Cambian - Aspen House

Quality Report

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Date of inspection visit: 27 October 2016
Date of publication: 23/01/2017

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

Are services safe?	
Are services effective?	
Are services caring?	
Are services responsive?	
Are services well-led?	

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 carried out an unannounced focussed inspection and found that:

- The hospital was using blanket restrictions. We found staff searched all patients on return from unescorted leave and staff supervised patients opening their parcels. In addition, patients had set bedtimes during the week and at weekends where staff asked them to return to their bedrooms. Access to outdoor space was at set times when it was permitted for patients to smoke. These were set times outside of the therapeutic and activity sessions and mealtimes. The telephone box was kept locked. We found that these restrictions had not been individually risk assessed. Care and treatment records that we reviewed did not contain information in relation to these restrictions and the rationale why this was proportionate for each individual patient.
- Items that patients' were not permitted to hold in their possession were stored in contraband storage. Individual care and treatment records contained a log of items which detailed if patients could access these with or without staff supervision. We could not identify how patients' needs and risks directly related to risk items in contraband in the records.
- We found that some staff had prevented patients from accessing the kitchen during the night for hot drinks by overriding key access. We raised this with the hospital manager who told us that this was not an agreed practice and would address this immediately.
- Not all staff had received training in the Mental Health Act code of practice since the last update in March 2015. Thirty three percent of staff still required this training. This equated to 15 members of staff.
- The hospital did not have a central record of informal complaints or issues raised.

However;

- Staff told us about the restrictive practice including the blanket restrictions identified and these were recorded on the hospital risk register.
- Four patients told us that they felt safe and happy at Aspen House and observations showed that staff knew patients well and treated them with kindness.
- The hospital had facilities to promote activities for therapy and recovery including a sensory room, gymnasium, hair salon and internet café.
- Staff involved patients in the development of their care plans. Care plans contained personalised information and patients' views and aspirations for the future.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Long stay/ rehabilitation mental health wards for working-age adults		Inspected but not rated.

Summary of findings

Contents

Cambian - Aspen House

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

Summary of this inspection

Background to Cambian - Aspen House

Aspen House is an independent mental health hospital in Mexborough, Doncaster. The unit provides long stay rehabilitation mental health services for up to 20 female patients aged 18 and over. Aspen House provides mental health services for patients with a primary diagnosis of mental illness with complex needs. The hospital is provided by Cambian Healthcare Limited.

At the time of our inspection Aspen House had a registered manager and is registered to provide assessment or medical treatment for persons detained under the Mental Health Act 1983 and treatment of disease, disorder or injury.

We last inspected Aspen House in April 2015. At the time of that inspection Aspen House was registered with another independent mental health hospital as one location. Since our last inspection the provider has registered these hospitals as separate locations. The last inspection was a comprehensive inspection. We rated Aspen House as 'good' overall during this inspection. We have not inspected or rated the location of Aspen House under our current methodology.

Our inspection team

The team that inspected the service was comprised of two Care Quality Commission inspectors.

Why we carried out this inspection

We carried out an unannounced focussed inspection at Aspen House following concerns around restrictive practice and the use blanket restrictions. Blanket restrictions are defined by the Mental Health Act code of practice 2015 as rules or restrictions which are routinely applied to all patients without individual risk assessments to justify their use.

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 Aspen House. We completed an unannounced focussed inspection. This meant that the provider did not know we were visiting.

During the inspection visit, the inspection team:

- visited Aspen House and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with five patients who were using the service
- spoke with the registered manager
- spoke with six other staff members; including nurses, occupational therapist, support worker, head of hotel services
- looked at four care and treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

Summary of this inspection

What people who use the service say

During our inspection we spoke to five patients. Four patients told us that they felt safe, happy and reported that the food provided was nice with options for different dietary requirements. One patient told us the hospital was clean and staff provided support to them when they needed it. Two patients told us that the hospital management team addressed any issues raised promptly and resolved complaints quickly.

Three patients told us that the hospital had a set time for patients to return to their bedrooms at night time. They told us that on weekdays staff asked them to go to their bedrooms at 11.30pm. Patients told us that they can have a last cigarette at 11.15pm before going to their bedrooms for 11.30pm. On weekends patients told us that staff asked them to go to their bedrooms at 12.45am. Patients told us that mostly they all go to bed when requested because they needed to be awake in the morning. One patient told us that after returning to their bedrooms that patients could watch television in their bedrooms if they chose to. One patient told us that a set bedtime was discussed with patients and agreed during a community meeting. However, another patient told us that the hospital manager decided this and afterwards patients agreed to this in a meeting.

