Ashley House

Quality Report

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Date of inspection visit: 24 August and 09 September 2016
Date of publication: 24/04/2017

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

Overall summary

- During our visit we found that the hospital was aware of the concerns around staffing levels that at times they fell below the required numbers. The hospital was had a robust action plan to address the issues around staffing and it was work in progress. They had implemented an action plan around staff recruitment and retention.
- The hospital monitored and investigated all incidents and concerns around staffing, responses to emergency alarm calls and the maintenance of patient observations. They responded with a range of recruitment initiatives and independent reviews to staffing levels.
- The governance meetings discussed all incidents and actions were put in place to address any shortfalls. They had increased the number of support workers required and offered agency nurses six-month contracts.
- The hospital regularly used agency staff to cover special observations, staffing shortfalls and annual leave.
- The hospital had a range of human resources policies that were followed when staff were injured at work or reported concerns about bullying.
- We saw that staff met to review, update and implement patient care and treatment that was responsive to changing needs. Staff monitored and responded to changes in patients physical health presentations.

However:

- Where staff gave short notice of sickness and absence the wards struggled to meet the needs of patients.
- Not all staff were offered debrief and support following any incidents of abuse or assault.

Summary of findings

Contents

Summary of this inspection

Background to Ashley House

Ashley House provides a locked rehabilitation service and is an independent mental health hospital, registered for the assessment and treatment of people detained under the Mental Health Act 1983. People admitted usually had a learning disability diagnosis and may have had a history of offending. The hospital had 46 beds spread across six wards.

- Bromley ward was a low secure ward for up to nine men with personality disorder and forensic histories. There were eight patients on the day of inspection.
- Fairoak ward was a low secure ward for up to eight female patients. There were eight patients on the day of our inspection.
- Lordsley ward was a low secure ward for up to eight men who had an autistic spectrum or learning disability conditions. There were eight patients on the day of our inspection.
- Oakley ward was a locked rehabilitation ward for up to seven men with autism. There were six patients on the day of our inspection.
- Willowbridge ward was a locked rehabilitation ward for up to seven female patients. There were four patients on the day of our inspection.
- Pinewood ward was closed for refurbishment at the time of inspection.

The CQC registered Ashley House to carry out the following services/activities:

• Treatment of disease, disorder or injury

• Accommodation for persons who require nursing or personal care

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

• Diagnostic and screening procedures

The hospital had a manager registered with the CQC in post at the time of the inspection.

There have been eleven inspections carried out at Ashley House. The most recent inspection was in April 2016 as part of our ongoing comprehensive mental health inspection programme. The hospital received an overall rating of Good at this time.Start here...

Our inspection team

Team leader: Chris Hollands

The team that inspected the service comprised two CQC inspectors on both visits.

Why we carried out this inspection

We carried out an unannounced, focused inspection on 24 August 2016 after receiving concerns through a whistle blowing alert. We conducted another visit on 9 September 2016 after further concerns had been raised through more whistle blowing alerts.

The concerns raised on 19 August 2016 were:

- low ward staffing levels and high use of agency staff at the hospital
- staff responses to emergency alarm calls were leaving wards with no staff to adequately maintain observations.
- no clear management plans for staff to follow on one patient's care and treatment within the low secure area of the hospital
- no regular clinical review of that particular patient.

Further concerns raised on 25 and 28 August 2016 included:

Summary of this inspection

- staff responses to emergency alarm calls were poor as a result of low staffing levels
- senior managers and administration staff did not respond to emergency alarm calls or support wards during incidents
- low staffing levels and high use of agency staff on wards
- staff being denied access to sick pay when they have been injured at work
- hospital managers were not responding to concerns about staffing levels at the hospital.

Whistle blowing concerns raised on 1 September 2016 included:

- senior members of the nursing team behaved in a way that intimidated and bullied junior staff
- staff members were given preferential access to training opportunities because of personal relationships with senior members of the nursing team
- the hospital discouraged staff from reporting incidents about low staffing levels on wards and incidents relating to low staffing levels were not thoroughly investigated.

How we carried out this inspection

On this inspection we only focussed on the areas that concerns were raised. Before the inspection visit, we reviewed information that we held about the location.

