Ash Green Hospital

Quality Report

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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, information we hold about quality, and information given to us from patients, the public and other organisations.

Overall rating for this service

Community inpatient services	

Summary of findings

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Summary of findings

Overall summary

Ash Green Hospital provides community inpatient and outpatient services for people with learning disabilities. There are two inpatient wards, Hillside with eight beds and Valley View with five beds.

Hillside ward provides assessment and treatment for people with learning disabilities who may have complex mental health issues and / or behaviour that challenges services. Patients may be detained under the Mental Health Act 1983.

Valley View ward provides short-term care for people with learning disabilities. This is usually planned as respite for families and carers, or can be provided urgently at short notice when needed.

The patients and relatives we spoke with were mostly positive about the care provided at Ash Green Hospital and we saw they were involved in making decisions about care. Patients were treated with kindness and respect and their privacy and dignity were upheld.

Patients at Ash Green Hospital were protected from abuse and avoidable harm by the systems, processes and practices in place. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns. Risks for individual patients and in the ward environments were identified, assessed and effectively managed.

Care and treatment was evidence based and resulted in good outcomes for patients. We saw effective collaboration and communication among members of the multidisciplinary team (MDT) to support the planning and delivery of patient-centred care. Staff were supported with clinical supervision, appraisal, and relevant training. However, staff uptake of clinical supervision was not monitored effectively

Patients received care and treatment to meet their needs. Patients and their relatives told us their health and wellbeing had improved since using the services at Ash Green Hospital. The service was accessible and provision was made for the specific needs of individual patients. However, the care plans were in a format that was not easy for some people with learning disabilities to understand.

Planning for the patient leaving hospital started on the day of admission and discussions involved the patient, their families, and support staff from other providers where appropriate.

Most staff we spoke with were aware of the Trust's vision and values. Staff told us they enjoyed working at Ash Green Hospital. They felt there was good team working and they were supported by their managers.

Summary of findings

The five questions we ask and what we found at this location

We always ask the following five questions of services.

Are services safe?

Patients at Ash Green Hospital were protected from abuse and avoidable harm by the systems, processes and practices in place. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns. Risks for individual patients and for the ward environments were identified, assessed and effectively managed.

Are services effective?

Care and treatment provided at Ash Green Hospital was evidenced based and resulted in good outcomes for patients. We saw effective collaboration and communication amongst members of the multidisciplinary team (MDT) to support the planning and delivery of patient-centred care. Staff were supported with clinical supervision, appraisal, and relevant training. However, However, staff uptake of clinical supervision was not monitored effectively.

Are services caring?

The patients and relatives we spoke with were mostly positive about the care provided at Ash Green Hospital and we saw they were involved in making decisions about care. Patients were treated with kindness and respect and their privacy and dignity were upheld. Staff were working enthusiastically towards a local authority dignity in care award.

Are services responsive to people's needs?

Patients received care and treatment to meet their needs. Patients and their relatives told us their health and wellbeing had improved since using the services at Ash Green Hospital. The service was accessible and provision was made for the specific needs of individual patients. However, the care plans were in a format that was not easy for some people with learning disabilities to understand.

Planning for the patient leaving hospital started on the day of admission and discussions involved the patient, their families, and support staff from other providers where appropriate.

Are services well-led?

Most staff we spoke with were aware of the Trust's vision and values. Staff told us they enjoyed working at Ash Green Hospital. They felt there was good team working and they were well supported by their managers.

Summary of findings

What we found about each of the core services provided from this location

Community inpatient services

Ash Green Hospital provides community inpatient and outpatient services for people with learning disabilities. There are two inpatient wards, Hillside and Valley View. Hillside ward has eight beds and Valley View ward has five beds.

Hillside Ward provides assessment and treatment for people with learning disabilities who may have complex mental health issues and / or behaviour that challenges services. Patients may be detained under the Mental Health Act 1983.

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Patients at Ash Green Hospital were protected from abuse and avoidable harm by the systems, processes and practices in place. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns. Risks for individual patients and for the ward environments were identified, assessed and effectively managed.

Care and treatment provided to patients was evidenced based and achieved good outcomes for them. We saw effective collaboration and communication amongst members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Staff were supported with clinical supervision, appraisal, and relevant training. However, staff, including managers, lacked clarity about the provider's expectations for the frequency and monitoring of clinical supervision.

