Ash House

Quality Report

Norris Street
Warrington
Cheshire
WA2 7RP
Tel: 01925 240515
Website: www.krinvestcaregroup.co.uk

Date of inspection visit: 10 March 2017
Date of publication: 08/05/2017

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

This was an unannounced focused inspection. We inspected because people had contacted us to raise concerns about patient safety. Ratings have not been given for this inspection.

We previously inspected Ash House in November 2016. We found breaches of the following Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 person-centred care
- Regulation 12 safe care and treatment
- Regulation 16 receiving and acting on complaints
- Regulation 17 good governance
- Regulation 18 staffing
- Regulation 19 fit and proper persons employed

We took enforcement action and rated the service inadequate overall. The Chief Inspector of Hospitals placed the service into special measures.

At this inspection we did not review the provider's progress against the breaches of regulation. We looked at the areas of concern that had been raised.

We found the following issues that the service provider needed to improve:

- Patient risk assessments did not include all relevant information or give clear guidance to staff on how to manage risks.
- Treatment goals were not recovery-oriented and patients were not involved in planning their care.
- Staff did not always feel able to raise concerns with managers and morale was low.

However we also found evidence of good practice in the following areas:

- Convex mirrors had been installed to improve lines of sight on the wards.
- Staff had access to telephones to be able to call for help in an emergency.
- Patients' medication administration records and Mental Health Act detention paperwork were up to date and stored appropriately.
- Unstructured activities for patients were available on the ward.
- Senior managers had met with the team to discuss the requirements of staff roles and the future of the hospital.

The service will continue to be monitored while in special measures and a further comprehensive inspection will take place to assess the provider's progress against all areas identified as inadequate or requires improvement.

Summary of findings

Contents

Ash House

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

Summary of this inspection

Background to Ash House

Ash House is an independent hospital for adults with complex mental health needs andpersonality disorders who require rehabilitation support. There are three wards, each with eight beds: Blake, Chaucer and Tennyson. At the time of our inspection there were six patients in the hospital, all on Blake ward.

Ash House 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.

At the time of our inspection there was no registered manager in place. A member of staff had applied to become the new registered manager.

We previously inspected Ash House on 3 and 15 November 2016. We rated the hospital inadequate and placed it into special measures.

Our inspection team

Team leader: Lindsay Neil, Inspection Manager (mental health), Care Quality Commission.

The team that inspected the service comprised a CQC Head of Hospitals inspection, a CQC inspector and a CQC enforcement inspector.

Why we carried out this inspection

We undertook this unannounced inspection because we received a number of concerns about patients' safety.

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 we reviewed information that we held about Ash House.

During the inspection visit, the inspection team:

- looked at the safety and quality of the physical environment
- reviewed four patients' care records
- reviewed all six patients' detention paperwork
- reviewed all six patients' medication administration records and looked at the arrangements for medicines management
- spoke with four members of staff
- spoke with a patient
- reviewed the incident log, senior management and team meeting minutes and complaints records for 1 January to 10 March 2017.

Summary of this inspection

What people who use the service say

We only spoke to one patient at this inspection. We have not reported his comments here to protect his confidentiality.

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 the following issues that the provider needed to improve:

- Patient risk assessments did not include all relevant information or give clear guidance to staff on how to manage risks.

However, we also found the following areas of good practice:

- Convex mirrors had been installed to improve lines of sight on the wards.
- Staff had access to telephones to be able to call for help in an emergency.
- Patient medication administration records were in order.

Are services effective?

We found the following issues that the provider needs to improve:

- Treatment goals were not recovery-oriented.
- Staff on the ward did not know whether there was approved clinician cover in place on the day of inspection and over the weekend.

However, we also found the following areas of good practice:

- Information needed to deliver care was stored securely and accessible to staff.
- Mental Health Act detention paperwork was up to date and stored appropriately.
- Patients had access to independent mental health advocacy services.
- Some patients were engaging in psychological therapy.
- Patients were being supported to cook some of their own food.

Are services caring?

We found the following issues that the provider needs to improve:

- There was no evidence that patients had been involved in planning their care.

Are services responsive?

We found the following issues that the provider needs to improve:

- There was no evidence of listening to and learning from patient complaints.

However, we also found the following areas of good practice:

Summary of this inspection

- Unstructured activities for patients were available on the ward.

Are services well-led?

We found the following issues that the provider needs to improve:

- Staff did not always feel able to raise concerns with managers and morale was low.

However, we also found the following areas of good practice

- Senior managers had met with the team to discuss the requirements of staff roles and the future of the hospital.

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.

Detention paperwork was completed correctly, kept up to date and stored appropriately. Consent to treatment forms were in place for all six patients. The Mental Health Act administrator had implemented a system to keep track of dates for section renewal, and to scrutinise Mental Health Act papers. Patients had access to independent mental health advocacy services.

However, care plans did not consider how staff might appropriately support patients to understand their rights.

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not review the use of the Mental Capacity Act during this inspection.