During the inspection visit on 24 August 2016, the inspection team:

- spoke with the hospital manger, deputy hospital manager and the clinician responsible for the care and treatment of the patient for who concerns had been raised
- spoke with two members of staff working within the low secure area of the hospital
- reviewed the care and treatment record of the patient for who concerns had been raised
- looked at a range of policies, procedures and other documents relating to the running of the service
- raised concerns relating to staffing with the hospital manager and agreed a return visit to undertake a thorough review of staffing at the hospital for the period from June - August 2016.

During the follow-up visit on 9 September 2016, the inspection team:

- spoke with the hospital manager
- spoke with four members of staff working across the hospital site
- looked at a range of policies, procedures and other documents relating to the running of the service.

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?

- The hospital had a staffing model that planned for each ward to have one qualified nurse on duty each shift. The hospital planned shifts to ensure that this was met or followed agreed processes when it was not.
- The hospital manager investigated and responded to incidents reported and concerns raised by staff locally. An independent review of the staffing model, incidents and policies had been arranged to further investigate the hospital's situation.
- Staff vacancies at the hospital were subject to ongoing recruitment initiatives. The hospital had recently increased staffing numbers in response to the number of patients cared for under special observations.
- The hospital was implementing a new site safety policy following a review of recent incidents specific to emergency alarm calls.
- We saw that staff reported and investigated incidents specific to individual patients. Changes were made to patient care as a result of this.
- The hospital contacted commissioners and made referrals to find a more suitable placement when a patient's needs could no longer be accommodated there.

However:

- Between June 2016 and August 2016 the hospital had recorded two occasions when one qualified nurse had been required to provide cover to two wards and where emergency assistance had not been provided to alarm calls.
- Between June 2016 and August 2016 the hospital had recorded four incidents where special observations for patients had not been maintained.
- Staff we spoke with reported that there were occasions when staff fell below the required numbers leaving them unable to respond to emergency alarm calls or that patient activities were cancelled.

Are services effective?

- We saw that staff followed and up-dated patients' care plans in response to changing needs.

Summary of this inspection

- We saw that responsible clinician and the multidisciplinary team met regularly to review the changing needs of patients on the ward. Ward staff were supported in implementing changes to patient care on the ward.
- There was evidence of good access to and monitoring of physical healthcare including access to out of hours services when needed.

Are services well-led?

- The hospital had implemented a range of recruitment initiatives and reviews in response to incidents and concerns raised at the hospital around staffing levels.
- We saw evidence that the hospital followed a sickness and absence policy when staff were injured at work.
- Staff were offered equal opportunities to access training and at times it involved recruitment by external agencies.
- The hospital followed a human resources policy when addressing concerns about bullying .We did not find evidence to support that that senior members of the nursing team behaved in a way that intimidated and bullied junior staff.

Detailed findings from this inspection

Wards for people with learning disabilities or autism

Safe	
Effective	
Well-led	

Are wards for people with learning disabilities or autism safe?