Patients were treated with kindness and respect and their privacy and dignity were upheld. Patients and their relatives or carers were involved in making decisions about their care. Patients and relatives we spoke with were mostly positive about the care provided at Ash Green Hospital. Staff were working enthusiastically towards a local authority dignity in care award.

Patients received care and treatment to meet their needs. Patients and their relatives told us their health and wellbeing had improved since using the services at Ash Green Hospital. The service was accessible and provision was made for the specific needs of individual patients. However, the care plans used were not available in an easy to read format used by some people with learning disabilities.

Planning for the patient leaving hospital started on the day of admission. Discussions and preparation for discharge involved the patient, their families, and support staff from other providers where appropriate.

Most staff we spoke with were aware of the provider's approach to delivering quality services: 'The DCHS Way'. Staff told us they felt well supported by their managers. They said they enjoyed working at Ash Green Hospital and felt there was good team working.

Summary of findings

What people who use the community health services say

Patients and relatives we spoke with were pleased with the care provided at Ash Green Hospital. They told us that patients' wellbeing had improved since using the service. Relatives told us they were concerned about the future of the service as they felt that cuts had already been made.

Areas for improvement

Action the community health service SHOULD take to improve

- Ensure people using the service are provided with their care plans in a format they can use and understand.

Action the community health service COULD take to improve

- Enhance staff understanding of clinical supervision and ensure processes are in place to monitor clinical supervision received per individual member of staff.

Good practice

Our inspection team highlighted the following areas of good practice:

- Staff demonstrated excellent commitment to providing the best care they could and putting the patient at the centre of what they did.
- Staff had developed a new assessment tool focused on dignity and respect, and were working towards the local authority Dignity in Care Silver Award.

Ash Green Hospital

Detailed findings

Services we looked at:
Community inpatient services

Our inspection team

Our inspection team was led by:

Chair: Helen Mackenzie, Director of Nursing and Governance, Berkshire Healthcare NHS Foundation Trust

Head of Inspection: Ros Johnson, Care Quality Commission

The team visiting Ash Green Hospital included CQC inspectors, a mental health practitioner and two experts by experience. Experts by experience have personal experience of using or caring for someone who uses the type of service we were inspecting.

Background to Ash Green Hospital

Ash Green hospital is managed by Derbyshire Community Health services NHS Trust which delivers a variety of services across Derbyshire and in parts of Leicestershire. It was registered with CQC as a location of Derbyshire Community Health Services NHS Trust in May 2011. Ash Green Hospital is registered to provide the regulated activities: Diagnostic and screening procedures; and Assessment or medical treatment for persons detained under the Mental Health Act 1983. The hospital was last inspected by CQC in 2011.

Ash Green Hospital is a purpose built facility providing community inpatient and outpatient services for people with learning disabilities. There are two inpatient wards, Hillside and Valley View. Hillside ward has eight beds and Valley View ward has five beds.

Hillside provides assessment and treatment for people with learning disabilities who may have complex mental health issues and / or behaviour that challenges services. Patients may be detained under the Mental Health Act 1983.

Valley View provides short term care for people with learning disabilities. This is usually planned as respite for families and carers, or can be provided urgently at short notice when needed.

Why we carried out this inspection

This location was inspected as part of the first pilot phase of the new inspection process we are introducing for community health services. The information we hold and gathered about the provider was used to inform the services we looked at during the inspection and the specific questions we asked.

Detailed findings

How we carried out this inspection

To get to the heart of patients' experiences of care, 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?

The inspection team looked at the following core service areas at this inspection:

Community inpatient services

Before visiting, we reviewed a range of information we hold about the community health service and asked other organisations to share what they knew about the provider.

We carried out an announced visit on 25 February and an unannounced visit on 6 March 2014. During our visits we observed how people were cared for. We talked with people using the service, their carers and / or family members, and with staff.

Community inpatient services

Information about the service

Ash Green Hospital provides a total of 13 inpatient beds on two wards. There were eight patients on Hillside ward and three patients on Valley View ward during this inspection. None of the patients were detained under the Mental Health Act 1983.

Summary of findings

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Patients at Ash Green Hospital were protected from abuse and avoidable harm by the systems, processes and practices in place. Staff had received training in safeguarding vulnerable adults and were confident about reporting their concerns. Risks for individual patients and in the ward environments were identified, assessed and effectively managed.