Patients told us where patients could safely use the kitchen independently they had their own key to access this area. One patient told us that staff will make hot drinks between ten minutes to the hour and the hour every hour during the day for patients that did not have independent kitchen access. All patients told us they had access to water at any time. Two patients told us that staff did not allow them to have hot drinks at night time. One patient told us that their key to the kitchen area did not work during the night because staff overrode the lock during the night. However, they told us that they have supper at 9pm each night and that staff would not deprive them of drinks or food if they felt unwell.

Three patients told us that during weekdays access to the garden area was restricted at set times. This was around the therapeutic timetable and mealtimes. From 4pm on weekdays the garden was open until 11.15pm. One patient told us that some patients have smoking plans to assist them with continuing smoking within their monetary budget.

One patient told us that they have private access to letters sent to them by post but staff were present when opening parcels received. However, on some occasions they reported that staff requested patients to open letters in the presence of staff. They explained that the reason staff gave for this was that there could be an appointment they needed to know about to make arrangements. One patient told us that parcels had to be opened in front of staff because of the risk of plastic entering the unit.

Patients told us that when they returned back to the hospital from unescorted leave that staff asked them to show what was in their bags and pockets. One patient told us that they were allowed to bring in one bar of chocolate or a packet of crisps and a small bottle of pop and anything in excess of this goes into contraband cupboard. They told us that the hospital did not allow energy drinks, razors or batteries onto the ward.

One patient told us that they did not like way they were treated by staff and told us they did not have access to as and when required medication. They also raised concerns about access to cigarettes. We raised these concerns with the registered manager and we were informed that during our inspection part of these concerns had been addressed already by the registered manager. The registered manager took action immediately to address the other concerns raised.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that:

- The hospital had blanket restrictions in operation in relation to the searching of all patients on return from unescorted leave, supervising all patients opening parcels received, set bedtimes where staff asked patients to return to their bedrooms and set times for access to garden areas for smoking. The telephone box was kept locked. These restrictions were not based on an individual risk assessment. Care and treatment records did not contain information in relation to these restrictions including rationale for these restrictions. This was not in line with the Mental Health Act code of practice 2015.
- We found that some staff had prevented patients from accessing the kitchen area during the night for hot drinks by overriding the key access. We raised this with the hospital manager who told us that this was not an agreed practice at the hospital and would address this immediately.
- Patients' records contained a log of items which staff had recorded could not be held by patients. This document recorded the item and whether patients could access this with or without staff supervision. We could not identify in the care and treatment records how patients' needs and risk had been assessed to determine that possession of these items was not safe.

Are services effective?

We found that:

- Not all staff had received up to date training in the Mental Health Act code of practice 2015. Thirty three percent of staff had not completed training in the Mental Health Act since to the update in the code of practice in 2015. The hospital manager told us that the hospital expected all staff to have completed this on courses in February and August 2017.
- Care plans did not reference any blanket restrictions in operation in relation to searching of patients, staff supervision when opening parcels, set bed times and set smoking times and access to outdoor space.

However;

- Patients' care plans contained personalised information including the patients' views and aspirations for the future.

Summary of this inspection

Are services caring?

We found that:

- Interactions between staff and patients showed that staff knew patients well and treated patients with respect.
- Four patients told us that they felt safe and happy at Aspen House.
- The hospital facilitated access to independent mental health advocacy. In the three month period between May and July 2016, 198 sessions between patients at Aspen House and advocates took place.

However;

- One patient raised concerns about their care and treatment. We raised this with the hospital manager and they informed us that some of these concerns had already been addressed and assured us that they would address the remaining concerns immediately.

Are services responsive?

We found that:

- The provider's policies on safeguarding and complaints contained easy read information to enable patients to understand and follow the process when needed.
- The hospital had adequate facilities to provide therapeutic and recovery orientated activities. This included a gymnasium, sensory room, an internet café and a hair salon.

However;

- The hospital did not have a single record to reference informal and low level complaints made. Staff told us that they resolved these informally and did routinely record these as complaints.

Are services well-led?

We found that:

- The hospital had clinical governance meetings which discussed restrictive practice. We saw that this meeting reviewed the restrictive practice in place around set bed times and smoking times.
- The hospital risk register contained items on blanket restrictions in place including risk items, bed times, smoking times and supervision of patients' opening correspondence.

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.

At the time of our inspection there were 18 patients at Aspen Hospital detained under parts II and III of the Mental Health Act 1983.

Staff training in the Mental Health Act was delivered with Mental Capacity Act training and training in Deprivation of Liberty Safeguards. Information sent by the provider showed that 67% of staff had completed training since the updated Mental Health Act code of practice in 2015.

There were 15 members of staff that required training in line with the current guidance on the Mental Health Act. Thirteen staff had completed this training prior to March 2015 and two staff had not completed training in the Mental Health Act. Managers told us that staff that had not completed up to date training in the code of practice were due to attend this training in February and August 2017. In addition, the hospital manager told us that additional in house training would be delivered on the code of practice by Mental Health Act administrators.

