Inadequate	Requires Improvement	Requires Improvement	Requires Improvement	Inadequate	Inadequate

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Safe	Inadequate
Effective	Requires Improvement
Caring	Requires Improvement
Responsive	Requires Improvement
Well-led	Inadequate

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

Inadequate

Safe and clean care environments

Staff did not complete and regularly update thorough risk assessments of all wards areas and remove or reduce any risks they identified. However, all wards were clean, well equipped, well-furnished and well maintained.

Safety of the ward layout

Staff could not observe patients in all parts of the unit due to the layout. Staff carried out hourly general observations of each patient, however the bedrooms did not have a vision panel on the door which meant staff needed to enter patient's rooms every hour to check on them.

The ward had female and male patients and complied with guidance on mixed sex accommodation. Each patient had their own en-suite room. The female patients had their own private lounge in addition to the communal lounge.

Staff did not know about any potential ligature anchor points or mitigate the risks to keep patients safe. At the time of inspection, the service did not have a ligature risk assessment or an audit process to review ligature risks in the environment. The service provided an environmental ligature risk assessment following the inspection. We were unable to assess at that stage whether it included all identified risks and effective mitigation for them as it was after the on-site visit.

Staff did not carry personal alarms. There was a nurse call system using buttons at intervals along the walls that patients and staff could use to call for help. The unit was next to the provider's residential care unit. There was a narrow set of corridors that linked the units together. The patient's laundry facility was on the residential side and isolated from the main unit. There was a timetable for laundry and patients were escorted by staff. This meant that staff may not be able to call for help in an emergency.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well-furnished and fit for purpose. The unit was clean and appropriately furnished.

Staff made sure cleaning records were up-to-date and the premises were clean. There were alcohol hand gels in place throughout the unit.

The patients had access to a communal kitchen. Staff carried out daily hygiene checks and patients had access to a list detailing the shelf-life of foods they were using.

Staff followed infection control policy, including handwashing. Staff used a cleaning station on entering the unit and followed guidance in the use of personal protective equipment.

Seclusion room (if present)

The unit did not have a seclusion room.

Clinic room and equipment

The clinic room was not fully equipped. We checked the resus bag against the list of what it should contain. We found that the defibrillator pads went out of date in April 2021. The defibrillator and suction machine had not been checked since 2019 (the sticker indicated the next check had been due in February 2020). The Yankauer, a suction tip on the suction machine went out of date in June 2021. In the resuscitation bag, all of the size two, three of the size three and two of the size four Guedel airways, used to maintain a patient's airway, were missing. There should have been five of each size.

The resuscitation bag checklist indicated checks should be completed weekly. The last completed check was in August 2021. It had indicated items that were missing, yet these were still missing on the day of our inspection. There was a new resuscitation checklist in place that only asked staff to check the green light on the defibrillator and to check the oxygen cylinder.

We raised this concern at our last inspection in 2018. We took enforcement action about this. See the areas for improvement section for more information.

The fridge in the clinic room was used for medication only and staff checked the temperature daily. Staff also checked the clinic room temperature daily to prevent medication losing its stability and reliability. The clinic room contained a height chart and weighing scales for physical health monitoring.

Safe staffing

The service had enough nursing staff, who knew the patients, to meet their staffing establishment levels. However, patients reported that staffing levels at night did not feel safe.

Nursing staff

The service had enough nursing and support staff to meet their staffing establishment levels. The staffing levels were one qualified and two unqualified during the day and one qualified and one unqualified during the night. We reviewed staffing rotas which showed staffing was usually at the required levels. However, we did review one incident report where a lone female staff member had been working at night when a patient returned intoxicated and disruptive. Patients also stated they did not feel there were enough staff during the night.

The registered manager explained they were able to book staff at short notice if needed to cover sickness and absences. The manager also stepped in to cover shifts when necessary.

The service had a low vacancy rate. There was one nurse vacancy. Levels of sickness were low. Two staff members were on long-term sickness. There was no significant sickness rate among the other staff. Cover was provided by two regular bank and two regular agency registered mental health nurses. The service also regularly used one bank healthcare support worker and two healthcare support workers from an agency.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. Bank staff received a similar induction to permanent staff.

