Making Space

Ashwood Court Nursing Unit

Inspection report

Woodford Avenue
Lowton
Warrington
WA3 2RB
Tel: 01925571680
www.makingspace.co.uk

Date of inspection visit: 14 September 2022
Date of publication: 13/01/2023

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	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Summary of findings

Overall summary

This was a focussed inspection of elements of the safe and well-led key questions only. We did not re-rate this service and the previous ratings remain in place.

- Policies, processes and other documentation were not robust enough to ensure the service was able to provide safe and consistent care. Many policies lacked specific detail to ensure staff knew what action to take. This included the child visitor procedure, the safeguarding adults and children policies and the missing persons policy. There was no search policy in place. The physical interventions policy did not describe how to manage situations of unplanned floor restraint. There were no processes in place to review blanket restrictions. Team meeting agendas were inconsistent. The admission criteria and pre-assessment paperwork did not demonstrate how patients who were likely to require higher levels of physical intervention were prevented from being admitted. The ligature risk assessment required further development.
- Mandatory training compliance figures did not always meet the required standard for all modules. First aid training was 44% and manual handling of people training was 65%. Some staff had been booked onto this training in the weeks following the inspection.
- Restraint training was only to a basic level and did not include floor restraint. There was no clear rationale how this met the needs of the patients. There was no evidence how this was risk assessed.
- Admission criteria and pre-assessment documents did not clearly demonstrate how patients at risk of being violent and aggressive were prevented from being admitted to the service.

However:

- All patients now had risk assessments in place. Risk assessments clearly identified all risks. Risk management plans were also now in place for all patients. Staff now knew about all patient risk and how to respond appropriately.
- The care record system had been improved. Care records were now an accurate, complete and contemporaneous record in respect of each patient. All patients now had comprehensive care plans and other documents that were individualised and person centred.
- A new suite of robust audits had been introduced to assess, monitor and improve the service. This included care record audits and medicines management audits. These had been completed regularly and information was shared with the senior management team to check the quality of the service.
- New policies had been developed such as the medicines management policy. Some policies required further consideration. We checked the medicines on site and the medication audits. All were seen to be correct and in order.
- Incidents were now reported appropriately. We saw examples of incidents being reported internally and externally. There was evidence of incidents being reviewed and actions taken to consider future learning.
- All staff had received training in physical interventions. There was a physical interventions policy and staff described being aware of always attempting de-escalation prior to any other action being taken.
- Staff now responded to incidents appropriately. There had been a series of minor incidents which staff had responded to correctly.
- There was a new care plan and risk assessment policy in place. This policy explained that risk assessments should be updated every six months as a minimum or following changes in needs. However, it not specifically state that risk assessments should be updated following incidents.

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	**Inspected but not rated**	See overall sumary

Summary of findings

Contents

Summary of this inspection

Background to Ashwood Court Nursing Unit

Ashwood Court Nursing Unit is an independent mental health hospital for people aged from 18 to 65 years. It is a community rehabilitation unit for people who require rehabilitation and support with a severe and enduring mental illness. It has ten 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 ten 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. Ashwood Court Nursing Unit has been registered with the Care Quality Commission since 23 November 2010.

There is a registered manager in post.

The service was last inspected in May 2022 where the service was rated as inadequate overall. The key questions safe and well-led were rated as inadequate. The key questions effective, caring and responsive were rated as requires improvement.

Following our inspection, we took enforcement action and issued two Section 29 warning notices. These were issued in relation to a lack of adequate risk management and systems and processes for effective audit and related to breaches of Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment and Regulation 17 HSCA (RA) Regulations 2014 Good governance.

We also took urgent enforcement action and issued a notice of decision imposing conditions on the providers registration. This meant that the provider was unable to admit any new patients and that the provider was subject to additional oversight by the Care Quality Commission.

We also issued three requirement notices relating to breaches of the following regulations:

- Regulation 9 HSCA (RA) Regulations 2014 Person-centred care
- Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

This inspection and report focussed on checking whether improvements had been made in relation to the Section 29 warning notices only.