The hospital had blanket restrictions in place in relation to: the searching of all patients on return from unescorted leave, staff observed all patients opening parcels, a bed time curfew was in place for patients to return to their bedrooms, access to fresh air was restricted to set times and the telephone box was locked on the ward.

The routine searching of all patients on return from unescorted leave was not in line with the Mental Health Act code of practice 2015. This states that searching of patients should be proportionate to an identified risk and should involve the minimal possible intrusion to the individual's privacy. Care and treatment records that we reviewed did not contain information about searching, risk specific to items entering the hospital or the risk of patients bringing items into the hospital. We did not see reference in patients' individual records that patients would be searched on return from leave.

The searching of patients was completed in the entrance air lock to the hospital. The Mental Health Act code of practice 2015 states that searches carried out should ensure the privacy and the dignity of the individual. The code of practice further states that searches could only be justified in public areas under exceptional circumstances. This practice was not line with legislation and guidance.

We found the hospital had a blanket restriction where staff observed all patients when they opened parcels received. The care and treatment records that we reviewed did not contain information regarding the opening of mail including parcels. The care and treatment records did not contain information relating patient risk to incoming mail into the service. The Mental Health Act code of practice 2015 states that blanket restrictions including involving incoming mail do not promote independence or recovery and may breach a patient's human rights.

The hospital operated a night time curfew at set times during the week and on weekends. Staff asked patients to return to their bedrooms at this time for the night. Community meeting minutes reviewed did not show where this was agreed with patients and reviewed. This practice was a blanket restriction and did not relate to individual patient need or risk in care and treatment records.

There was a blanket restriction in relation to outdoor space. Patients could access outdoor space outside of the therapeutic and activity timetable and mealtimes. Patients' care and treatment records did not contain information about any individual risk in access outdoor space or using smoking equipment to justify this restriction. There was no evidence in community meeting minutes that access to outdoor space and smoking times was discussed with patients.

Patients did not have access to the telephone box freely as this was locked. Staff opened this for patients to use when needed. Care and treatment records did not show why this was required for individual patients' needs or risks.

Some staff had restricted access to the kitchen during the night for patients to make hot drinks and one staff told us

that they discouraged patients from making hot drinks between 2am and 4am. The registered manager told us that this was not an agreed practice and told us that they would address this immediately.

Staff and one patient told us that on return from leave patients were limited to how many carbonated soft drinks they could have. Any excess drinks were stored in the contraband cupboard. The hospital had a contraband cupboard where any items determined as a risk item were stored. Patients care and treatment records show individualised logs for risk items. However, these logs did not related patients individual risks to explain why these items posed a risk for the individual patient.

Patients had access to their own mobile telephones and a telephone box. Staff told us that the telephone box was locked when not in use. Patients could access this by asking staff to open it. Staff told us this was due to individual risk of some patients on the ward. However, we reviewed four care and treatment records and we did not see information relating to the phone box being locked in patients' care plans or risk assessments.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act is a piece of legislation which maximises an individual's potential to make informed decisions wherever possible. It provides guidance and processes to follow where someone is unable to make a decision.

Ninety six percent of staff had completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards. At the time of our inspection there was one patient that was informally receiving care and treatment. They had provided their informed consent to staying at Aspen House to receive care and treatment. There were no patients subject to a Deprivation of Liberty authorisation.

We saw examples on patients' care and treatment records of capacity assessments completed in relation to making decisions about money. These capacity assessments incorporated the stages of the two part test of capacity. This was in line with legislation and guidance.

We also saw examples of how patients had the right to make unwise decisions. Examples of this were where patients had health conditions and wanted to continue smoking. We saw that staff worked with patients to understand and weigh up the information including the potential risks to health from smoking. We saw that some patients did not consent to taking part in smoking plans to regulate and reduce the amount of cigarettes they smoked. These patients continued to smoke cigarettes by choice.

Long stay/rehabilitation mental health wards for working age adults

Safe	
Effective	
Caring	
Responsive	
Well-led	

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

Safe and clean environment

The ward was laid out across two levels. The ground floor level was the main ward area with communal facilities and amenities and some patient bedrooms. The upper level was where other patient bedrooms were situated. The ward layout did not allow staff to observe all areas of the ward. However, this was mitigated through staff observation of ward areas and mirrors positioned to enable staff to observe potential blind spots. Staff could access ligature cutters on both levels of the ward when needed. Ligature cutters are equipment used to release items used by individuals in an attempt to restrict their airway and cause strangulation.

The ward provided care and treatment to female patients only. This complied with guidance on same–sex accommodation. The hospital did not have seclusion facilities.