The service had low turnover rates. Most of the staff had been in post for several years.

Not all patients had regular one- to-one sessions with their named nurse. Two of the four patients we spoke with did not know who their named nurse was and stated they did not have regular one-to-one sessions.

Medical staff

The service did not have enough medical cover to support patient's care and treatment.

Cover was provided by a consultant psychiatrist for six hours a week, which was divided between seeing patients and administration. Outside of this, telephone support was provided by this consultant. The consultant attended multi-disciplinary meetings once a month for individual patient reviews.

The consultant stated they could get to the unit in half an hour if needed. However, they also worked for another provider. There was no on-call cover for out of hours. There was no junior doctor. In the event of an emergency, staff would escort patients to the acute trust.

Mandatory training

Not all staff had completed and kept up to date with their mandatory training. The service did not provide a set target for compliance. At the time of inspection, 77% of the staff had a compliance rate of over 70% for their mandatory training.

The mandatory training programme was not comprehensive enough to meet the needs of patients and staff. The records provided showed staff had not received training in conflict management and de-escalation in accordance with the provider's policy. Staff were not trained in basic life support. There was also no specific Mental Health Act training.

Training records did not clearly identify the frequency at which each course needed to be completed for staff to be complaint. Staff were past due dates for training completion but still showed as compliant. Compliance levels at the time of inspection were recorded as follows:

Data protection 68%

Dementia Awareness 95%

Equality and Diversity 100%

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Fire Awareness 81%

First Aid 9%

Health and Safety 72%

Infection prevention and control 81%

Mental Capacity Act and Deprivation of Liberty Safeguards 81%

Food Safety 4%

Medication Foundation 77%

Mental Health 100%

Moving and Handling Inanimate Objects 77%

Moving and Handling People 59%

Safeguarding 86%

At the factual accuracy stage the provider told us that only one staff member required training in food safety. The 4% reflects the percentage of all staff that had received training in food safety.

Assessing and managing risk to patients and staff

Staff did not assess and manage risks to patients and themselves well. They did not achieve the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff did not follow best practice in anticipating, de-escalating and managing challenging behaviour. The unit did not use restraint and seclusion. The unit did not have a restrictive interventions reduction programme.

Assessment of patient risk

Staff did not complete risk assessments for each patient on admission using a recognised tool, or review risk regularly or after incidents.

We reviewed the records of six patients. For five out of six patients there was no risk assessment in place. There were four patients subject to Ministry of Justice restrictions who had high risk index offences.

Staff at the unit were unable to locate the risk assessments. Staff had not noticed risk assessments were not in place for these patients. This highlighted that no reviews of risks had taken place during this time despite evidence on the incident reporting system of incidents of violence, aggression, self-harm, sexually inappropriate behaviour and police involvement with patients that had been absent without leave.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

We took enforcement action about this. See the areas for improvement section for more information.

Following our inspection, the service completed risk assessments and crisis plans for all patients. We reviewed these and found the assessments gave a comprehensive view of historic risk. However, they did not address current risk in detail. The risk assessments did not consider trends in incidents or behaviour or use this information to determine how to manage current risk or predict future risk.

Management of patient risk

Staff did not respond appropriately to patients' presentation in order to keep people safe. A review of incident data showed that when detained patients were deteriorating in presentation or becoming agitated and aggressive, they were able to leave the unit and place themselves or others at risk of harm. The registered manager informed us that the procedure for staff to follow was to direct patients to their rooms, lock themselves in the office and call the Police.

Staff did not identify and respond to any changes in risks to, or posed by, patients. Staff did not complete crisis plans for patients. There was no process for reviewing risk or updating risk following incidents. There was no process for learning from incidents to mitigate risk and no evidence that the patient's wellbeing and needs were reviewed following incidents.

We took enforcement action about this. See the areas for improvement section for more information

Following our inspection, the service submitted updated risk assessments and crisis plans for all patients on a fortnightly basis. We reviewed these and found that they did not take specific mitigating action in response to incidents other than standard measures such as sanctioning leave. The crisis plans did not address the current risks individually and subsequently failed to adequately mitigate risks.

