Requires Improvement

Birmingham and Solihull Mental Health NHS Trust

Acute admission wards

Quality Report

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Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Barberry	RXTD3	Jasmine suite Magnolia, Melissa, Japonica wards at Oleaster	B15 2FG
Eden Unit, Northcroft	RXT54	Eden, George wards	B23 6AL
Mary Seacole House	RXT47	Wards 1 and 2	B18 5SD
Solihull Hospital	RXT76	Bruce Burns unit	B91 2JL
Newbridge House	RXT37	Little Bromwich Centre	B10 9GH

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for acute admission wards	Requires Improvement 
Are acute admission wards safe?	**Requires Improvement** 
Are acute admission wards caring?	**Requires Improvement** 
Are acute admission wards effective?	**Good** 
Are acute admission wards responsive?	**Good** 
Are acute admission wards well-led?	**Good** 

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

The acute admission wards are based in five hospital sites and are purpose-built facilities for inpatient mental health services for adults aged between 16 – 65 years.

Most staff had a good understanding of safeguarding procedures and had received the right training for this. We saw that staff worked hard to ensure that the ward areas supported people's therapeutic needs. The records reviewed did not show us that clinical risks were always fully assessed to ensure that all staff knew how to safely support each person who used the service. Also, records did not indicate that people's medicines were stored at the safe temperature for them to be effective. We found that there were delays in people receiving some of their prescribed medicines, which may put their health at risk. There were some unaddressed ligature points on Mary Seacole House that may present a risk to the safety of people who used that service. The physical health needs of people who used the service were assessed and monitored to ensure people's health and wellbeing. However, at Mary Seacole House and Newbridge House we found that physical health care medical support could be delayed in the event of an emergency.

We saw that professionals worked together to ensure that all the needs of people who used services were met. Staff received the training they needed to meet the needs of people who used the service. We found some inconsistencies in recording on some wards visited when people were detained for treatment under the Mental Health Act 1983, which could have an impact on people's legal detention under the Act. We saw that activities were not offered to all people who used services.

We found the services provided by the trust had caring and compassionate staff that worked across the service. We saw that staff worked positively with people and supported them well. Staff were skilled and knowledgeable so that they could respond to people's individual needs and preferences. People who used the service were treated with dignity and respect.

Staff worked with community teams to ensure people's discharge from hospital was planned. We saw that assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of responsive admission assessments and discharge procedures.

Staff felt well supported by their managers and by the senior management within the trust. People who used the service were listened to and improvements made as a result of this. It was not clear how action was taken to ensure that outcomes from audits were addressed by the service.

Summary of findings

The five questions we ask about the service and what we found

Are services safe?

Requires Improvement

Records did not show that risks were always fully assessed to ensure that all staff knew how to safely support each person who used the service. Staff received training in how to safeguard people who used the service from harm and demonstrated that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.

Records did not indicate that people's medicines were stored at the safe temperature for them to be effective. We found that there were delays in people receiving some of their prescribed medicines which may put their health at risk. There were some unaddressed ligature points on Mary Seacole House that may present a risk to the safety of people who used that service. At Mary Seacole House and Newbridge House we found that physical health care medical support could be delayed in the event of an emergency.

We noted that some incidents were not always reported appropriately. This meant that the service could miss opportunities to manage the risks to people's safety.

Are services effective?

Requires Improvement

The physical health needs of people who used the service were assessed on admission and monitored to ensure people's health and wellbeing.

Staff received the training they needed to meet the needs of people who used the service. We found some gaps in the recording of induction for some agency staff.

Staff from all professions worked together to ensure that the needs of people who used the service were met. We found some inconsistencies in compliance with the requirements of the legislative requirements of the Mental Health Act 1983 on Bruce Burns unit, Magnolia, Newbridge and George units when people were detained for treatment. This could have an impact on people's legal detention under the Act.

We saw that activities were not offered to all people who used services and some people told us that they were bored.

Are services caring?

Good

Staff were caring and showed compassion to the people who used the service. Staff were genuinely motivated to ensure that people were supported to recover and to rehabilitate within the community.

Summary of findings

People who used the service were treated with dignity and respect. People's mental capacity was assessed and, where people lacked the mental capacity to make decisions about their care and treatment, decisions were made in their best interests.

Are services responsive to people's needs?

Good

Staff worked with community teams to ensure people's discharge from hospital was planned. We saw that assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of responsive admission assessments and discharge procedures.