The hospital was clean and well-maintained. The hospital employed a domestic cleaning team which included a head of hotel services to manage the cleaning and catering of the hospital.

On arrival all staff and visitors to the ward were provided with a personal alarm. When activated this sounded to alert staff to people in need of assistance. During our inspection, we heard the alarm sound and saw that staff responded promptly to the location where the alarm had been activated. Staff and patients told us that staff responded quickly to the alarm sounding.

Safe staffing

The hospital had a minimum staffing requirement of two qualified staff and five support workers during the day shift and two qualified staff and four support workers during the night shift each day. At the time of our inspection staff reported that the hospital did not use agency staff. The hospital employed bank staff who were asked if they could work shifts as and when required.

During our inspection we reviewed information in relation to mandatory staff training. As of 27 October 2016 the overall completion rate of mandatory training was 98%.

Assessing and managing risk to patients and staff

The hospital used the short term assessment of risk and treatability risk assessment tool. The tool was used to develop a risk score based on patients' current and historical risk. This tool included information on: verbal aggressions, physical aggression against objects and people, self-harm, suicide, unauthorised leave, substance misuse, self-neglect, vulnerability to exploitation or victimisation, sexually inappropriate behaviour and stalking. We reviewed four patients' care and treatment records and found that these contained a completed and regularly reviewed short term assessment of risk and treatability risk assessment.

In addition the hospital used a red, amber and green risk assessment. This provided a one page summary of risk. The multidisciplinary team used this risk assessment to rate risk based on the three colours. Red represented a high risk, amber a medium risk and green a low risk. The red, amber, green risk assessment stated the presenting risk which represented the reason for the colour rating given. Staff reviewed patients on a red risk each morning in the multidisciplinary meeting. We reviewed four care and treatment records and found that all records contained red, amber and green risk assessments. Staff told us that when

patients were identified as being a red risk there was a minimum period of 7 days where patients remained on a red risk status with a daily review. There was evidence that staff reviewed risk daily for patients' identified as red risk.

We found that the hospital had blanket restrictions in operation. Blanket restrictions are defined by the Mental Health Act code of practice 2015 as rules or restrictions which that restrict a patients' liberty or other rights, which are routinely applied to all patients, or groups of patients, within a service without an individual risk assessment to justify their application. During our inspection, we spoke to staff, patients and reviewed care and treatment records. We found that the hospital had a blanket approach to searching patients on return from unescorted leave and supervising patients opening parcels received. We also found that there was a set bedtime on evenings for patients to return to their bedrooms, set times for access to garden areas and lighters for smoking. The provider's policy on reducing restrictive interventions stated that where there is not an immediate risk that restrictive interventions should be based on individual risk assessment and a person centred care plan. The policy further states that blanket restrictions should be entered on the risk register and blanket restrictions should have a reduction plan in place with regular reviews and reductions where possible in restrictive practice.

We found that the hospital undertook routines searches of all patients on return from unescorted leave. At the time of our inspection the hospital had 19 patients. Eighteen patients were detained under the Mental Health Act 1983 and one patient had informal status. This meant that this patient had given informed consent to staying at Aspen House to receive care and treatment. The hospital had no patients subject to a Deprivation of Liberty Safeguards. Staff and patients told us that on return from unescorted leave staff asked all patients to show items that they are carrying back into the service. Staff and patients told us that patients always show staff what they have brought back into the service. Staff told us when patients are reluctant to; they explained to patients this is to prevent items of risk from entering the hospital. We asked staff what would happen if a patient refused being searched on return from leave and staff told us that they would encourage the patient whilst in the air lock entrance and would escalate this to their managers if the patient would not consent. The Mental Health Act code of practice 2015 states that searching of patients should be proportionate to an identified risk and should involve the minimal possible intrusion to the individual's privacy. The provider's policy on searching stated that searches should not be a routine practice unless there were exceptional circumstances. The policy further states that searches must be completed based on individual patient risk. The care and treatment records that we reviewed did not contain information about searching, risk specific to items entering the hospital or the risk of patients bringing items into the hospital. We did not see reference in patients' individual records that patient's would be searched on return from leave. The hospital risk register did not contain information about searching patients. In addition, the Mental Health Act code of practice 2015 states that searches carried out should ensure the privacy and the dignity of the individual. The code of practice further states that searches could only be justified in public areas under exceptional circumstances. This was not line with legislation and guidance or the provider's policy on reducing restrictive interventions.

Staff and patients told us that there were items that were not permitted into the unit for all patients and these included: razors, tin cans, glass, aerosols, lighters and plastic bags. Staff and managers told us that the hospital does not allow plastic bags to enter the ward areas due to current individual patient risk. One member of staff told us that plastic bags had not been allowed for the past two years. We saw that the hospital had a notice in the reception area which stated that plastic bags and what other items were not permitted in the hospital. The hospital risk register contained a log of items that were not permitted in the service which were: plastic bags, glass bottles and jars, lighters, metal cans and alcohol. The risk register contained information in relation to an incident involving a plastic bag. Following this incident it was decided that plastic bags would not be allowed in the hospital.