Staff did not follow the provider's absent without leave policy. We reviewed two incidents where patients had gone absent without leave. The policy stated risk assessments must be updated following a patient absconding or an attempt to abscond. The risk assessments were not updated for both incidents. The same policy also stated if a member of staff became aware that a patient has left the hospital without authorised leave, they should inform the service manager or nurse in charge who will immediately inform the responsible clinician. This process was also not followed in the actions or outcomes of the incidents.

Use of restrictive interventions

Staff did not have the necessary knowledge and skills to manage patient risk. The service stated they did not carry out physical interventions with patients. However, the service policy stated that 'as a last resort physical redirection or intervention can be used to prevent patients harming themselves or others.'

The service did not provide adequate training and support for staff in managing risk and preventing harm to patients. The service stated they provided verbal de-escalation training for staff, however, could not provide records of this when asked. We reviewed incident data which showed that patients and staff were put at risk because staff had not taken action to minimise the potential risk.

We took enforcement action about this. See the areas for improvement section for more information

Safeguarding

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not understand how to protect patients from abuse and the service did not work with relevant agencies to do so. Although staff had safeguarding training, they were unable to recognise and report abuse.

Staff did not make safeguarding referrals or follow procedure on who to inform if they had concerns. Staff did not follow their own policy to safeguard patients from harm. Section 3 of the provider's Safeguarding Adults Policy stated it was the responsibility of staff and volunteers to raise a concern/alert if they identified abuse, and to refer cases of abuse to relevant local authority adult social care as required.

Staff did not report twelve of the fifteen incidents that occurred between November 2021 and April 2022 to the local authority, which had met the threshold for reporting to the local authority in line with the provider's policy. Some of the incidents documented involved sexually inappropriate behaviour from a patient, against another patient. There were other documented incidents of financial abuse, self-harm and going absent without leave where safeguarding concerns were not raised.

We took enforcement action about this. See the areas for improvement section for more information.

Staff reported having a good clear understanding of safeguarding and its procedure. The registered manager reported not having many safeguarding incidents and that a recent one was the only one they'd had to raise for a long time. However, this was not the case as we saw evidence of safeguarding incidents that were not recognised as such and not reported as required.

Staff kept up with safeguarding training. However, the service's training matrix did not identify the level of safeguarding training undertaken by staff.

The service's systems and processes did not identify that their Safeguarding Adults Policy had not been followed. The registered manager stated they did not have a safeguarding lead. They explained one of the nurse's was their 'go to' for safeguarding support. However, a safeguarding lead was identified on a list of governance and regulatory leads. Staff were not aware of this.

Staff access to essential information

Staff did not have easy access to clinical information.

Patient notes were not comprehensive, and sections were missing. The service had an electronic system that had gone live in March 2021. Staff reported not all patients' notes had transcribed to the new system. There was information missing for patients that had been admitted following this date. The information completed was not consistent for each patient. Some patients had initial assessments and others didn't.

Medicines management

The service did not always use systems and processes to safely prescribe, administer, record and store medicines. Staff did not always review the effects of medications on each patient's mental and physical health.

Staff did not follow systems and processes to prescribe and administer medicines safely. The provider's Medicines Management Policy stated a medicines audit needed to be completed every three months. At the time of inspection, the last medicines audit had taken place in June 2021.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff did not always follow guidance in the prescribing and administering of when required medicines. We reviewed one record where a patient was administered a when required medicine. However, the records lacked both a reason for the administration and post administration physical health monitoring. This was not in line with National Institute for Health and Care Excellence (NICE) Guidance NG 10.

Another patient record indicated high usage of as required medication, alongside a high strength painkiller. The need for these medications was not reflected in the patient's risk assessment and there was no evidence that staff explored the reasons for the high usage or considered other treatment methods.

Staff completed medicines records accurately and kept them up to date. The medicines charts were completed appropriately and had no errors. The consent to treatment forms were up to date.

The service had recently commenced a contract with a new pharmacy. The pharmacy did not carry out any audits within the service, their role was solely the provision of medicines.

Track record on safety

The service did not have a good track record on safety. The service had not notified the Care Quality Commission of any incidents in the last 12 months, despite incidents occurring that met the threshold for reporting.