Safe staffing

- All of the whistle blowing notifications received included concerns about staffing levels at the hospital. Concerns included low staffing levels on wards, high use of agency nurses and low staff responses to emergency alarm calls.
- The hospital had 25 whole time equivalent posts for qualified nurses of which 17.5 were in post. Of these, four were agency nurses working on six-month contracts. The hospital had 7.5 whole time equivalent nurse vacancies of which two had been successfully recruited to and the others were subject to ongoing recruitment initiatives.
- The hospital had recently increased its number of whole time equivalent support workers from 85 to 100 because of increases in the number of patients requiring special observations. The hospital had 89 support workers in post with a further seven posts successfully recruited to. The remaining four vacancies were subject to ongoing recruitment activities.
- The hospital employed three whole time equivalent charge nurses and five whole time equivalent recovery support workers. There was also a range of staff from other mental health disciplines including psychiatry, psychology. They were further supported by a teacher, speech and language therapist, social worker and occupational therapy.
- Charge nurses, recovery workers, and staff from other mental health disciplines were based on wards and worked in addition to ward baseline staffing levels.
- The hospital also employed staff in clerical, housekeeping and maintenance roles.
- The hospital was trialling an off duty co-ordinator role to oversee and respond to hospital staffing needs. This role would free charge nurses of administrational responsibility for staffing and allow them more time to support wards directly during periods of shortfall.
- The hospital employed a staffing model of one staff member for every two patients admitted to a ward. This formed a ward's baseline staffing level with no additional special observation levels. The hospital increased a ward's baseline staffing levels to facilitate special observation levels. For example, if a patient was on one-to-one observations, an additional staff member above the baseline level was used to facilitate this. The hospital also increased staffing above baseline levels to facilitate planned patient escorts outside of the hospital.
- The hospital planned for each ward to have a qualified nurse on duty each shift. Records from June to August 2016 showed that on two occasions one nurse had been required to cover two wards because of sickness or absence. The hospital had a protocol in place that staff used when this occurred and wards within the secure area of the hospital were not left without a nurse. Three staff we spoke with told us that there was always one qualified nurse in a ward area. One staff member recalled occasions when this had not happened or that the nurse on-duty was often from an agency.
- The hospital used bank and agency staff to cover special observations, staffing shortfalls and annual leave. All agency staff held a recognised training in conflict resolution and safe physical intervention method. The hospital manager told us that they used three agencies to try to ensure that nurses were familiar with the hospital and patients. We saw evidence that staff completed a local and site specific security induction prior to commencing shifts on wards.
- The hospital allocated one named responder from each ward's baseline staffing level. The role of the named responder was to provide emergency assistance to alarm calls around the hospital. All staff we spoke with told us that there was usually enough staff on duty to

respond to emergency alarm calls around the hospital. They reported that staff not carrying out patient observations were expected to respond to alarms and that multidisciplinary or clerical staff provided response.

- Records demonstrated that from June 2016 to August 2016 the average fulfilment rate of qualified nurse shifts was 97%. During this period the lowest recorded rate was 92%. Of the total qualified nurse shifts during this period 62% was covered by substantive staff members and 38% by bank or agency staff.
- Records demonstrated that from June 2016 to August 2016 the average fulfilment rate of support worker shifts was 97%. During this period the lowest recorded rate was 96%. Of the total support worker shifts during this period, 67% was covered by substantive staff members and 33% by bank or agency staff.
- The hospital manager reported that shortfalls in staff fulfilment rates were because of unplanned and short notice sickness or absence. Charge nurses checked staffing needs daily and took action to fill shortfalls when they occurred. On the day we visited the hospital the manager explained that four members of staff had failed to attend for shifts. We saw that hospital staffing levels had been checked the previous day at 5:30pm and all shifts were filled. Where agency staff showed frequent non-attendance for shifts the hospital informed the supplying agency and no longer booked that individual. The hospital manager reported that no pattern to staff absenteeism had been identified.
- From June 2016 to August 2016 the need to provide special observations to patients accounted for 58% of the total number of required support worker shifts. The hospital manager explained using bank and agency staff to fulfil these shifts provided flexibility in meeting the often short-term changes in special observation levels. Recruitment of substantive staff to meet current levels of special observations could mean future staff redundancies when special observation levels dropped.
- The hospital had two whole time equivalent and one part time equivalent consultants on site during working hours with out of hours provision covered by an on-call rota. Staff provided an example where on-call had been used to support staff in providing care for the patient experiencing an infection. The outcome had been positive and prevented the use of medication to manage the patient's presentation.
- Staff we spoke with reported occasions when wards felt short staffed or that ward staffing numbers did not take into account levels of patient activity on the ward. They reported that this left wards unable to assist during times of alarm calls or that patient activities would occasionally be cancelled.
- From September 2016, the hospital was introducing a new system to plan and implement patient therapeutic and leisure activities. The hospital manger reported that this would provide greater co-ordination of off-site activities and help ensure that sufficient staff remained at the hospital to provide assistance in the event of an emergency. The new system would also allow the hospital to track the impact of staffing levels on planned patient activities.
- All staff were trained in a recognised conflict resolution and safe physical intervention method. Some staff not involved in direct patient care had been trained to maintain personal safety and were not expected to routinely provide assistance to alarm calls around the hospital.
- All staff carried personal safety alarms and nurse call systems were fitted throughout the hospital. Staff told us that personal alarms were accurate, responsive and checked at the change of each shift. One staff member told us that the hospital had introduced additional radios and alarms to which allowed for more non-clinical staff to provide assistance.