Care and treatment was evidence based and resulted in good outcomes for patients. We saw effective collaboration and communication among members of the multidisciplinary team (MDT) to support the planning and delivery of patient-centred care. Staff were supported with clinical supervision, appraisal, and relevant training. However, staff uptake of supervision was not monitored effectively.

Patients received care and treatment to meet their needs. Patients and their relatives told us their health and wellbeing had improved since using the services at Ash Green Hospital. The service was accessible and

Community inpatient services

provision was made for the specific needs of individual patients. However, the care plans used were not available in an easy to read format used by some people with learning disabilities.

Planning for the patient leaving hospital started on the day of admission and discussions involved the patient, their families, and support staff from other providers where appropriate.

Most staff we spoke with were aware of the Trust's vision and values. Staff told us they enjoyed working at Ash Green Hospital. They felt there was good team working and they were supported by their managers.

Are community inpatient services safe?

Safety in the past

We found that patients were protected from abuse and avoidable harm as staff were confident about reporting safety incidents. Staff told us they knew how and what to report and we saw this in practice. We saw that staff had recognised the possible abuse of a patient and had taken appropriate action to report their concerns and protect the patient. All staff we spoke with told us they had received training in safeguarding vulnerable adults

Learning and improvement

We saw that there were systems in place to report incidents that may affect the safety, health and welfare of patients. We looked at three of the electronic records of incidents reported and saw that these corresponded with details in individual patient records. All incident reports were seen by the ward managers and the matron. The ward managers and matron looked at reports of the types of incidents to identify any emerging trends. For example, they could monitor the number of falls reported during a specific period, or incidents where staff intervention was needed in response to challenging behaviour from patients. Information about incidents was shared with senior managers and reported at board level. The matron told us about regular meetings to discuss lessons learned from incidents.

Staff we spoke with were familiar with the reporting system and could give examples of what they would report. Staff told us that they had feedback about learning from incidents through supervision, shift handovers and team meetings.

Systems, processes and practices

Staff we spoke with told us they had access to all of the provider's policies and procedures electronically using the intranet.

Staff told us their line managers were supportive and approachable. This meant that staff felt able to report incidents or raise concerns without fear of negative consequences.

There were effective systems and practices in place regarding the use of restraint and seclusion. Staff told us that physical restraint of patients was used as a last resort and rapid tranquilisation was never used. The patient

records we saw confirmed this. All incidents where restraint was used were recorded and this included details of the type of restraint, the effect on the patient, and checking patients after the restraint. There was a seclusion room on Hillside ward. Staff told us that seclusion was not commonly used, though had been used more regularly recently for one patient. Records were kept of the reason for seclusion, the duration of the seclusion, the effect on the patient, and checking the patient's wellbeing during and after the seclusion.

Staff told us that there was a debrief after incidents of restraint and seclusion to look at what went well and what could be improved on. The ward managers told us they saw the records of all incidents. All incidents were reported to the patient safety team.

We saw that there were effective arrangements for safely managing medicines, including medicines prescribed 'as required' and controlled drugs. We saw that patients' care plans included details of when 'as required' medicines should be offered to patients. Medicines were stored securely and were administered by qualified nurses. We looked at the records of administration of medicines for three patients and found these were completed correctly. One patient told us, "I take lots of tablets because of epilepsy. The nurses monitor that I take them on time. If I am not up at 8am, the nurses will bring my medication to my room."

We found that the rate of reported venous thromboembolism (VTE) for the provider was below the England average for the period December 2012 to December 2013. This measure records whether or not a patient is being clinically treated for a VTE of any type. The matron at Ash Green Hospital told us that all patients were assessed on admission for their risk of developing VTE. We saw that the VTE assessments had been completed in the four patient records we looked at.

We observed appropriate practices to protect patients against the risks of acquiring infections. This included provision of hand washing facilities for patients, staff and visitors, and staff following hand hygiene guidance. There were suitable arrangements for the disposal of waste, including clinical waste. The areas of the hospital we saw looked and smelled clean and fresh. One patient told us, "It's always clean, always."

Patient records were kept securely in locked facilities and staff were able to easily locate records we required.

Monitoring safety and responding to risk

We saw that risks to the safety and welfare of patients were identified and managed. This included environmental risks, such as fire safety risks on both wards and ligature points on Hillside ward. Risks were monitored by regular checking and review.