Reporting incidents and learning from when things go wrong

The service did not manage patient safety incidents well. There was no incident management policy. Managers did not investigate incidents or share lessons learned.

Staff did not know what incidents to report or how to report them. The provider did not have an incident policy which meant they could not be assured that incidents were graded consistently or appropriately. There was no process in place for escalating incidents to the senior leadership team, reviewing incidents, or sharing learning from them.

Staff did not report incidents to the Care Quality Commission or the local authority as required.

Staff did not understand the duty of candour. They did not give patients and families a full explanation when things went wrong. The service's incident reports showed staff did not communicate with families and carers when patients harmed themselves or absconded. The Mental Health Act Code of Practice Section 28.20 states where a patient is missing for more than a few hours their nearest relative should normally be informed (if they have not been already), subject to the normal considerations about involving nearest relatives.

The service did not learn from incidents. The Mental Health Act Code of Practice (Section 28.22) states that incidents in which patients go absent without leave or abscond should be reviewed and analysed so that lessons for the future can be learned, including lessons about ways of identifying patients most at risk of going missing.

Managers did not debrief or support staff after any serious incident. Staff did not receive feedback after incidents occurred and there were no evidence investigations took place.

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

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Requires Improvement

Assessment of needs and planning of care

Although staff developed care plans that were holistic and reflected patients' needs, they did not review and update them as needed. Staff also did not undertake a full assessment of all patients on admission.

Staff did not complete a comprehensive mental health assessment of each patient either on admission or soon after. Of the six patient records looked at only one had an initial assessment.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. The patients would undergo a physical health check by a senior healthcare assistant within 48 hours of admission. This included a full blood count, testing for blood borne viruses, urinalysis, individual family history, lifestyle check for issues such as smoking and substance misuse as well as a review of medications. Staff discussed the results in multi-disciplinary meetings and used them to inform care plans and make referrals to more specialist services if required.

The service had a lead physical health co-ordinator who carried out and co-ordinated the physical health checks. Patients were also referred for eye and hearing tests via their GP.

Staff developed a care plan for each patient; however, they did not always reflect the patient's needs. The care plans reviewed did not reflect patient or family/carer involvement. Two care plans did not reflect the patient's needs. For example, one of them did not address or evaluate the patient's index offence which could be a potential risk on discharge.

Staff did not review and update care plans when patients' needs changed. Care plans were not updated following incidents or changes in presentation.

Care plans were recovery orientated. They reflected patient involvement in a variety of activities that included volunteering and paid work with family. Some of the care plans included living skills and detailed recovery plans.

Best practice in treatment and care

Therapy staff provided care and treatment based on national guidance and best practice. The service provided access to psychological therapies, support for self-care and the development of everyday living skills and meaningful occupation. Staff supported patients with their physical health and encouraged them to live healthier lives.

The occupational therapist and psychologist used assessment tools such as the Model of Human Occupational Screening Tool (MOHOST).

Staff identified patients' physical health needs and recorded them in their care plans. The senior support worker carried out monthly observations and annual screening including electrocardiograms, screening for prostate cancer, cervical screening, a well woman clinic and phlebotomy.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. The service had links to Healthy Routes (a programme of support for smoking cessation, a healthy diet, physical activity, weight loss, well-being and alcohol support) provided by the local council.

Staff used technology to support patients. The service recently purchased a mobile laptop for staff to use for remote working as well as e-learning.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. The service had just undertaken an AIMS assessment with the Royal College of Psychiatrists and were awaiting feedback.

Skilled staff to deliver care

The unit had access to a range of specialists required to meet the needs of patients on the unit, however there was not enough medical input. Managers did not provide staff with necessary training to provide high quality care. They did not adequately support staff with appraisals, supervision and opportunities to update and further develop their skills.

The service had access to a range of specialists to meet the needs of the patients on the ward. The service had a consultant psychiatrist for six hours per week, an occupational therapist for 30 hours per week, a psychologist for six hours per week, a senior healthcare support worker who was also the physical health lead, an activity co-ordinator, nursing and healthcare support workers as part of the multi-disciplinary team.