Assessing and managing risk to patients and staff

- We saw that the hospital completed a daily review of patient observation levels and staffing levels. This review identified baseline staffing levels, additional staff required to complete special observation and the required staffing gender mix.
- Hospital staff contacted commissioners to find a more suitable placement when a patient's needs could no longer be accommodated there. We saw evidence of patient referral and discharge in clinical governance reports. One patient on special observations was waiting for a placement at a medium secure unit. We

saw communication to the commissioner identifying the impact of the patient's behaviour to the staff team and requesting a clear discharge plan that could be communicated to staff.

Reporting incidents and learning from when things go wrong

- Staff reported incidents through an electronic recording system. The hospital reviewed recorded incidents at monthly clinical governance meetings.
- Records demonstrated that staff recorded incidents specific to the patient experiencing an infection. This included the administration of medication under restraint, duration of restraint and monitoring physical observations following administration. Incidents were investigated and actions following investigations were implemented. For example, ward staff requested greater guidance and support from the multi-disciplinary team.
- We saw that the multi-disciplinary team had reviewed all incidents over a six month period specific to a patient within the secure area of the hospital that had experienced an infection. Staff reviewed this because of an identified increase in the number of reported incidents specific to the patient. The responsible clinician had identified learning outcomes from this review.
- The hospital recorded staff providing assistance to emergency alarm calls as part of its incident reporting system.
- The hospital was introducing a new site safety policy following a review of incidents. This identified that staff from outside of the secure area should respond to alarm call from within it and the introduction of a new alarm code that staff could use to quickly communicate the reason for an alarm call.
- Incident reports demonstrated that senior staff members provided assistance to emergency alarm calls in the hospital. The hospital manager reported that they provided emergency assistance to alarm calls in the hospital's therapy unit and response to emergency physical health calls across the hospital.
- We saw that from June 2016 to August 2016 the hospital had recorded two incidents where emergency assistance to alarm calls had not been provided. The hospital manager told us that both incidents had occurred during periods of high patient activity and were under investigation.
- We saw that from June 2016 to August 2016 the hospital had recorded four incidents where special observations had not been maintained for patients. The longest period recorded that a patient had been without special observations was 45 minutes. All incidents had occurred at times of emergency alarm calls during periods of identified shortfalls in staffing levels because of absenteeism. We saw that the hospital had completed incident reports and made safeguarding referrals to the local authority when this had occurred. The hospital had investigated these incidents and no direct negative impact on patient care identified. Letters of apology were provided to the patient involved or their nearest relative.
- The hospital had a policy in place to support staff following an incident. Some support workers had received specific training to provide debrief to staff following an incident. Only one member of staff that we spoke with identified an occasion when they had not received a de-brief following an incident.
- We saw that the hospital manager had reviewed incidents relating to staffing, identifying causes and impact. Concerns had been raised to divisional governance boards and an independent review of the hospital's staffing model, incidents and policies was scheduled for the following week.

Are wards for people with learning disabilities or autism effective?
(for example, treatment is effective)

Assessment of needs and planning of care

- Records for the patient experiencing an infection included up to date and personalised care plans. Care plans included interventions to manage medication, restraint, autism symptoms and nutrition. We saw that during the period of infection staff reviewed and updated care plans according to the patient's presentation.

- Patient records demonstrated that staff accessed appropriate physical health care in response to patient's reports and recorded physical observations. Staff had regularly recorded temperature, blood pressure and pulse to monitor a period of infection experienced by a patient within the secure area of the hospital. The responsible clinician had undertaken additional urine and blood tests which had resulted in a referral to a physical health specialist.
- We saw that the patient had a nutritional plan in place during a period of infection. This plan included high calorie items and personal preferences of the patient. Weight charts were up to date, complete and demonstrated weight gain during admission to hospital.
- All information was recorded on an electronic care notes system. Staff accessed this securely with individual log-on identifications and passwords. Records demonstrated that agency nurses recruited to fixed term contracts were provided with passwords and access to the hospital's electronic records system. We saw that the provider was introducing a policy around the immediate access to information technology systems for temporary staff.