We saw that appropriate risk assessments were completed when patients were admitted. This included the risk of falls, inadequate nutrition and hydration, and of developing pressure ulcers. We saw that the risk assessments were regularly reviewed according to the level of risk. Appropriate action was taken in response to the risks identified. For example, one patient was referred to a dietician because their food intake was poor and they were at risk of inadequate nutrition. Another patient was assessed as at high risk of falls and so needed staff supervision when walking around the ward. We observed this happening in practice.

Patients we spoke with told us they felt safe on the wards. We spoke with a group of 12 relatives and carers of people using the service. They all said they felt patients were safe using the services at Ash Green Hospital.

We saw that there were sufficient staff with the right skills to deliver safe care. Two patients we spoke with told us there were always staff available when they needed them. Staff we spoke with on both wards told us that staffing levels were usually sufficient to ensure patients' needs were met as planned.

Anticipation and planning

Patients on Valley View ward were usually admitted for short periods of care, often planned though also in an emergency. The relatives and carers we spoke with were pleased that admission to Valley View ward was flexible and could be arranged at short notice, (and commented that this was not the case at the provider's other short stay units for people with a learning disability). Patients on Hillside ward were often admitted urgently, sometimes from other hospitals. The ward managers told us they could respond to changing circumstances by using staff from the other ward if possible, or using bank or agency staff.

Community inpatient services

Are community inpatient services effective?
(for example, treatment is effective)

Evidence-based guidance
We saw that care provided was evidence based and followed recognised and approved national guidance, such as the National Institute for Health and Care Excellence (NICE), and nationally recognised assessment tools. For example, staff were using the Malnutrition Universal Screening Tool (MUST) to determine patients' nutritional needs, and 'life star' assessment of the patient's current needs, abilities and wishes.

The provider's policies were available electronically via the intranet and some in paper format so all staff had access to these. The policies reflected national guidance with appropriate evidence and references. For example, all inpatients were assessed for their risk of Venous Thromboembolism (VTE) following national guidance from the Department of Health (DH). The policy noted the evidence base and references included DH reports regarding the prevention of VTE.

A member of staff told us about achieving the Dignity in Care award at the first level, (bronze), and working towards the next level, (silver). The awards, which are administered by Derbyshire County Council, are designed to promote high quality care which respects people's individual circumstances. Staff had developed a tool, 'The Dignity Wheel', to use when planning care and treatment. The tool worked through six steps to ensuring patients had choice and control in their care and treatment.

The matron told us that a recent review of care on Hillside ward by Hardwick Clinical Commissioning Group identified that the operational pathway was out of date. The matron said work was already in progress to address this. Changes were being made to clarify how patients were referred to the service and how they moved through the service.

Monitoring and improvement of outcomes
There were processes in place to monitor the quality of care and treatment provided and to make improvements as needed. We saw that the performance and delivery of this service was included in reports from quality and safety committees to the board. For example, in February 2014, the board discussed the challenges facing the learning disabilities service regarding discharging patients and the plan for more effective partnership working with Derbyshire County Council.

Patients were encouraged and supported to attend weekly multi-disciplinary team (MDT) meetings to discuss their care and treatment. We saw that patients' views about their care and treatment were recorded and action was taken to address issues raised.

Staff told us they could bring their views, ideas or concerns to regular team meetings or to supervision or informally to the ward managers. Staff said the ward managers were approachable and willing to listen to staff. Staff told us about improvements made following their feedback and suggestions. This included changing nursing observations of patients from evening to morning so that medical staff were available if needed, and changes to make handovers and one to one working with patients more effective.

Staffing, equipment and facilities
There were systems and processes in place to ensure that staffing arrangements enabled the delivery of care and quality was not compromised. On Hillside ward the ward manager told us that staffing was adjusted according to patients' needs and the level of observation they required. We saw that the level of observation was noted in patients' care plans and was reviewed at least weekly. Most patients required one to one staffing, sometimes two to one. We visited the ward on two occasions, once unannounced, and saw that there were sufficient staff to meet patients' needs. Staff we spoke with told us there were usually enough staff available to meet patients' needs.

The ward manager on Valley View ward told us the staffing levels were determined according to the needs of patients. Some patients needed two staff to help with physical care as identified in their assessments and care plans. Staff told us there were usually enough staff to meet patients' needs, although they could be very busy at times. There was not always a qualified nurse on duty on Valley View ward, particularly for the night shifts. The matron told us this was because the ward operated more like a community unit where qualified nurses were not provided. There were always qualified nurses on duty on Hillside ward, only a short distance from Valley View ward, who could provide help and support if needed. Staff told us this arrangement worked well.