The service shared administration staff, cooks and a general assistant with the provider's adjacent residential care unit. They had recruited their own cook who was due to start employment.

Managers gave each new member of staff a full induction to the service before they started work.

Managers did not support staff through regular, constructive appraisals of their work. The registered manager stated appraisals had been paused over the past two years. They were in the process of starting Personal Development Plans for staff. This meant that staff's competence and ability had not been reviewed and that areas for development had not been identified. The consultant psychiatrist did receive their appraisals but not from this service.

Managers did not make provision for constructive clinical supervision of their work. Staff had not received formal clinical supervision. The manager informed us staff received clinical supervision verbally and this had not been recorded when we inspected the service. The service provided a copy of their supervision policy titled 'My Performance and Development Policy' which outlined line management supervision as well as appraisals. Following our inspection, the service informed us they were in the process of making clinical supervision more formalised.

Staff on duty attended the monthly team meetings. Meeting minutes were then emailed to staff.

Managers supported staff to access additional training. The senior support worker and lead in physical health had previously been seconded to a GP surgery. Another support worker was trained in running a book club and had also been delivering reading and writing skills to some of the patients.

Multi-disciplinary and interagency teamwork

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff took part in multi-disciplinary team meetings. They did not have effective working relationships with staff from all services providing care following a patient's discharge.

Staff held regular internal multidisciplinary meetings to discuss patients and improve their care. Multidisciplinary reviews were held once a month. These were mainly attended by staff on the unit. The service did have links with the community mental health team.

Staff did not have effective working relationships with external teams and organisations. The service did not have information on the category or level of Multi Agency Public Protection Arrangements (MAPPA) for their patients under MAPPA on the day of inspection. As a result they would be unable to form part of a co-ordinated plan to manage risk. The service did not share information as required with the local authority to safeguard patients. The service did not always work effectively with community providers, evidenced by a discharge placement breaking down when the service did not respond to a provider's concerns about the patients conduct.

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

Staff did not understand their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and failed to discharge these well.

Staff did not have access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff demonstrated a lack of understanding or application of the Mental Health Act. Staff allowed an informal patient to leave the ward in order to harm themselves. They had on occasion requested the police to place a patient on section 136 and been informed it would not be appropriate. In these situations, staff could have utilised the nurses' holding power (Section 5(4) of the Mental Health Act which allows a qualified mental health or learning disability nurse to prevent a patient from leaving an in-patient facility) until they are seen by a doctor.

Staff did not know who to ask for support regarding the Mental Health Act. The service did not have Mental Health Act administrators. They were about to train a staff member in order to take on the role. The lack of a Mental Health Act administrator had the risk of not having a system or process to ensure compliance with the Mental Health Act. Some of the patients were subject to Ministry of Justice restrictions. There was no clear documentation stating what restrictions were in place in relation to the patient's index offence. The restrictions would inform care plans and section 17 leave arrangements.

Patients had easy access to information about independent mental health advocacy There was a folder in the main reception area with guidance on how to access advocates. One of the patients was aware of how to access an advocate if they needed to.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice. The unit had a separate section 17 leave folder that staff referred to prior to a patient taking leave. It contained risk assessments that staff had completed prior to leaving as well as on return. However, in one incident staff had taken no action to stop a detained patient from leaving the unit despite noticing a deterioration in their mental state.

Staff did not store copies of patients' detention papers and associated records appropriately and they were not easily accessible. We were unable to access patients' detention papers and staff did not know where to access them. There was no information available regarding patient's index offences or corresponding restrictions. This would help to plan their care as well as any leave restrictions accordingly.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Managers and staff did not make sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. The service did not carry out Mental Health Act audits. There was no record of specific training on the Mental Health Act.

Good practice in applying the Mental Capacity Act

Staff did not carry out capacity assessments to reflect patients' abilities to make decisions on their care for themselves. They did not understand or apply policy on the Mental Capacity Act 2005. They did not assess or record capacity clearly for patients who might have impaired mental capacity.

Two of the staff members we spoke with had good knowledge of the Mental Capacity Act. Eighteen out of 22 staff had received training on the Mental Capacity Act. However, we did not see evidence of mental capacity assessments in the patient records. Staff did not know where to get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards. There was no dedicated lead role on site. The Registered Manager reported they could receive information from the provider's solicitors.