We found that the Section 29 warning notices had been complied with. The removal of the notice of decision conditions is a separate process outside of this report.

What people who use the service say

Summary of this inspection

All patients described feeling safe and that their care was decided with them collaboratively and that they were all offered, but declined, a copy of their care plan. All patients explained that they understood their medication and that this was explained well to them during ward round meetings and afterwards. Patients said they had good access to the doctor on regular and on ad hoc occasions.

All patients confirmed that their physical health care needs were well met by attending local GP surgeries, dentists, opticians and local specialists as needed. Patients remarked that they were supported to make healthy decisions around food and exercise.

Patients all felt that they had opportunities to raise issues via weekly community meetings or have your say forms.

All patients felt that staff were experienced in de-escalation techniques and that restraint was rarely used.

Most patients felt there were enough staff. One patient felt there were not always enough staff to facilitate leave as much as they would like and thought that more day trips should be offered.

One patient also felt that activities offered were not always age appropriate such as colouring books and that often patients would spend long periods in their rooms watching television.

How we carried out this inspection

This was a focussed inspection reviewing key elements of the following key questions that led to warning notices being issued:

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

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

During the inspection visit, the inspection team:

- visited the service and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with registered manager and clinical lead
- spoke with three other staff members
- looked at four care and treatment records of patients
- did a specific check of all patients risk assessments
- carried out a specific check of the medicine management
- looked at a range of policies, procedures and other documents relating to the running of the service.

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.

Summary of this inspection

Areas for improvement

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 policies, procedures and associated documents are robust and fit for purpose. Policies and procedures must be comprehensive and detailed to ensure staff have a clear understanding of their actions and responsibilities. (Regulation 17 (1))
- The service must ensure that physical intervention training needs of the service are risk assessed and meet the needs of the patient group. Training needs must be reviewed on a regular basis to ensure the safety of patients, staff and the public. (Regulation 12 (1) (2) (c)

Action the service SHOULD take to improve:

- The service should ensure that all staff have completed the mandatory training to the required standard.
- The service should ensure that ligature risk assessments are further developed and actions completed to time.
- The service should ensure that admission criteria and admission documents clearly demonstrate how patients who may require higher levels of physical intervention are not admitted to the service.

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	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Not inspected	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

Safe	Inspected but not rated
Well-led	Inspected but not rated

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

Inspected but not rated

This was a focussed inspection of elements of the safe and well-led key questions only. We did not re-rate this service and the previous ratings remain in place.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified. There were a range of environmental risk assessments now in place. There were twice daily security and environment checks, a monthly health and safety audit checklist, a monthly service walk about and a quarterly health and safety risk assessment. A fire risk assessment had been completed in June 2022 highlighting any associated fire risks. Fire risks had been added to an overall improvement plan and included changes such as replacement of fire doors, loft compartments in situ and regular fire drills to be in place. A separate ligature risk assessment had also been completed. The ligature risk assessment required further development which the provider agreed to improve as soon as possible. There was a plan in place to remove some ligature points on fire doors by the end of October 2022. The service provided an updated environmental ligature risk assessment following the inspection which included ligatures in each room.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. Staff were aware of areas of the environment that could be utilised to make a ligature. There were frequent environmental checks in place to mitigate this risk. Staff were aware of the location of the ligature cutters and knew how to use them. At the time of the inspection there were no patients identified as at risk of self harm by ligature.

The front door was now locked and only opened by staff. This prevented detained patients leaving when this had not been assessed or agreed.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training. Mandatory training for staff had been completed and was 92% compliant overall. There were two modules that fell below 75% which were:

- First aid training 44%. Three members of staff had been booked onto the first aid training in the weeks following the inspection.
- Manual handling of people 65%. Seven more staff had been booked onto the manual handling training.

The mandatory training programme was comprehensive and met the needs of patients and staff. There were 22 mandatory training modules for staff to complete. These included learning disability training and Mental Health Act training.