Multi-disciplinary and inter-agency team work

- We saw that the multi-disciplinary team had met weekly to discuss the care and treatment of a patient within the secure area of the hospital during a period of infection.
- We saw that the responsible clinician had reviewed a patient within the secure area of the hospital eight times in four weeks. This included the period when the patient was experiencing an infection.
- The responsible clinician for the patient with an infection told us that he had attended morning ward handovers while the patient had been unwell. This had allowed him to support staff directly and discuss care plans prior to their implementation. Staff we spoke with reported feeling supported and believed that the multidisciplinary team worked well together.
- We saw that staff had effectively used physical health pathways within the hospital and out of hours services for a patient experiencing an infection.

Are wards for people with learning disabilities or autism well-led?

Good governance

- Records demonstrated that the nurse vacancy rate was identified on the hospital's risk register and clinical governance reports. The hospital was addressing this with continuous advertising of posts, recruitment of agency nurses on fixed term contracts of up to six months, and on-going liaison with a central recruitment team.
- Following a review of patient special observations, the hospital was in the process of recruiting additional full time equivalent support workers.
- The hospital was implementing a new site safety policy following a review of recent incidents specific to emergency alarm calls.
- Following a review of incidents and patient concerns the hospital had arranged an independent review of its staffing model, incidents and policies.

Leadership, morale and staff engagement

- The hospital manager discussed one ongoing incident of bullying in the organisation. This had been escalated in line with policy to the human resources department locally and at a corporate level. The hospital manager reported that they had received no concerns about bullying of staff from charge nurses at the hospital. The manager described the role of a charge nurse as the first level of management in the hospital which made them vulnerable to complaint from other staff members. To assist charge nurses in their roles, the hospital manager had undertaken a review of their roles and requested additional training from the human resources department in leadership and managing people. One staff member spoke positively about a charge nurse, reporting that they provided support to ward staff when needed.
- The hospital manager acknowledged staff personal relationships within the hospital but did not believe that this led to preferential treatment. Specific to the concerns raised to CQC, the hospital manager explained that staff chosen to do recent training had been selected by the external provider of the course following application. Staff across the site had been supported to complete applications.

Wards for people with learning disabilities or autism

- The hospital had processes to support staff during periods of sickness or injury at work. This included occupational health review, physiotherapy service, and counselling. There were also processes to support staff returning to work and pregnancy.
- The hospital had a sickness and absence policy which covered staff injury at work. One staff member reported that staff continued to attend for work when injured because they feared that they would not be paid sickness pay. The hospital manager explained that historically this policy had not been followed at the site but was now being fully adhered to. The hospital manager had informed staff of this change through emails, weekly staff bulletins and staff meetings. In the period June 2016 to August 2016 staff had raised two grievances related to the level of pay received following an injury at work. Both outcomes had been reviewed independently and upheld the decision of the hospital manager.
- In the period June 2016 to August 2016 the hospital had made seven reporting of injuries, diseases and dangerous occurrences regulations 2013 notifications. These were incidents where staff were unable to work for a period of seven days or more following an injury at work. Records showed that these injuries had occurred as the result of physical assault or avoiding assault.
- The hospital manager was reviewing how absence and sickness was addressed locally and as a company with the corporate human resources lead. This was as a result of concerns raised by staff and lessons learnt from implementing the policy at the hospital.
- The hospital manager met monthly with the steward and regional representative of a staff union.
- The hospital provided a confidential whistle-blowing process called 'Safecall'. Details of this were displayed on staff identification cards and posters around the hospital. The hospital manager reported that a concern regarding staffing levels at the hospital had been raised through this process.
- The hospital manager identified that high levels of patient activity and the implementation of changes across the site may have impacted negatively on communication with staff. They identified plans to visit wards with senior members of the staff team to communicate the outcomes of planned reviews and locally implemented changes.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

The provider should review their baseline numbers of staff to determine the adequate numbers required to maintain safe staffing and staffing to meet patient care and treatment at all times including where staff gave short notice of sickness or absence.

The provider should ensure that all staff are offered debrief and support following any incidents of abuse or assault.