We saw that people's preferences and wishes were considered. A choice of menu was available that catered for people's specific dietary needs and reflected their cultural and religious needs**.** We found that people who used the service knew how to make a complaint and told us that when they had done so, action had been taken to resolve these and make improvements.

Are services well-led?

Good

Staff felt well supported by their managers and by the senior management within the trust. People who used the service were listened to and improvements made as a result of this.

It was not clear how action was taken to ensure that outcomes from audits were addressed so that improvements could be made to benefit people who used the service.

Summary of findings

Background to the service

The acute admission wards were based in five hospital sites at Barberry/Oleaster, Mary Seacole House, Bruce Burns, Northcroft and Newbridge House. They were purpose-built facilities and provided inpatient mental health services for adults aged between 18 – 65 years.

There was one ward – Japonica – for women who were 16 and 17 years old at Oleaster.

Oleaster – Magnolia ward for up to 16 men.

Oleaster – Japonica ward for up to eight young women aged 16 and 17 years.

Oleaster – Melissa ward for up to 16 women.

Barberry – Jasmine ward for up to 12 Deaf and Deaf-blind men and women.

Mary Seacole House – ward 1 for up to 16 men. Ward 2 for up to 14 women.

Bruce Burns unit was a stand-alone unit with the grounds of Solihull General Hospital for up to 10 men and eight women.

Northcroft – George ward for up to 18 men.

Northcroft – Eden ward for up to 16 men.

Newbridge House for up to 18 women.

Our inspection team

Our inspection team was led by:

Chair: Dr Peter Jarrett

Team Leader: Julie Meikle, Care Quality Commission

The team included CQC inspectors and a variety of specialists:

The team who inspected these services consisted of a CQC inspector, Consultant psychiatrist, Mental Health Act Commissioner and an Expert by Experience who was a person who had previously used mental health services.

Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before visiting the service, we reviewed information which was sent to us by the provider and considered feedback from relevant local stakeholders including Health watch, advocacy services and focus groups held with people who used the service.

We reviewed the last Mental Health Act 1983 monitoring visit reports and previous Care Quality Commission inspection reports for these services and the subsequent action plan responses provided by the trust. These helped to inform our inspection plan.

Summary of findings

We carried out an announced visit to the services between 12 and 15 May 2014. We spoke with people who used the service.

We observed how people were treated and we examined treatment plans and spoke with senior clinicians, lead therapists, and other staff.

This assisted the Care Quality Commission to obtain a view of the experiences of people who used this service.

What people who use the provider's services say

People told us they felt safe at the hospital. They told us they had been involved in their care plans and had copies of these. They were also involved in all review meetings of their care.

People told us that staff treated them really well and were caring. They said that even when staff were busy they made time to listen to them. They confirmed that staff treated them with dignity and respect and did not judge them.

Some people told us that there were too many bank or agency staff and they did not know staff that supported them. This meant that sometimes their needs were not met as they did not approach staff they did not know. However, they knew how to make a complaint and were listened to.

Several people told us that they would like a wider range of activities provided and sometimes they got bored. Some people responded to us using the provided comment cards: They said that staff respected and listened to them. Staff put them at ease and helped them to feel safe. They told us that staff really cared and were approachable. People told us that if they needed someone to talk to, staff were always there and listened to them. One person told us that restraint was only used as a last resort to keep people safe and was done for the minimum amount of time. One person said that they would like more one-to-one time with the nurses.

Good practice

We saw that specialist services had been provided; for example, a service for deaf people and a service for young women under 18 years old.

Areas for improvement

Action the provider MUST or SHOULD take to improve

The trust must ensure that all people who use the service are protected against the risks associated with the unsafe use and management of medicines.

The trust must ensure that all records for people who use the service are accurate and fit for purpose.

The trust must ensure that all ligature risks are assessed and action taken to reduce these.

The trust must ensure that the people who used the service at Mary Seacole House and Newbridge House have access to physical health care medical staff when needed.

The trust should ensure that the privacy of all people who use the service is respected at all times.

The trust should ensure that actions identified in audits are available to staff on the wards so that improvements can be made.

Summary of findings

The trust should ensure increasing the amount of activities that people are offered during their stay on the ward.

The trust should ensure increasing the input from psychologists to improve the treatment options available to people who use the service.

The trust should ensure the need for newly qualified nurses to have access to the preceptorship programme.