Managers monitored mandatory training and alerted staff when they needed to update their training. The registered manager and clinical lead had oversight of mandatory training compliance data. Data was also collated by the senior management team. Staff were aware of when training was due and had time to complete it. Managers were able to prompt staff when training was due or overdue.

Physical intervention training had been completed by all staff. Staff were not trained to restrain patients to the floor but limited to seated arm holds only. The training provider was not British Institute of Learning Disability approved or restraint reduction network affiliated. It was not clear how episodes of mental health relapse that may include violent or aggressive behaviour would be managed by staff.

Following the inspection the provider plans to introduce a positive behaviour support model for staff and patients to follow.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible in order to facilitate patients' recovery. Staff followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All patients had a comprehensive risk assessment in place which clearly identified all risks and had a clear risk management plan to mitigate any risks. Risk assessments were written in plain language and that could be understood by staff and patients.

Staff used a recognised risk assessment tool. The service had introduced a new electronic care record system which includes a new risk assessment tool.

Prior to admission patients were assessed using a pre-admission assessment template. This assessment template considered the patients level of violence and self harm but did not clearly identify whether the patient was likely to require high levels of physical intervention. However, following the inspection the provider amended the pre-assessment document to reflect this risk.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. The care records identified each patient's risks and staff we spoke to knew the patients well. Staff said they could easily keep up to date with any changes to risk by attending handover meetings or reading handover notes and reading risk assessments. Staff in the nursing team had been issued with mobile devices where the electronic record system could be accessed from.

Staff identified and responded to any changes in risks to, or posed by, patients. We saw evidence of risk assessments now being reviewed following changes to risk presentation for patients. Incidents were managed well and the correct processes were now being followed to mitigate risks.

Staff followed procedures to minimise risks where they could not easily observe patients.

The quality of care plans, assessments and other associated documents had improved. Care plans were detailed, written in the first person and personalised to reflect the patient's preferences and opinions.

There was a robust audit system in place to check the quality of the documents. Extra training had been provided to staff, and managers feedback to staff during supervision to consider learning and improvement.

Use of restrictive interventions

Levels of restrictive interventions were low and reducing. The service had not been required to use any physical interventions in the last three months.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Patients' care records demonstrated that staff clearly attempted de-escalation and distraction techniques with patients during incidents to good effect. Staff we spoke to understood patients triggers and were aware of personalised distraction and de-escalation techniques for each patient.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff had now received training in safeguarding adults level three. All staff were also due to receive supplementary safeguarding adults level three training delivered by the local authority. The safeguarding lead was due to receive safeguarding adults level four training for their role.

Staff kept up-to-date with their safeguarding training. All staff were now up to date with their safeguarding training. There were measures in place to monitor training records. The safeguarding lead was due to be up to date with her training within one month.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff were able to describe recent safeguarding incidents and actions taken following the event. Staff had received safeguarding training and had safeguarding children and safeguarding adults policies to refer to for guidance.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. New safeguarding adults and safeguarding children policies had been developed and implemented during June and July 2022 and were available for staff to refer to. The safeguarding policies did not stipulate timeframes for initial reporting or contain useful safeguarding contact numbers. However, we saw examples of safeguarding referrals being made to the local authority and safeguarding meetings taking place attended by local authority staff.

Staff followed clear procedures to keep children visiting the ward safe. The provider had a child visitor policy in place. Child visits were required to be risk assessed in advance and to be held in the ladies lounge which is located in the admin area away from other main communal and sleeping areas. Children are required to be supervised by an accompanying adult at all times. Visitors, including children could access the staff toilets which were located next to the ladies lounge within the locked office area.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were aware to raise a safeguarding concern with the safeguarding lead in the first instance. There was a clear procedure in place to report safeguarding concerns to the local authority immediately if appropriate to do so.

