Birmingham and Solihull Mental Health NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

The acute wards and psychiatric intensive care units for adults of working age were provided on 16 wards over six sites in Birmingham and were purpose-built facilities for inpatient mental health services for adults aged between 25 – 65 years. Some of the buildings that the trust use are part of a private finance initiative agreement. This requires the trust negotiate any changes to buildings or environments with third parties.

We conducted an unannounced focused inspection as a result of insight we had gathered around this service.

At the last comprehensive inspection in April 2019, we rated the trust overall as requires improvement.

During the inspection we spoke with staff, patients and carers, visited six of the sixteen wards across four sites, observed a multidisciplinary team meeting, reviewed documentation including patients care records and policy documentation, undertook 6 clinic checks, undertook 6 ward tours and reviewed medication records including prescription charts.

Patients and carers we spoke to about this service were, for the most part, very positive about their experiences. They stated that they felt that staff had been caring and had treated them with dignity and respect. Carers stated that they had been involved in the development of care for their relatives and had been well supported by staff within the service. We did receive some feedback that stated that staff had not involved patients and carers in the development of care plans and had been impersonal in their approach to enquiries about relatives care.

We found the following:

- Some of the ward areas we inspected were not clean and well maintained. We found that one clinic room we checked was being used to store boxes and patient's property and it was not possible to use the room for patient examinations. Some of the furniture and soft furnishings in some areas was not well maintained.
- Ligature risks were present across the service and, though the trust had begun to address these, there was no clear time frame for when this work would be undertaken or completed across all wards.
- We found that not all risks, that had been identified in patients risk assessments, had been addressed with a specific care plan in care records. In some cases the care records were well written but we saw examples that were generic and repetitive. These care plans did not reflect the patients voice and were not specific to the individual.
- Documentation relating to the review of some medications had not been completed. Though the reviews had taken place this was not recorded in multidisciplinary team meeting minutes or patients notes in some cases.

However,

- Staffing levels were good across the service.
- The service used systems to safely prescribe, administer and store medications. Staff regularly reviewed the effects of medication on patients physical and mental health.
- Ward staff were adhering to infection control procedures linked to COVID 19 and there was sufficient PPE available across all services we visited.

Our findings

- We saw that staff were communicating well with patients. We saw that they were treated with dignity and respect and adjustments could be made for patients and carers that had specific requirements. We saw staff on one ward organising for a translator to assist a family member of a patient on the ward.
- Leaders on the ward were visible and well respected by staff. We were told that leaders were approachable and listened to concerns from staff and patients

Is the service safe?

Inspected but not rated

- Ward areas at the Zinnia centre, Oleaster and Mary Seacole 2 were safe, clean, well equipped, well furnished, well maintained and fit for purpose. Ward areas at Mary Seacole 1 and The Eden Picu were not clean. At The Eden Picu we found that the seclusion area had staining across the walls and ceiling. There were dirty marks on the walls and the furniture was marked and in some cases damaged. The clinic room was being used to store boxes and patients property and we found what looked like dried blood on some medical equipment. At Mary Seacole 1 we found that the ward area including the dining area was not clean. tables in the dining area were sticky to the touch and there was damaged furniture and soft furnishings around the ward.
- The service had responded quickly to safety concerns in most cases. We found that they had not responded quickly to address the ongoing ligature risk presented by en-suite bathroom doors. Though work was underway on one ward at the time of our inspection there were no clear timelines as to when this work would be carried out across the service.
- We found that not all risks were addressed in the care plans we looked at. In some cases risks had been identified in the risk assessment but were not covered in current up to date care plans.Staff assessed and managed risks to patients and themselves and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.
- We found some cases where patients were prescribed high doses of some medication. In these cases there was a clear rationale for this and there was evidence of discussion at multidisciplinary team meetings. Some of the medication prescribed required regular review and we found that, in some cases, documentation of these discussions were poor.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm
- 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 had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- 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 physical health.
- We saw that staff were adhering to infection control procedures and there was sufficient personal protective equipment available to staff on the wards.
- 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.

Our findings

Is the service caring?

Inspected but not rated

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.
- We found some evidence that staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. But we also found that some of the care records we checked had not included the patient in the development of care plans. Sections that should have reflected the patients voice were completed by nursing staff in a generic way. The trust ensured that patients had easy access to independent advocates.
- Feedback from patients was, for the most part, very positive and we were told that staff informed and involved families and carers appropriately. We did have a number of carers that we contacted who felt that they were not included in the development of care for their relatives and were not kept informed. We were unable to verify these claims that the patients in question were no longer being cared for by the service.

Is the service well-led?

Inspected but not rated

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff informed us that trust senior leadership were visible and approachable and that there were regular communications. Staff stated that they could easily contact senior leaders if required and that they would feel confident that they could raise issues or concerns with them if they needed to. Staff also told us that senior leaders had been proactive in communicating with staff throughout the ongoing Covid pandemic.

Our findings

Outstanding practice

NA

Areas for improvement

The trust must ensure that environments are safe and fit for purpose. they must ensure that ligature risks are identified and mitigated.

The trust must ensure that care records contain all information required to deliver care. they must ensure that risk assessments are undertaken and any identified risks are addressed in care plans.

The trust must ensure that ward areas including furnishings and decoration are maintained, clean and fit for purpose.

The trust must ensure that, where reviews have taken place, this is documented

Our inspection team

The team that inspected the service comprised of two CQC inspection managers, and six CQC inspectors and three expert by experience who had used community mental health teams to interview staff, patients and carers and on site we had two CQC inspectors and a specialist advisor in acute wards for adults of working age.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Section 31 HSCA Urgent procedure for suspension, variation etc.