Staff and one patient told us that on return from leave patients were limited to how many carbonated soft drinks they could have. Any excess drinks were stored in the contraband cupboard. One patient and the hospital manager told us that patients could not bring energy drinks into the hospital. We saw the contraband cupboard was a store room for any items determined as a risk item. We reviewed four patients' care and treatment records; they contained an individual log of the patients' items that were kept in the contraband cupboard. This log stated whether patients could access these with staff supervision or

without. This log was not always in line with the items prohibited from the hospital for all patients. We saw examples of items such as baby wipes and other household items which were stored in the contraband cupboard and only accessible with staff supervision. Staff reviewed these logs regularly. Although patients' had an individual risk assessment, we could not identify from the records how patient risk in the risk assessment related directly to the risk items as a rationale for access to these items being restricted.

We found the hospital had a blanket restriction where staff observed all patients when they opened parcels received. Staff and patients told us that letters received by patients are handed out by staff and signed for by patients to say they have received these and the quantity received. One patient told us that staff asked them to open letters in front of staff because staff told them that there could be an appointment contained. One patient and staff including managers that we spoke with told us that patients open their letters in private but opened parcels in the presence of staff. Most staff and all patients told us that this was due to the risk of plastic packaging within parcels and the risk of this entering the hospital. However, one staff member told us that this was to reduce the risk of drugs entering the hospital. The care and treatment records that we reviewed did not contain information regarding the opening of mail including parcels. The provider's policy on correspondence stated that where it is suspected that correspondence may contain items of risk or danger then it can be permitted for staff to observe this correspondence being opened. However, the policy further stated that this must be identified through an individual risk assessment and also recorded in the patient's notes. The hospital's risk register had an item entered that patients' with a risk of self-harm or illicit substance misuse were requested to open their post in the presence of staff where patients' were identified as a risk. However, the care and treatment records did not contain information relating patient risk to incoming mail into the service. The Mental Health Act code of practice 2015 states that blanket restrictions including involving incoming mail do not promote independence or recovery and may breach a patient's human rights.

Staff including hospital managers and three patients told us that the hospital had a night time curfew. This was a set time during the week and weekends where staff asked patients to return to their bedrooms for the night. Staff and patients told us that patients are asked to return to their bedrooms by 11:30pm during the week days. Some staff and all patients told us that the time is 12:45am on weekends and 6am in the mornings. One staff told us this was by 2am on weekends. Staff and patients told us that all patients go their own bedrooms at this time each night. One patient told us that they can choose to watch television in their bedrooms at night time. One patient told us that a set bedtime was discussed with patients and agreed during a community meeting. However, another patient told us that the hospital manager decided this and afterwards patients agreed to this in a meeting. Staff and managers told us that this was agreed with patients in a community meeting. We reviewed the minutes from the last 12 community meetings and we did not see evidence of set bedtimes being discussed or agreed with patients. We reviewed the minutes from a clinical governance meeting this discussed the set bedtimes in place. It was agreed during this meeting that set bed times would be entered onto the hospital risk register. The hospital risk register had items recorded that the hospital had set bedtimes to encourage a healthy sleep routine and promote engagement in the therapeutic timetable during the day.

Patients had keys to access the kitchen when assessed as safe to use the kitchen independently. Staff supported patients who did not have access to the kitchen to make hot drinks. One patient told us that staff made hot drinks for patients between 10 minutes to the hour and the hour. However, patients and staff told us that they have free access to cold drinks at any time of the day or night. Two patients told us that staff did not allow patients to have hot drinks at night time. One patient told us that access to the kitchen was prevented during the night as the lock was overridden by staff. This meant that their key to the kitchen did not work. Two members of staff told us that the kitchen was locked so that patients could not access this during the night. One member of staff said that staff discouraged patients from making hot drinks between 2am and 4am during the night. However, two members of staff and hospital managers told us that patients with keys to access the kitchen had access at any time during the night. During our inspection we informed the hospital manager that it had been reported to us that kitchen access was not always available for patients. They assured us that this had not been an agreed practice and would address this.