The service had developed a safeguarding quality improvement schedule. This schedule allowed senior managers to have oversight of safeguarding incidents and ensure appropriate actions and service improvements were taken forward.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. The service had an electronic patient record system that clearly documented each patients journey and any changes to risks and plans. Documentation now clearly showed the patient journey, highlighting risks with clear risk management plans in place for each risk. Care plans, risk assessments and risk management plans had now been updated following incidents and timelines of progress and incidents were easy to follow. The paper communication book had been replaced by an electronic messaging system that allowed staff to review handover notes and other documents prior to starting a shift.

Records were stored securely. The electronic patient record system was password protected and could only be accessed by staff from the service.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. There was a medicines management policy in place which had been developed and implemented in July 2022. This was available for staff to follow and refer to.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. All patients had access to regular multidisciplinary team meetings where their medication could be reviewed. Patients confirmed that they had been provided with information about their medication including usage and side effects.

Staff completed medicines records accurately and kept them up-to-date.

Staff stored and managed all medicines and prescribing documents safely. The service had recently introduced a number of medication checks and audits. These included daily checks, and weekly, monthly and quarterly audits. There had also been external audits from an independent pharmacist and the commissioner's pharmacist. We checked the medicines stock during the site visit and this matched the medicines recorded.

Staff followed national practice to check patients had the correct medicines when they were admitted or they moved between services.

Staff learned from safety alerts and incidents to improve practice. We reviewed a medication error incident that had been documented on the providers electronic incident reporting system. There was clear learning identified regarding this incident. Changes had been made to the storage of as required medication separate from the everyday medicines.

Emergency resus equipment was now all in place and in date. There were regular checks of the emergency equipment that showed the equipment had been calibrated and maintained to the manufacturers instructions.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff were aware to report any incident that appeared untoward and could give clear examples of issues they would report. Staff also knew how to use the incident reporting system and what information was pertinent to include. Staff also reiterated that all staff have the responsibility to report incidents and that the staff member involved or who witnessed the incident should complete the incident report in the first instance.

Staff reported serious incidents clearly and in line with the providers policy. We saw evidence of incidents being recorded clearly on the electronic incident reporting system. There was a policy in place support staff with any serious incidents that occurred. Where necessary, incidents had been reported the the Care Quality Commission. This included safeguarding and police incidents.

The service had no never events.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. There had not been any recent incidents that would involve the duty of candour. However, there was a duty of candour policy in place and staff understood when it was appropriate to consider following this guidance.

Managers debriefed and supported staff after any serious incident. The incident reporting system had sections to complete to demonstrate how staff and patients had been debriefed following any incident. This had been completed to show that patients had been spoken to and reassured and that staff had received opportunities to discuss the incident. There was a de-brief form available to provide a format for debrief discussions.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Incidents were reviewed daily by the registered manager or the clinical lead. Incidents were also reviewed by the regional lead.

It was unclear how staff received feedback from investigation of incidents, both internal and external to the service. Team meeting agendas and minutes did not have a section to discuss learning from incidents. The accident and incident reporting policy implemented in February 2022 stated that lessons learnt should be collated and sent to managers on a quarterly basis. Action plans should then be created if required and information shared during team meetings to all staff.

Staff met to discuss the feedback and look at improvements to patient care. Feedback from incidents was discussed in team meetings.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

There was evidence that changes had been made as a result of feedback. We saw evidence of changes being made due to reviews and suggestions made regarding learning from incidents by the management team. This included changes to medication practice and a reminder to report any weapons found to the police.

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

Inspected but not rated

This was a focussed inspection of elements of the safe and well-led key questions. We did not re-rate this service and the rating for well-led remains the same.

Leadership

Leaders were gaining skills, knowledge and experience to perform their roles. They were developing a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

A new clinical lead had been employed to support the improvement of the service. The clinical lead worked alongside the registered manager who knew the service well. It was clear that much improvement had been made and the service was much safer and well-led than at the previous inspection in May 2022. However, much of the improvement was in its infancy and required further improvement and embedding. Both the clinical lead and the registered manager were a visible presence within the service and staff and patients confirmed that they were available and approachable.