Birmingham and Solihull Mental Health NHS Trust

Acute admission wards

Detailed findings

Locations inspected

Name of service(e.g. ward/unit/team)	Name of CQCregistered location
Jasmine suite Magnolia, Melissa, Japonica wards at Oleaster	Barberry
Eden, George wards	Eden Unit, Northcroft
Wards 1 and 2	Mary Seacole House
Bruce Burns unit	Solihull Hospital
Little Bromwich Centre	Newbridge House

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the provider.

People were informed of their right to access an Independent Mental Health Advocate (IMHA) if they were detained there under the Mental Health Act 1983. People were informed of their right to appeal under the Act and if they had refused to listen to staff telling them this it had been recorded.

Most Section 17 leave forms, for people who were detained there under the Mental Health Act 1983, had been completed appropriately to ensure the person's safety and that of others.

We found some inconsistencies in compliance with the requirements of the legislative requirements of the Act on Bruce Burns unit, Magnolia, Newbridge and George units when people were detained for treatment. This could have an impact on people's legal detention under the Act. These concerns were brought to the attention of senior staff during the inspection.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We saw that all staff had received training in the Mental Capacity Act 2005 and the deprivation of liberty safeguards. We saw that this legislation had been used appropriately in a person's best interests to ensure their safety and welfare.

People's mental capacity to consent to their care and treatment was assessed. We saw that where people were able to they had consented.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Summary of findings

Records did not show that risks were always fully assessed to ensure that all staff knew how to safely support each person who used the service. Staff received training in how to safeguard people who used the service from harm and demonstrated that they knew how to do this. Staff received training in the management of violence and aggression. We found that restraint was used safely and only as a last resort.

Records did not indicate that people's medicines were stored at the safe temperature for them to be effective. We found that there were delays in people receiving some of their prescribed medicines which may put their health at risk. There were some unaddressed ligature points on Mary Seacole House that may present a risk to the safety of people who used that service.

We noted that some incidents were not always reported appropriately. This meant that the service could miss opportunities to manage the risks to people's safety.

Our findings

Oleaster - Magnolia ward

Track record on safety

All staff spoken with demonstrated that they knew how to identify and report any abuse to ensure that people who used the service were safeguarded from harm. All people who used the service told us that they felt safe and knew how to raise any concerns about abuse. We saw that information was displayed to inform people who used the service, and staff, how to report abuse.

Learning from incidents and improving safety standards

We saw that incidents were reported however it was not always clear that actions had been taken as a result. The ward manager told us that these actions had been completed but this had not been recorded. Staff told us that they received feedback following incidents through meetings, handover and supervision and that lessons learnt were recorded. All staff told us that they received a debrief session following an incident and they could also access the trust staff support team for debrief.

We looked at restraint records which clearly recorded the length of time the person was restrained and how and which staff were involved. We saw that all staff had been trained in the physical intervention method used within the trust called 'Approaches to Violence through Effective Recognition and Training for Staff' (AVERTS) and all staff spoken with confirmed this.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that the trust's rapid tranquillisation policy had been followed by staff who prescribed medicines given in an emergency.

Staff told us and we saw that there was a safety alarm system in place to summon assistance from other staff on the ward and staff from other wards when needed. This helped to ensure the safety of people who used the service and that of staff.

We saw that the ward was clean and staff practiced good infection control procedures. The environment was purpose built and included anti-ligature fittings to ensure the safety of people who used the service.

Assessing and monitoring safety and risk

We saw that care plans and risk assessments clearly identified how staff were to support each person when they behaved in a way that could cause harm to them or to others.

We saw that there were inconsistencies in the monitoring of the temperature of the room and the fridge where medicines were stored. This was not recorded daily and in some weeks of records we looked at, there were gaps of two to three days without checks being recorded. Staff had not recorded what the minimum and maximum temperatures were, so it was not clear whether the medicines were stored at a safe level for them to be effective. We also saw that there were gaps in recording that emergency life support equipment had been checked.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

We saw that all staff had received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. We saw that this legislation had been used appropriately in a person's best interests to ensure their safety and welfare.

We saw that the staffing levels had recently been increased by one across all shifts to five during the day and four during the night. There was a high use of bank and agency staff and the ward manager told us this was due to the increase in staffing levels. There was no recorded evidence available that agency staff received an induction. The ward manager told us that they orientated staff to the ward but did not record this. One agency staff spoken with confirmed this.