Community inpatient services

The matron told us they were currently recruiting qualified nurses, including covering for maternity leave. Staff we spoke with were positive regarding recruitment practices and told us that the induction was helpful to new starters. Staff told us they were supported by their managers to attend training days and to complete online training. Staff said the training they had received was appropriate and relevant to their work role. One member of staff told us they were pleased they could access training to meet the specific needs of individual patients, such as patients with a feeding tube in place. Another member of staff said, "I'm a band 3 and there's plenty of opportunity for training at my grade."

Staff we spoke with told us they had an annual appraisal which included discussion of their personal development and training needs. Staff told us they had clinical supervision and also used the 'Brief and Boundaried' model that had been introduced alongside the existing clinical supervision. This was developed to give staff opportunities for brief supportive discussions with colleagues about issues and challenges in day to day practice. Staff told us, "We can have formal supervision if we request it." and, "I can arrange supervision when I want to – every two months or so. We can look on the intranet and choose who we want to do the supervision." Staff said that providing evidence of supervision was a requirement at their annual appraisal. The provider's information for staff described different forms of supervision and recommended a minimum of three sessions per year. Supervision uptake by staff at Ash Green Hospital was recorded, but it was not easy to track when individual staff had had supervision.

Multidisciplinary working and support

We saw effective collaboration and communication amongst members of the multidisciplinary team (MDT) to support the planning and delivery of patient centred care. Weekly MDT meetings, involving the patient, families and carers, nursing staff, therapists and doctors, ensured the patient's needs were fully explored. This included identification of the patients' existing care needs, relevant social and family issues, mental capacity, and any support needed from other providers on discharge, such as support from community nurses. We saw evidence of the outcomes of these meetings in patients' records.

The ward managers told us that patients were often already known to the service, particularly patients using Valley View ward for short stays. This meant the patients already had involvement from the community team who were based at Ash Green Hospital. Staff told us that staff from the community team came onto the wards to support patients and this was especially useful when working towards discharge. One member of staff said, "It's good that the community team is based on site. We have great links."

We found evidence of good working relationships with other providers and outside agencies. We saw effective communication with another provider who was supporting a patient before they were admitted to Hillside ward. The support workers who had been providing care for the person before admission visited the person on the ward and were involved in MDT meetings. Staff told us about collaborative working with the local hospice for a patient needing end of life care. Medical staff cover was provided by local general practitioners, except for out of hours cover which was provided by an external agency. A member of staff told us, "Links are good with police locally – they'll always come if ever we need them."

The matron told us there were monthly meetings with adult social care staff to discuss and resolve delays in discharges. The matron said that this collaboration had helped to resolve issues around discharge and reduce the length of stay for patients on Hillside ward.

Are community inpatient services caring?

Compassion, kindness, dignity and respect

We saw that patients were treated with kindness and compassion by staff supporting them. One patient told us, "Staff listen and are very supportive." Another patient said, "The staff treat me very well. If I want to go to the bathroom, the staff would be right behind so I don't fall." The relatives and carers we spoke with told us they were happy with the care provided to inpatients at Ash Green Hospital.

Patients' privacy and dignity were maintained. We saw that patients were accommodated in single rooms on both wards. We observed staff knocking on doors before entering bedrooms or toilets. Patients were asked how they liked to be addressed and this was noted in their records. We saw that patients on Hillside ward were encouraged to use a designated quiet area if they wanted to spend time away from the busier areas of the ward. There was a range of activities and opportunities offered to patients, on and

Community inpatient services

off the wards. Patients were asked about their interests and preferences and we saw that these were taken into account. Examples of this were a patient who told us that staff supported them to use local shops so they could choose what they wanted, and another patient who told us, "I can ask to make things if I want and they help me in the kitchen."

We saw that a member of staff on Hillside ward had been appointed as the privacy and dignity champion. They told us that staff had worked together to achieve the Dignity in Care award at the bronze level and were now working towards the silver level by developing a new assessment tool. The member of staff told us that they had collected positive feedback from staff about the impact on their work of working toward and achieving the award.

Involvement in care

Patients and their relatives or carers were involved in making decisions about their care. Patients we spoke with told us they understood why they had been admitted to the hospital. We saw that patients who were able to had signed their care plans to indicate their agreement and involvement. Patients were encouraged to attend weekly meetings with the multi-disciplinary team to review their care and treatment. We saw records of discussions with patients about the plans for their care, treatment and discharge. A relative told us they were, "…always kept fully informed" about the patient's care and discharge plans.