Governance

Our findings from the other key questions demonstrated that governance processes operated were becoming more effective at team level and that performance and risk were managed much better.

The service had introduced many new quality checks and systems and processes to allow managers to have a much greater oversight of the service. This included improvements in the audits of the environment, medicines, care records and incidents.

Policies had been updated and there were more effective ways for information to flow between staff and the senior management team. Risks were better managed as all patients now had a robust risk assessment and management plan and all other patient documents were in place.

The service had a complaints policy for staff to follow if a complaint was raised. There was evidence of complaints being received and addressed at an informal level. Complaints, compliments and comments were logged and fed into management reports.

Safeguarding and police incidents had been reported to the police and the Care Quality Commission and there were processes in place to identify learning and make changes.

More reliable electronic systems had replaced some paper records allowing staff better access to up to date information. An over-arching action plan to keep track of all the improvements had been developed and updated as actions were completed.

However, there were areas where further improvement was needed. The safeguarding adults and children policies did not show staff how to report a safeguarding incident to the local authority. The document lacked contact information that would support staff to make safeguarding alerts in a timely manner.

The missing person policy was reviewed and revised in June 2022. The policy stated that staff were to inform a list of people prior to contacting the police. Contacting the police was described in the policy as an additional action.

There was no search policy in place.

The policy on the Prevention and Management of Behaviour policy July 2022 did not specifically say which holds were used and what to do in the event of a floor restraint accidentally occurring.

There were a list of items that were not permitted into the hospital. These included fire arms and sharp objects. The list also included animals and wax melts. There was no suggestion that this list would be reviewed regularly or considered by a restrictive practice reduction programme.

The visitors policy including children visiting the building was contradictory. The policy stated visitors must be accompanied at all times but fails to say by whom. The policy also stated patients must be able to receive visitors in private. In relation to children visiting the service, the policy remained unclear how safety was maintained. Although the service has developed a child visiting local protocol with guidance for staff, this was vague and lacked detail. All patients had individualised visitor risk assessments incorporated into their risk profiles.

The admissions criteria stated that patients must not be a the acute stage of mental illness. However, the admission criteria was not clear about assessing levels of restrictive interventions that might be required by patients.

The pre-assessment documents for patients being considered by the service, did not clearly demonstrate that patients at risk of presenting with violent and aggressive behaviour would not be admitted.

There was a new care plan and risk assessment policy in place. This policy explained that risk assessments should be updated every six months as a minimum or following changes in needs. However, it did not specifically state that risk assessments should be updated following incidents.

Following the inspection the provider agreed to improve the policies as soon as possible.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Staff now had easy access to clear and up to date patient information to allow them to support patients and manage risks effectively. Documents had been improved. Staff now knew each patients risks and how to manage them.

There were a number of performance reports that allowed the service to have oversight of key targets and assurance regarding the quality of care. These included:

- The local commissioners quarterly contract monitoring report. This included commissioning for quality and innovation targets, financial issues, service issues, bed occupancy tracker, patient progress update, staffing reports, health and safety, incidents and analysis, safeguarding, and complaints and compliments.

Long stay or rehabilitation mental health wards for working age adults

Inspected but not rated

- Monthly resource audit list. Many new audits had been introduced.
- Operational indicators report which includes the number of safeguarding notifications made and the number of CQC notifications made.
- The local commissioner quality assurance improvement schedule which includes any initial learning identified.
- CQC notifications log

There was a risk register in place containing all pertinent risk and any identified mitigating factors.

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
Treatment of disease, disorder or injury Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that policies, procedures and associated documents were robust and fit for purpose. Policies and procedures were not comprehensive and detailed to ensure staff had a clear understanding of their actions and responsibilities. (Regulation 17 (1))

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider had not taken reasonable steps to demonstrate that the physical intervention training needs of the service had been risk assessed and that there was a process in place to review the training needs.