Barberry - Jasmine ward

Track record on safety

All safeguarding incidents had been recorded. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed.

Learning from incidents and improving safety standards

We saw that incidents were reported and analysed. Staff were given feedback following incidents so that lessons could be learnt as to how incidents were responded to. All staff spoken with told us they were debriefed following an incident and they could also access the trust staff support system for this.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that information was provided on an electronic screen using sign language so that people who used the service had the information they needed to know how to report abuse. All people spoken with told us that they felt safe on the ward and knew how to raise any concerns.

We saw that the ward was clean and staff practiced good infection control procedures. The environment was purpose built and included anti-ligature fittings to ensure the safety of people who used the service.

Assessing and monitoring safety and risk

We saw that there were four staff on duty during the day and three staff at night. There was not a high use of bank and agency staff which meant that staff who worked there knew the people using the service well. Interpreters were always available so that people who used the service could communicate using British Sign Language.

We saw that care plans and risk assessments clearly stated how staff were to support the person when they behaved in a way that affected their safety or that of others.

We saw that there were inconsistencies in the monitoring of the temperature of the room and the fridge where medicines were stored. Staff had not recorded what the minimum and maximum temperatures were so it was not clear whether the medicines were stored at a safe level for them to be effective. We saw that emergency life support equipment had been regularly checked to ensure it would work if needed.

Oleaster - Melissa

Track record on safety

All staff had received training in safeguarding vulnerable adults from abuse. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed. Most people spoken with told us they felt safe because there were always staff around which they trusted.

Learning from incidents and improving safety standards

We saw that incidents were reported and analysed. Staff were given feedback following incidents so that lessons could be learnt as to how incidents were responded to. All staff spoken with told us they were debriefed following an incident and they could also access the trust staff support system for this.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that the ward was clean and staff practiced good infection control procedures. People who used the service told us that the ward was always clean. The environment was purpose built and included anti-ligature fittings to ensure the safety of people who used the service.

Assessing and monitoring safety and risk

We saw that there were five staff on duty during the day and four at night. The ward manager told us that for various reasons a number of qualified nurses had left. However, these posts had been recruited to and nurses

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

were now employed to work on the ward. This had meant that there had been a high use of bank and agency staff over the last six months. One person who used the service said that there were enough staff on duty during the day but at night there were often agency staff who did not know them so they did not feel safe at all times.

Oleaster - Japonica

Track record on safety

All staff had received training in safeguarding children and also in safeguarding vulnerable adults from abuse. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed.

Learning from incidents and improving safety standards

Records showed and staff spoken with confirmed that all staff had received training in the trust method of physical intervention AVERTS. Staff told us that they had additional training so that this method was tailored to ensure the safety of the young people they worked with.

Staff told us that they felt confident that as a team they worked together and supported each other which made it safe for them and people who used the service.

Staff told us that a monthly analysis of incidents was undertaken to identify any themes and trends. They said that this meant that they could respond and put the necessary strategies in place to reduce the risk of harm to people who used the service, staff and visitors.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

On the adult wards within Oleaster there was an alarm system that sounded when staff needed help from staff on other wards. The ward manager told us that this had been silenced in Japonica as the sound disturbed the young people that used the service and made them more vulnerable to self-harm.

Staff demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed. All people who used the service we spoke with told us that they felt safe and knew how to report any concerns of abuse.

All staff told us that they had received training in life support so that they could respond and provide emergency first aid when needed.

Staff told us that there were clear boundaries set on the ward, which people who used the service were informed of, which included that there was to be no violence or aggression. People who used the service also told us and knew what was expected of them.

A consequence system was in place that was based on each person's behaviours that were a risk to their safety and that of others. The consequences of the person behaving in this way was not punitive but ensured the safety of each person and encouraged them to take responsibility for their behaviour. Staff told us that each week all people who used the service received a certificate of achievement which helped to encourage them to behave in a way that promoted their safety and wellbeing.

Assessing and monitoring safety and risk

We saw that there were five staff, two of which were usually qualified nurses, on duty during the day. The ward manager was extra to the numbers of staff on the ward. Two people who used the service told us that there was always this number of staff on duty.

We saw the quiet room and people told us this was used for one to one sessions with staff or to spend some time alone without staff as long as they were assessed to be safe to do this. We saw that the door closure to this room was a ligature risk. The ward manager told us that staff would always be near this room but at a distance to give people some privacy. They informed us that a further risk assessment would be carried out on this door closure.