Staff did not assess and record capacity to consent clearly each time a patient needed to make an important decision. Informal patients did not have their mental capacity assessed when they were in a distressed state and wanted to leave the unit. This would have informed the actions by staff to either allow the patient to make an informed choice or to act in their best interests. Lack of following this process had resulted in an informal patient leaving the unit and harming themselves.

The service did not monitor how well it followed the Mental Capacity Act. The service did not have a process for monitoring the use and application of the Mental Capacity Act. Staff did not recognise when a patient's ability to make decisions was impaired in order to act in their best interests.

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

Requires Improvement

Kindness, privacy, dignity, respect, compassion and support

Staff did not always involve patients in their care. Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They were able to support patients with their needs.

Staff were discreet, respectful, and responsive when caring for patients. The patients could add personal effects to their room such as posters and photo's. Patients referred being spoken to as equals and stated they felt comfortable. Staff gave patients help, emotional support and advice when they needed it. The staff were available to speak to patients privately when needed and were supportive.

Staff directed patients to other services and supported them to access those services if they needed help. If a patient had physical therapy needs, staff were able to facilitate a referral to NHS physiotherapy. The service also had good links to the local gym and to services that provided support with lifestyle, budgeting and healthy eating.

Patients said staff treated them well and behaved kindly.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff understood and respected the individual needs of each patient. Staff were non-judgemental and had an open approach to all patients on the unit. They provided an environment that allowed patients to adjust to community settings. Staff had supported a patient with social anxiety to start going out into the community.
Involvement in care

Staff did not involve patients in care planning and risk assessment and did not actively seek their feedback on the quality of care provided.

Involvement of patients

Staff did not always involve patients in their care planning.

Although the care plans were detailed, they did not evidence patient involvement. Of the four patients we spoke with, two of them did not know what their care plan was. They also reported not knowing who their named nurse was. None of the patients had copies of their care plans.

Staff involved patients in decisions about the service, when appropriate. Staff involved the patients in some of the decorative work on the unit which helped to personalise their living environment.

Patients could not give independent/autonomous feedback on the service and their treatment. The service was not able to provide anonymised patient feedback information. They did however state that patients could provide feedback in one-to-one sessions.

Involvement of families and carers

Staff did not always involve family and carers where appropriate.

There was no evidence of family involvement in the patient's care planning or reviews.

For patients with family involvement, the service supported patients in maintaining those relationships.

The service sent out feedback questionnaires to family members annually. At the time of inspection, they were waiting to send out the 2021/2022 questionnaire.

The service used to run a carer's group prior to COVID-19, but this had stopped. At the time of inspection, the service did not offer carers assessments but informed us they were in development.

The two carers we spoke with were both positive about the staff. They were able to contact staff for information and updates when needed. They expressed the need for more activities off the ward but were generally happy with the care received.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Are Long stay or rehabilitation mental health wards for working age adults responsive?

Requires Improvement

Access and discharge

The service admitted patients from the local area. However, staff did not always plan and manage patient discharge well.

The service operated with an open door and patients were a mix of informal patients, patients detained under the Mental Health Act and patients subject to Ministry of Justice restrictions who had stepped down from secure services. We were concerned some patients were not appropriately placed in this unit and escalated this to the clinical commissioning group. The lack of risk assessments and risk management plans was amplified by the admission of patients with high risk index offences.

Managers made sure bed occupancy did not go above 85%. The current bed occupancy was 70%.

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. The expected length of stay was a maximum of two years. They were able to extend this due to taking on forensic patients. Three of the patients had been there for less than a year and one patient had been there for four years.

The service had no out-of-area placements. All the beds were funded by the local clinical commissioning group. The service did not accept out-of-area patients and very rarely moved patients out of area on discharge.

Staff did not move or discharge patients at night or very early in the morning. All admissions and discharges were planned. Discharges followed a gradual process that included graded leave from the service.

Discharge planning was not always well managed. One of the patients had started graded leave to their community accommodation but staff at the accommodation had raised concerns about the patient's conduct. There was lack of adequate action taken by staff to mitigate further risk which resulted in the breakdown of this plan.