We found that there was a blanket restriction in relation to access to outside space. During our inspection three

patients told us that access to the hospital garden areas including access for smoking was at set times during weekdays and during the night. Patients told us that access to the garden was possible during breaks in the therapy and activity timetable and outside of mealtimes. They also told us that the garden area was closed during the night time. Three staff members told us that there is an hourly slot time where the garden was accessible and the garden was closed around activities, meals and medication times. One member of staff told us that the garden can be open at all times but access to the lighter to light cigarettes was permitted at smoking times each hour which were did not include times when patients were expected to be engaged in therapy. The hospital manager told us that there were set smoking break times during the day on weekdays. They told us that there had been no complaints from patients regarding smoking times. Support had been offered to patients around creating smoking plans to support patients in regulating or reducing their smoking. In order to smoke patients required access to a lighter to light cigarettes. The hospital did not allow patients to have lighters. The provider's policy on smoking stated that patients must have an individual risk assessment to assess smoking support required and this must include the independent use of lighters. The policy further stated where a blanket restriction is in place around the use of lighters that the hospital must follow the reducing restrictive interventions policy. The care and treatment records that we reviewed did not contain information regarding patients' access or ability to use smoking equipment. However, at the time of our inspection the risk register contained lighters listed as a prohibited item.

We saw occasions recorded in care and treatment records that during the night some patients had accessed the garden to smoke cigarettes. The minutes from the clinical governance meeting that took place on 12 September 2016 discussed the smoking times and staff agreed these would be placed on the hospital risk register. There was an action point that this would be discussed with patients during a community meeting. We reviewed the minutes from the last 12 community meetings with patients and did not see evidence that smoking times and access to the garden was discussed or agreed with patients.

Patients had access to their own mobile telephones and a telephone box. Staff told us that the telephone box was locked when not in use. Patients could access this by asking staff to open it. Staff told us this was due to individual risk of some patients on the ward. However, we reviewed four care and treatment records and we did not see information relating to the phone box being locked in patients' care plans or risk assessments.

We reviewed information relating to safeguarding during our inspection. All staff told us that they would report concerns to the hospital manager or the on call manager if this was out of hours. The provider's safeguarding policy was in line with current legislation and detailed the Care Act 2014. The hospital had individual safeguarding files for each patient. Between 5 April 2016 and 5 October 2016 there were 19 recorded safeguarding records. We saw that these were all referred to the local authority safeguarding teams within 24 hours and a CQC statutory notification was completed for each safeguarding referral. This was in line with the provider's policy. However, the outcome of safeguarding referrals was not always recorded. We asked managers and they told us they sometimes are not informed of the outcome from the local safeguarding team.

Are long stay/rehabilitation mental health wards for working-age adults effective?
(for example, treatment is effective)

Assessment of needs and planning of care

During our inspection we reviewed four care and treatment records. We saw that all records contained an assessment of needs on admission. Three records contained a full record of physical examination completed on admission. One record contained a brief physical assessment. However, the record documented that a full physical examination had been refused by the patient.

All care and treatment records that we reviewed contained personalised care plans. The care plans covered a range of aspects of care and treatment which included information about: key aims, assessment of needs, personal needs, social needs, mental health needs, rehabilitation needs, restrictions, potential risk, physical needs, leave and contingency plans. However, the records that we reviewed did not contain any reference to restrictions in place in respect of access to the garden area, smoking times, bed times, access to parcels, or prohibited items.

There was documentation to show how the patients' individual views and aspirations had been obtained through person centred care planning documentation. Staff reviewed patient's care plans regularly.

Patients' care and treatment records were mostly handwritten and filed in patients' personal files. Staff printed the records which were electronically recorded such as risk assessments and care plan documentation and filed these in patients' personal files. All records relating to patients' care and treatment were stored as a single contemporaneous record in the patients' personal files.

Skilled staff to deliver care

During our inspection, information reviewed showed that as of 27 October 2016 that the appraisal rate was 67%. We reviewed the supervision log and this showed that on average between January 2016 and October 2016 that qualified and unqualified staff received an average of four to six supervision sessions during this time. Supervision logs for the hospital manager and the head of care showed that within the same period two supervisions were received.

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

At the time of our inspection there were 18 patients at Aspen Hospital detained under the Mental Health Act 1983. The hospital provided care and treatment to patients on parts II and III of the Mental Health Act.

Training in the Mental Health Act was not up to date. Information provided by the hospital showed that 67% of staff had attended training in the Mental Health Act since the updated code of practice in March 2015. Thirteen staff had attended Mental Health Act training prior to March 2015 and had received training in line with previous guidance on the Mental Health Act. Two staff had not completed Mental Health Act training. The hospital had training dates scheduled for February and August 2017 for remaining staff to attend training in the updated code of practice. The hospital manager informed by that further in house training would be delivered by Mental Health Act administrators to staff.

The hospital operated with blanket restrictions in place. Staff searched all patients on return from unescorted leave. The Mental Health Act code of practice 2015 sets out guidance for the searching of patients which states that this should uphold the privacy and dignity of individuals and should only occur in public places in exceptional circumstances. The code of practice states that searching should not be routinely carried out and should be based on individual patient risk. Staff completed routine searches and these took place in the air lock entrance to the hospital. This was not line with legislation and guidance.