Overview of ratings

Our ratings for this location are:

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

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

All patients had been moved to Blake Ward, which was an 8-bed ward on the middle floor of the hospital. Convex mirrors had been installed to improve lines of sight on the ward. Lights had been changed so that they no longer automatically switched off. The ward was for men only, which meant that it was compliant with guidance on same-sex accommodation. The clinic room and general ward environment was clean and tidy. Resuscitation equipment was present and checks were up to date. The drugs cupboard and fridge were in order. Rooms were ventilated either by windows (fitted with window-restrictors) or air-change machines. Bedrooms contained nurse call buttons. Staff carried radios and there were at least two functioning cordless phones in the nursing office. This meant that patients and staff would be able to call for help in an emergency.

Safe staffing

A new responsible clinician, a consultant psychiatrist, had started working at Ash House the day before our inspection. The responsible clinician was contracted to work two days a week on site and provide 24 hour, 7 days a week on-call cover at all other times. The provider had assessed this to be sufficient to meet the needs of six patients. A locum consultant psychiatrist had been contracted to cover the responsible clinician's annual leave.

Assessing and managing risk to patients and staff

We reviewed four patients' care records. There was a 'hospital passport' at the front of each patient's file that gave a brief, accessible summary of risks. Each record also included a detailed risk assessment dated within the last three months. Previous risk assessments were stored within the record. However, the three risk assessments that had been completed using the 'short-term assessment of risk and treatability' framework did not include all relevant information and did not give clear guidance to staff on how risks should be managed. We saw from a summary of incidents that one patient's risk of self-harm had recently increased. This was not recorded in his risk assessment. There was no staff name or signature on three of the risk assessments, which meant that we could not identify the author.

We reviewed all six patients' current medication administration records, and a sample of historic medication administration records going back to December 2016. We found that these were in order.

We saw that Ash House had implemented a system to audit the number of tablets remaining in stock after medication was given to each patient. For the period 1 February to 10 March 2017 there were eight occasions when the audit sheet was missing.

We did not find any evidence of errors in medicines management. However, the system that was in place did not effectively keep track of stock.

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

Assessment of needs and planning of care

All four care records contained a care plan that had been reviewed within the last three months. However, evidence of patient involvement in these care plans was limited.

Long stay/rehabilitation mental health wards for working age adults

None were signed by patients. Although all appeared to be written from the perspective of patients, the language used suggests that these were not things that patients had actually said. Stated goals were not recovery oriented and did not evidence the voice of the patient (for example 'to remain compliant with clozapine'; 'to attend ward round').

Information needed to deliver care, including historic risk assessments and copies of Mental Health Act paperwork, was kept in lockable filing cabinets in the staff office. It was stored securely and available to staff when they needed it.

Best practice in treatment and care

We would expect to see patients in a rehabilitation unit being supported to complete tasks of daily living and being offered therapeutic intervention. There was evidence that three of the four patients whose records we reviewed had been offered input from a clinical psychologist. The clinical psychologist had started a motivational interviewing intervention with one patient. Patients had also been involved in cooking some of their own food.

Multidisciplinary and inter-agency team work

We did not see evidence of effective handover and communication within the team. There was confusion over psychiatric cover for the day of our inspection and the following weekend. The nurse in charge did not know whether cover was in place. One of the support workers telephoned the occupational therapist, who advised him that the new consultant would be covering. We telephoned the new consultant, who confirmed this. The new consultant had met with the previous consultant the day before our inspection for a handover.

We requested copies of senior management and team meeting minutes covering the period between January and March 2017. None of the minutes included information about approved clinican/psychiatry cover. They did however evidence that managers were discussing some issues affecting the service with staff.

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

Detention paperwork was completed correctly, kept up to date and stored appropriately. Consent to treatment forms were in place for all six patients. The Mental Health Act administrator had implemented a system to keep track of dates for section renewal, and to scrutinise Mental Health Act papers.

There were copies of the Mental Health Act Code of Practice in the Mental Health Act administrator's office and in the staff office.

Care plans made reference to staff informing patients of their rights under the Mental Health Act, but did not consider appropriate support for patients (for example, making information more accessible). One care plan stated that if the patient did not understand his rights then the Mental Health Act administrator should repeat the process until the patient gained full understanding.

Patients had access to independent mental health advocacy services.

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

The involvement of people in the care they receive

There was no evidence of patient involvement in any of the four risk assessments and care plans that we reviewed.

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

The facilities promote recovery, comfort, dignity and confidentiality

More unstructured activities were available on the ward since the previous inspection. There was a pool table, table tennis table, board games, TV room and books. We saw patients and staff playing pool together.

Listening to and learning from concerns and complaints

There were posters and leaflets on the ward informing patients how to complain. We could not view records of patient complaints on site on the day of inspection. Staff told us that they were locked away. We requested these records following the inspection. The service forwarded a brief document which stated that a complaint had been made about a staff member's attitude. Although there were

some immediate actions recorded, there was no evidence of an investigation or formal acknowledgement and response to the patient. The provider is currently reviewing their complaints policy.

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

Leadership, morale and staff engagement

Senior managers had met with the team to discuss the requirements of staff roles and the future of the hospital. However, there was no evidence of staff being involved in decision-making in the service. Staff on shift on the day of inspection were unaware of arrangements for consultant cover. Staff did not always feel able to raise concerns with managers. Staff told us that morale in the unit was low.