Two of the patients did not have a discharge plan and had been at the service for a year.

When they were present, discharge care plans included rehabilitation goals and living skills.

Facilities that promote comfort, dignity and privacy

The service did not always maintain the privacy and dignity of all service users.

Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. The food was of good quality and patients could make hot drinks and snacks at any time.

When male patients were in the garden, they were able to look into female patients' bedrooms. The service was looking into partitioning the garden in order to provide privacy for the female bedrooms, but this was not in place at the time of inspection.

Each patient had their own bedroom, which they could personalise. They had access to their bedrooms during the day and could also lock them.

Patients could use the medication storage cupboard in their bedrooms to store their personal possessions securely.

Staff used a full range of rooms and equipment to support treatment and care.

The service used the female lounge as an area where patients could meet with visitors privately.

Patients could make phone calls in private. Patients could use their own mobile phones and had access to a computer on the unit. The only exception was for patients whose Ministry of Justice restrictions meant they could not have their own phone.

The service had an outside space that patients could access easily. There was a communal garden that patients could access throughout the day with no restrictions to using it. The doors were locked at midnight and staff would open them should patients request this.

Patients could make their own hot drinks and snacks and were not dependent on staff. There was a communal lounge with kitchen space where patients took part in communal cooking to improve their skills. It was adequately equipped with a microwave, fridge, a dishwasher and utensils.

The service offered a variety of good quality food. The menus were planned around patient preference.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships. However, patients and carers reflected that they felt access to activities off the unit were limited.

Staff made sure patients had access to opportunities for education and work, and supported patients. Patients took part in educational courses as well as voluntary work with support from the service's occupational therapist. Patients had also taken part in the interview process for new staff.

The service developed links with charities and community agencies to provide employment, courses and positive activities for patients. This included budgeting, healthy lifestyle and healthy relationships as well as exercise groups. They also ran a co-production group with service users from different settings me to look at shared ideas or improvements.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff were also able to link patients with volunteering opportunities and two of the patients had secured volunteering positions. They also provided activities that promoted community integration such as patients litter picking in their neighbourhood.

Some of the patients and carers expressed wanting the service to provide more activities off the ward including group activities. They also expressed wishing there was more staff to provide this. The service had provision to book extra staff for planned activities. The rotas did not reflect that extra staff were booked frequently

Meeting the needs of all people who use the service

Long stay or rehabilitation mental health wards for working age adults

Inadequate

The service observed other cultures by having theme days celebrating other religious festivals.

Staff were able to access interpreters if required.

Listening to and learning from concerns and complaints

The service accepted complaints and provided information on how to raise a complaint.

The service clearly displayed information about how to raise a concern in patient areas. Of the four patients spoken to, one of them reported knowing how to complain if they needed to.

The registered manager stated they generally didn't receive many complaints and had not received one for some time. There were no complaints reported between December 2021 and May 2022.

There was no evidence of oversight of complaints or identification of themes. Complaints were documented in the staff meeting record.

There were some compliment cards on the wall, and these were also noted in the staff meeting.

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

Inadequate

Leadership

Leaders did not have the skills, knowledge and experience to perform their roles. Senior leaders did not have had a good understanding of the service and were not visible or approachable for patients and staff.

Senior leaders had little oversight of Ashwood Court Nursing Unit. They were not aware of the issues found during inspection and were not visible in the service. When immediate assurance was sought by way of a letter of intent, senior leaders were unable to provide the assurance needed that action would be taken to ensure the safety of patients.

The registered manager was also the registered manager for the provider's nursing home adjacent to the unit. This meant they were not able to be present full time at the unit. There had been a deputy manager who had left and not been replaced.

Vision and strategy

Staff did not know or understand the provider's vision and values and how they applied to the work of their team.

Staff were not aware of the provider's vision of putting 'wellbeing at the heart of health and social care' as well as their mission that read 'Together we build relationships, connect communities and provide quality care as unique as the people we support'.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Culture

The culture was not one of safety. Staff seemed unaware of their duty to report incidents to other statutory agencies or to continually review and assess patient risk. Staff appeared unsupported by senior leaders in the organisation.