All patients opened their parcels in the presence of staff. The care and treatment records reviewed did not contain information regarding any restrictions in place with mail. This was not in line with the code of practice guidance.

Other blanket restrictions in place included set bed times where staff asked patients to return to their bedrooms at set times of the night. Patients had access to fresh air at set times which were outside of the therapeutic and activity timetables and meal times. The telephone box was locked on the ward. Patients' care and treatment records did not contain information about how individual patient risk justified the application of these restrictions. This was not in line with the Mental Health Act code of practice 2015.

The hospital had restrictions on how many carbonated soft drinks that patients could have. Any additional drinks were placed by staff in the contraband storage. The contraband cupboard was a store room for any items determined as a risk item. We reviewed four patients' care and treatment records; they contained an individual log of the patients' items that were kept in the contraband cupboard. Patient's items deemed as risk items were stored in the contraband cupboard along with items that the hospital had prohibited for all patients. Care and treatment records contained information about individual risk items which identified the level of supervision patients required when using items. These records were reviewed regularly however, risk assessments did not detail how individual patient risk related to the risk item to justify restricted access.

Patients had keys to access the kitchen when assessed as safe to use the kitchen independently. Staff supported patients who did not have access to the kitchen to make hot drinks. During our inspection, some staff and some patients told us that patients could not access the kitchen during the night because staff overrode the lock which meant that their keys to the kitchen did not work. One staff member told us that they discouraged patients from making drinks between 2am and 4am during the night. Patients had access to cold drinks at any time. During our

inspection we informed the hospital manager that it had been reported to us that kitchen access was not always available for patients. They assured us that this had not been an agreed practice and would address this.

Good practice in applying the Mental Capacity Act

Staff received training in the Mental Capacity Act and the Deprivation of Liberty Safeguards. Information provided by the hospital showed that 43 out of 45 staff had completed this training. This meant that 96% of staff were compliance in Mental Capacity Act training.

At the time of our inspection there was on informal patient. This meant that this patient had provided informed consent to their stay at Aspen House to receive care and treatment. There were no patients subject to a Deprivation of Liberty Safeguards authorisation. We did not inspect this aspect of the Mental Capacity Act adherence.

Patients' records contained some examples of mental capacity assessments. These were in relation to making decisions about finances and handling personal finances. These capacity assessments followed the two stage test and were in line with legislation and guidance. Records also contained information to show how patients' with capacity to make unwise decisions were supported. Examples of this were in relation to patient with capacity deciding to continue smoking. Staff provided information to patients to enable them to understand and weigh up the potential risks involved in smoking. This included financial and health risks. Some patients had agreed to a smoking plan to reduce the amount of cigarettes they smoked. Other patients with capacity had chosen to continue to smoke.

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

Kindness, dignity, respect and support

During our inspection we spoke to five patients. Four patients told us that they felt safe, happy and reported that the food provided was nice with options for different dietary requirements. One patient told us the hospital was clean and staff provided support to them when they needed it. Two patients told us that the hospital management team addressed any promptly and resolved complaints quickly.

One patient told us that they did not like way they were treated by staff and told us they did not have access to as and when required medication. They also raised concerns about access to cigarettes. We raised these concerns with the registered manager and we were informed that during our inspection part of these concerns had been addressed already by the registered manager. The registered manager took action immediately to address the other concerns raised.

We observed interactions between staff and patients during our inspection. We saw that staff knew patients and their needs well. Staff spoke to patients respectfully and we saw that they took the time to listen to what patients said to them. During our inspection we saw that staff prioritised patients who approached them or needed support and if they did not have the capacity then they asked their colleagues to help.

The involvement of people in the care they receive

Patients' care and treatment records contained documents which patients' completed to take part in their care and treatment planning. We saw that these had been completed by patients to support their inclusion in their care and treatment.

We reviewed information in relation to independent mental health advocacy support available. In the three months between May to July 2016 the hospital supported 198 patient sessions with advocates. A report into the themes of advocacy sessions showed that these were as follows: 28% external issues, 14% advocacy support with meetings, 14% finance, 22% leave or discharge, 9% ward and 7% treatment.

Each week the hospital had a community meeting for patients to attend. Patients and staff told us that patients could put forward items for discussion forward.

Long stay/rehabilitation mental health wards for working age adults

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

Access and discharge

On admission to the hospital staff told us that patients were allocated a peer buddy to show them around the hospital and orientate them to their accommodation. In addition, patients received an information welcome pack about the hospital and amenities provided. The hospital provided patients with basic items such as, towels and toiletries. Patients received an amount of money from the hospital to enable them to settle into the service and purchase anything that they needed.