We saw that one person was cared for by two staff in a separate area of the ward called the extra care area. The ward manager told us that this person had been in the area for two months. The person's records showed that the risks to their safety and welfare had been assessed and they needed to be cared for in this environment.

We saw that detailed care plans were in place to support the person in the least restrictive way and to enable them to move to other areas of the ward when safe to do so. We observed the person was supported to spend time in the garden and in the communal area of the ward during our inspection.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Mary Seacole House

Track record on safety

All safeguarding incidents had been recorded. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed. All people who used the service spoken with told us that they felt safe and knew how to report any concerns of abuse.

Learning from incidents and improving safety standards

Incidents were recorded and analysed. Staff were given feedback following incidents so that lessons could be learnt as to how incidents were responded to. All staff spoken with told us they had been debriefed following an incident and they could also access the trust staff support system for this.

We looked at restraint records and saw that this was not used often. When restraint had been used this was clearly recorded with the length of time used to restrain the person, how this was done and which staff were involved. Records showed and staff spoken with confirmed that all staff had received training in the trust method of physical intervention AVERTS.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

There was an alarm system on each ward so that staff could be summoned for assistance from other wards when needed.

In both wards we found that the temperatures in the room and fridge where medicines were stored had not been consistently recorded. Staff had not recorded what the minimum and maximum temperatures were so it was not clear whether the medicines were stored at a safe level for them to be effective. The thermometer we looked at showed temperatures outside of the required range. In ward two staff told us that the fridge had broken and when it was repaired they were not aware that the thermometer needed to be reset. We saw that emergency life support equipment had been regularly checked to ensure it would work if needed.

One person in ward two told us that they had gone for three days without their steroid medicine for asthma as this was not available. The same person had been prescribed a new anti-depressant medicine on the day before our inspection, however, we left the ward at 4pm and the medicine had not been provided from the trust central pharmacy.

We saw that the ward was clean and staff practiced good infection control procedures.

We observed some ligature points on en suite doors and taps in people's bedrooms. This was identified at a previous CQC inspection but action had not been taken to provide anti-ligature fittings. The ward managers told us that the observation policy had been reviewed to reduce these risks by enhanced observations of those people assessed at being at greatest risk, however this did not fully address the risks. They also told us that a ligature risk assessment had been completed; however this was not available on the ward at the time of our inspection.

Assessing and monitoring safety and risk

We saw that care plans and risk assessments clearly identified how staff were to support each person when they behaved in a way that could cause harm to them or to others. All people spoken with told us they had been involved in these.

In both wards one and two we saw that there were five staff on duty during the day and four staff at night. Staff told us that the staffing levels had recently been increased by one member of staff on each day and night shifts in each ward. There were three occupational therapists between the three wards in Mary Seacole House and one activity worker. There were currently two vacancies for activity workers. We saw that at least one or two bank or agency staff were employed on each shift in ward one. In ward two we saw that at least four to five shifts each day were covered by bank or agency staff. Staff told us that this was due to the recent increase in staffing levels. There was no evidence that agency staff completed an induction when they started work on the wards. The ward matron told us that agency staff were orientated to the ward but induction forms had not been completed.

We saw that rapid tranquillisation was used and there was a trust policy on this to guide staff to use this safely. However, staff told us that this policy cannot always be followed as the policy stated that 'a doctor should be quickly available at all times to attend an alert by staff

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

members when rapid tranquillisation is used.' The policy referred to the National Institute of Clinical Excellence (NICE) guidance that recommends that the doctor should aim to be at the scene within 30 minutes.

However, staff told us that they do not have immediate support from doctors and when rapid tranquillisation had been given at times it had taken over two hours for a doctor to respond. Staff told us that when urgent physical health care medical support was needed it could take from two to six hours for a doctor to respond as they were not based on the hospital site.

We saw that the ward was clean and staff practiced good infection control procedures.

We saw that all staff had received training in the Mental Capacity Act 2005 and the deprivation of liberty safeguards. We saw that this legislation had been used appropriately in a person's best interests to ensure their safety and welfare.

Eden

Track record on safety

All safeguarding incidents had been recorded. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed. All people who used the service spoken with told us that they felt safe and knew how to report any concerns of abuse.