There was limited interaction with outside agencies due to failings on the part of the service to submit mandatory information such as notifications or safeguarding referrals.

Staff were not afforded the opportunity to reflect on their practice or the needs of their patients. There was no psychology led reflective practice sessions and a lack of clinical supervision.

Staff were not provided opportunities for career development and progression as they had not had an appraisal for two years.

Staff had not raised concerns with the provider about the care and treatment provided at the unit, such as the lack of governance, risk management and training amongst others. It was unclear whether this was because staff did not see these risks for themselves or did not feel able to raise these concerns.

Staff appeared anxious but were generally positive with regards to their working environment. Most of the staff had been in post for many years. The staff with the shortest employment term had been in post for five years.

Governance

Our findings from the other key questions demonstrated that governance processes did not operate at team level and that performance and risk were not managed well.

The service did not have robust audit systems in place to assess, monitor and improve the quality and safety of the service. Staff had not reported incidents to the Care Quality Commission or local authority as required, but this had not been identified by managers.

Managers did not audit care records to ensure they were accurate, complete and contemporaneous for each service user. The IT system indicated when a care plan was due for completion, but there was no system in place to check whether it was actioned or assess the quality of the care plan.

The medicines management audit was overdue, but no action had been taken to correct this. The clinic room checklist identified lifesaving equipment was missing or out of date, but no-one followed this up or actioned it.

The service did not have a policy that identified when care plan documentation or risk assessments should be reviewed. Mangers and staff were unaware that five patients had no risk assessments or crisis plans in place.

The service told us they did not carry out restrictive interventions, yet their policy stated it could be used as a last resort. The service did not have an incident management policy; therefore, incidents were not accurately graded, reported or reviewed and there was no evidence of learning from incidents.

We took enforcement action about this. See the areas for improvement section for more information

Long stay or rehabilitation mental health wards for working age adults

Inadequate

Staff training records were confusing, with due dates for completion having passed but staff marked as compliant. Staff were not given adequate training to keep people safe. Only two staff were compliant with first aid training and staff did not receive basic life support training. Staff were not trained in managing violence and aggression, despite incidents occurring on the unit.

Staff did not receive formal clinical supervision.

Management of risk, issues and performance

Teams did not have access to the information they needed to provide safe and effective care.

The service had a new IT system installed in March 2021. The manager reported not all of their documentation had transcribed to the new system.

There were gaps in the completion of incident forms. The service did not have a dashboard for monitoring incidents or trend analyses.

The service did not have a risk register at the time we carried out the inspection. The service developed one following the inspection.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The service had a good electronic system however information was either missing or not fully completed in the care records.

Managers used an electronic system to support their management of staff rotas.

Staff had access to information via the provider's intranet.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service worked alongside the local clinical commissioning group, however this was not a transparent relationship as they were not made aware of some of the incidents or issues on the unit.

Learning, continuous improvement and innovation

There was a lack of learning, innovation and continuous improvement. The service had not undertaken any quality improvement projects.

Long stay or rehabilitation mental health wards for working age adults

Inadequate

One staff member had received a national award for developing the Physical Health Pathway.

The service had just undergone a quality assurance and accreditation process undertaken by the Royal College of Psychiatrists and was awaiting feedback.

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 9 HSCA (RA) Regulations 2014 Person-centred care The service must ensure that patients and their carers or families are involved in their care and treatment, where appropriate.

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 The service must ensure that staff are adequately trained in basic life support. The service must ensure that all staff are up to date with the provider's mandatory training. The service must ensure that patients have access to enough medical cover to support with their safe care and treatment. The service must ensure that staff have access to formal clinical supervision and appraisals. The service must ensure that they have adequate management arrangements in place. The service must ensure that staff understand their role and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and Mental Capacity Act 2005.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

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

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

The service must ensure that the privacy and dignity of all patients is protected. The service must ensure that male

patients cannot see into female patient's bedrooms and that staff are able to observe patients whilst maintaining

their privacy and dignity.

This section is primarily information for the provider

Enforcement actions

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Lack of adequate risk management

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 Lack of systems and processes for effective audit