We saw evidence through observation of practice and review of patient records that staff were assessing patients' capacity to give valid consent to their care and treatment. We observed staff supporting and encouraging patients to make their own decisions, such as choosing meals and activities. Staff we spoke with told us, "We always try and take into account what they want and what they feel is best for them." and, "Everything we do is around the patient."

We saw that a range of information was available to patients and their families or representatives. This included information about each of the wards, how to make a complaint, and the staff on duty each day. We saw that some information was available in an easy to read format. The easy to read information included leaflets explaining patients' rights if they were detained under the Mental Health Act 1983.

Trust and respect

We observed positive interactions between staff and patients, demonstrating that staff knew the patients well and had built up a good rapport. One patient told us, "I know I can approach the staff if I have any need to."

We saw that each patient's culture, beliefs and values were taken into account in planning their care and treatment. Patients had individual programmes of activities that reflected their interests and preferences.

Emotional support

We saw that patients were offered appropriate emotional support. One patient had recently been bereaved and we saw that they were referred for counselling to help them to cope. Staff showed sensitivity about the emotional support needed by the relative of a patient. We saw staff offering reassurance and comfort to patients. We saw that patients who wanted to were supported to maintain contact with their family during their stay at the hospital. An independent advocacy service was available to patients, providing additional support if needed.

Are community inpatient services responsive to people's needs?

(for example, to feedback?)

Meeting people's needs

Most patients using Ash Green Hospital lived within Derbyshire. The matron told us that if there were patients from outside Derbyshire, links with their families, friends and social workers were maintained and patients were discharged to services near to their home whenever possible.

We found that patients received care and treatment to meet their needs. Patients told us, "I take medication here. It's helping. (Relative's name) says he sees a big difference." and, "(Staff) are caring and helpful. They're very supportive with my needs." Three relatives told us they had seen improvements in the wellbeing of their family member since coming for short stays at Ash Green Hospital. One of the relatives said the person, "Used to speak very little at home but, since coming here on respite, their communication has improved."

Patients had care plans with details of their needs and how these were to be met. Patients had been involved in planning and reviewing their care, as evidenced from the

records and from talking to patients and their relatives. Staff demonstrated their knowledge of the individual needs of patients and of how patients preferred their care and support to be provided. An example of this was a patient who liked specific set routines in their days. This was clearly documented in their care plan and followed in practice by staff.

The care plans used were the same as those used throughout the Trust and were not specifically designed for people with learning disabilities. This meant the care plans were in a format that was not easy for some people with learning disabilities to understand. Also, there were some aspects of the documentation that were not applicable, such as care rounding charts – observations made of inpatients usually at one or two hourly intervals.

Adjustments had been made in response to patients' needs. There were quiet areas on each ward for patients who wanted to spend time away from the often noisy and busy main areas. Patients could choose their meals from a pictorial menu. Specialist moving and handling equipment and bathing facilities were provided for patients with limited mobility.

Access to services

Accessibility at Ash Green Hospital was good as the premises were purpose built and all patient areas and services were at ground floor level. Free car parking was available and the hospital was on a bus route.

Patients were referred to Hillside ward through various routes, such as their GP, the community team or an acute hospital. The ward manager told us that there were times when beds were not available and patients had to be admitted to acute hospitals. Admissions to Valley View ward were usually planned as short stays for respite for families and carers. Some patients were admitted in more urgent circumstances, such as deterioration in their physical health or for review of their medication.

The relatives and carers we spoke with were concerned about the future of services at Ash Green Hospital. They felt that cuts had already been made in services as the therapy pool and sensory rooms were no longer available during the evenings or at weekends. They felt that further cuts could follow that would affect the provision of respite care.

Vunerable patients and capacity

Arrangements were in place to ensure staff understood the requirements of the Mental Capacity Act 2005 (MCA) and applied these requirements when delivering care. All staff received mandatory training in consent, safeguarding vulnerable adults, the MCA and Deprivation of Liberties Safeguards (DoLS). In addition to the mandatory training, staff working at Ash Green Hospital had received training for caring for patients with dementia and those who displayed challenging behaviour. Staff we spoke with understood the legal requirements of the MCA and had access to social workers and staff trained in working with vulnerable patients, such as their safeguarding lead.