At the time of our inspection the hospital had 19 beds out of 20 beds occupied. Eighteen patients were subject to the Mental Health Act 1983 and one patient was informal status.

The facilities promote recovery, comfort, dignity and confidentiality

Patient bedrooms on the ward had en suite bathrooms. We saw that patients could personalise their bedrooms with personal items to reflect their interests.

The hospital had adequate rooms for therapies and activities. We saw that there was a sensory room. A sensory room is a dedicated space to promote relaxation and stimulation of the senses. Staff told us that they worked with patients to create their own individualised box that contained items to promote relaxation. Patients could take their box into the sensory room. The hospital also had therapy rooms, a gymnasium, internet café, laundry and a hair salon. The hospital had a gym instructor visit once per week. However, patients could access the gym at other times during the week. The internet café had a hot drinks machine. Patients could access these areas by obtaining a key from staff.

On the ward there were different rooms available as sitting rooms. These rooms could be used as a quiet space for patients or for patients to host visitors.

Patients and staff told us that access to outdoor space was as set times during week and night times. They told us that staff opened the garden areas at break times in the activity and therapeutic timetables and outside of mealtimes between Mondays to Fridays. Between 4pm and 11.15pm on weekdays the garden was open. On weekends staff and patients told us that the garden was open during the day and closed at night time between 12.45am and 6am. Staff told us that during the night the garden area was closed to increase the security of the hospital. They also told us that patients had agreed to the set smoking times in the patients' community meetings. We reviewed care and treatment records for four patients. We did not see information relating to access to garden areas at any set times in patients' care plans or risk assessments. We reviewed the last 12 community meeting minutes and we could not see evidence that smoking times, access to the garden and set bedtimes had been discussed or agreed with patients. However, we saw that in the care and treatment records that staff had opened the garden area during the night time so that patients could go outside and have a cigarette.

Meeting the needs of all people who use the service

The hospital had some patient bedrooms situated on the ground floor. All patient bedrooms had call points fitted so that patients could raise the alarm if they required assistance.

We saw that policies on safeguarding and complaints contained easy read and pictorial guide to support patients to understand the processes.

Listening to and learning from concerns and complaints

Staff and patients told us that any concerns, complaints or compliments would be reported to the hospital manager or head of care in their absence. We saw that the procedure in place for the handling of complaints was last reviewed in August 2016. The procedure detailed timescales of the response required depending on the complaint being informal, formal or an appeal following the outcome of a complaint. In the last 12 months the hospital received two formal complaints. We saw that these were in relation to accessing GP appointment and alleged unprofessional staff conduct. One of these complaints was not upheld.

We did not see any record of informal complaints received by the hospital. We asked the hospital manager and they told us that the hospital had an open door culture to

receiving informal complaints. They told us that issues are mainly resolved prior to becoming an informal complaint so would be recorded in the patients' individual care and treatment care notes.

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

Good governance

During our inspection, we reviewed minutes from the last governance meeting that took place on 12 September 2016. We saw that attendees discussed effectiveness and research, audits, risk management and restrictive practice. The governance minutes noted that prohibited items were discussed during the meeting and the decision for these to continue to be prohibited was agreed. The reason for this decision was due to the incidents of self-harm and harm towards others. There was an action point for a patient leaflet to be developed to inform patients of the prohibited items. The smoking and bedtimes restrictions were discussed and decided to be added onto the risk registered. An action from this meeting was for restricted items to be discussed in the community meeting with patients.

During our inspection we reviewed the hospital risk register. This recorded that the hospital did not currently permit visits to patients in their own bedrooms. The decision for this recorded as upheld after review in the clinical governance meeting. Plastic bags, lighters, glass jars and bottles, metal cans and alcohol were recorded on the risk register as prohibited items. This was recorded as reviewed during the clinical governance meeting on 12 September 2016. The risk register also contained items on set smoking times and bedtimes and supervising patients opening mail present on the risk register.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that care and treatment is provided using the least restrictive option to maximise independence. Any restrictions in place should be in accordance with the Mental Health Act 1983 and the code of practice 2015. The code of practice states that blanket restrictions should be avoided.
- The provider must ensure that restrictions or rules that apply to patients are justified by individual risk assessments.

Action the provider SHOULD take to improve

- The provider should ensure that all staff complete training in the Mental Health Act relating to the updated code of practice 2015.
- The provider should ensure that there is a record of informal complaints received by the hospital.

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 **How the regulation was not met:** The hospital operated using blanket restrictions in relation to searching of all patients on return from unescorted leave, observing all patients opening parcels, set bed times and set smoking times including access to outdoor space. Care and treatment records did not contain information about how these restrictions were justified due to the patients' individual risk. Records relating to items place in contraband due to being risk items did not show how individual patient risk related to the specific restricted items. This was a breach of regulation 9(1)(a)(b)(c)