Where patients lacked the capacity to make their own decisions, staff sought consent from their family members or representatives. Where this was not possible, staff made decisions about care and treatment in the best interests of the patient and involved the patient's representatives and other healthcare professionals.

Leaving Hospital

We saw that planning for the patient leaving hospital started on the day of admission. Multidisciplinary team meetings (MDT) were held every week where patient discharges were discussed and provisional dates agreed. We saw evidence of discussions around discharge in patients' records. The discussions and preparation for discharge involved the patient, their families, and support staff from other providers where appropriate. Most patients were already known to the community learning disabilities team and so continued to be supported by the same team on leaving hospital.

There was a system in use where each patient's journey from admission to discharge was tracked. This system noted all assessments, interventions, treatments and any constraints affecting discharge for each patient. The matron told us this system had been useful in resolving delays and reducing the length of stay of patients on Hillside ward. The matron said the average length of stay on Hillside ward had reduced during the previous 12 months and was currently 23 days. We saw that one patient had been on the ward for significantly longer than this. The reasons for the delays in their discharge and discussions exploring various options for them were clearly documented.

The usual reasons for delay in discharging patients were patients not being physically or mentally fit for discharge,

the lack of suitable accommodation / social care placements, or waiting for a place to become available. Delays in discharge were discussed at monthly meetings with adult social care staff.

Learning from experiences, concerns and complaints

The provider's board meetings included feedback from patients through the Patient Experience and Engagement Group, and also looked at trends in complaints and incidents.

We saw that information was available for patients and their families about how to make a complaint or raise concerns, including an easy to read format for patients who needed this. Patients told us they would go to the ward staff if they were unhappy about anything. We heard from one person, (not a patient), who had made a complaint. They told us they were not satisfied with the action taken in response to their complaint and said the provider's complaint procedure was not correctly followed.

Patients were encouraged to attend a weekly meeting where they could share their views about the service and raise any issues. One patient told us they had raised an issue at the weekly meeting about fire alarms being tested during mealtimes, but this had not been addressed. We brought this to the attention of the matron who took action to ensure the fire alarms were not tested during mealtimes.

Are community inpatient services well-led?

Vision, strategy and risks

Information about the provider's vision and values was prominently displayed in the hospital. Most staff we spoke with were aware of the provider's approach to delivering quality services: 'The DCHS Way'.

Risks at ward level were identified and monitored. This included risks specific to individual patients, such as moving and handling and self-harm. Environmental risks were included, such as fire safety, infection control and security. The ward managers told us they had overall responsibility for monitoring and managing risks, though this was shared by delegation to specific members of staff.

Quality, performance and problems

Staff were able to share ideas and raise concerns through team meetings, supervision, shift handovers, and informally with their managers. Staff told us they were asked for their opinions on new ideas being trialled, such as changes to documentation.

Leadership and culture

Most staff we spoke with were aware of the basic structure of the organisation and knew the name of the Chief Executive. One member of staff said, "Trust board members pop in. We do see them, they have meetings here."

Staff told us they had good support from their line managers. Staff on both wards said that the ward managers were approachable and there was good team working. They said, "(The ward managers) are good at taking action and they'll improve things if they can." and, "There's a good support network here." Staff said the ward managers and the matron were, "Always around when we need them." and, "They're 'hands on' with patients." One member of staff told us they had lacked confidence using a computer, but since receiving support from their line manager they were now able to use it more confidently. This meant they could more easily access training and guidance and report incidents.

Patient experience and staff involvement and engagement

Communication about changes in the Trust was cascaded to staff through several routes. The Trust issued a weekly bulletin, 'The Voice', and the Chief Executive wrote a weekly email to staff. Updates were discussed at ward team meetings. Staff told us they enjoyed working at Ash Green Hospital.

Patients, relatives and carers we spoke with were mostly positive about the service provided at Ash Green Hospital. Patients and their families were provided with opportunities to raise concerns or complaints. Patients told us they would speak to staff if they were unhappy.

Continuous improvement and innovation

Staff had a five day induction when first employed, followed by a probationary period of three to six months. During the probationary period, staff performance and behaviour was monitored through supervision and appraisal. Staff told us that learning and personal development were encouraged and supported by their managers. An example of this was a member of staff who

was supported to undertake training to care for patients who were fed through a tube. The member of staff was pleased that their manager had recognised the value of them having this training as it would improve the quality of service for patients.