Learning from incidents and improving safety standards

Incidents were recorded and analysed. Staff told us they received feedback following incidents so that lessons could be learnt as to how incidents were responded to. All staff spoken with told us they had been debriefed following an incident and they could also access the trust staff support system for this. Records showed and staff confirmed that all staff had received training in the trust method of physical intervention AVERTS.

We saw that ligature risks had been identified from taps in the bathrooms and ensuite bedrooms. We saw that risk assessments had been completed by the trust to reduce the risks of this for individuals by increasing observation levels and keeping doors locked to bathrooms where needed. Some bathrooms had recently been upgraded to provide anti-ligature fittings and work was on going to remove this risk.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We saw that the ward was clean and staff practiced good infection control procedures. Staff told us that there were identified staff who led on infection control on the ward to ensure that procedures were safe in minimising the risk of cross infection.

We saw that one person was admitted to the ward that was not 18 but would be within the next week. We saw that the risks to this young person of being on an adult ward had been assessed and that the person received one to one staff support to minimise these risks.

Assessing and monitoring safety and risk

We saw that there were five staff on duty during the day and four staff during the night. Staff told us that staffing levels had been increased recently by one member of staff on each shift.

We saw that care plans and risk assessments clearly identified how staff were to support each person when they behaved in a way that could cause harm to them or to others. All people spoken with told us they had been involved in these.

One person who used the service told us that staff were supportive and talked to them during their restraint procedure which helped them to feel safe. All staff spoken with told us that restraint was only used as a last resort and de-escalation techniques were a much better way of helping a person to calm down.

We saw that not all staff had received training in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. However, we saw that this was scheduled for all staff to attend by the end of June 2014.

George

Track record on safety

All safeguarding incidents had been recorded. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed. All people who used the service spoken with told us that they felt safe and knew how to report any concerns of abuse.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

Learning from incidents and improving safety standards

Incidents were recorded and analysed. Staff were given feedback following incidents so that lessons could be learnt as to how incidents were responded to. All staff spoken with told us they had been debriefed following an incident and they could also access the trust staff support system for this. Staff also received group supervision from the psychologist which they said helped them to feel more confident and safe on the ward.

Staff and people who used the service spoken with told us that restraint was rarely used on the ward. Records showed and staff spoken with confirmed that all staff had received training in the trust method of physical intervention AVERTS.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

People who used the service told us they felt safe on the ward and an alarm system was in place which helped to ensure their safety.

We saw that the ward was clean and staff practiced good infection control procedures.

We saw that in one corridor one of the toilets was being refurbished. This meant that people had to walk into another corridor to use the toilet there, which they said could put them at risk of falling during the night. People told us, and we saw, that not enough toilets were provided close to people's bedrooms and for the number of people who used the service.

Staff told us that the last risk assessment completed of the environment identified that anti-ligature fittings needed to be provided in the bathrooms and this had been done.

We saw that the fridge should have been tested in November 2013 to ensure it was safe to use. However, there was no record to state this had been tested and staff were unsure whether this had been done or not. We saw that some medical equipment stored in the ward was out of date, for example bandages and urine dipsticks. This could put people who used the service at risk of harm.

Assessing and monitoring safety and risk

We saw that there were six staff on duty during the day and five at night. Staff told us that the staffing levels had recently increased by one member of staff on each of the day and night shifts. An occupational therapist was employed full time and an activity worker had recently been recruited but not started working there yet. We saw that bank or agency staff were employed however these were often staff that worked there regularly and knew people who used the service. The deputy ward manager was acting ward manager as the ward manager was off sick. The deputy manager was not considered as part of the staff numbers on each shift but was extra to this.

Records we sampled showed that one person had attempted to harm themselves on the day before our inspection. We saw that the person's risk assessments had been updated following this. However, their care plan had not been amended to reflect the increased level of observation that the person needed. This could mean that the person was at risk of not being observed as much as they needed to maintain their safety.

Newbridge House

Track record on safety

Learning from incidents and improving safety standards

Staff told us there was not an opportunity to be debriefed following incidents which meant that they did not discuss how they could have done things better and what they did well. This meant that the safety of people who used the service could be at risk. Some staff told us that incidents were not always reported.

Agency staff told us they had seen restraint used and this was done appropriately to ensure the safety of the person who used the service. Some staff spoken with told us that as a number of bank and agency staff worked there this affected the safety of people who used the service when using restraint. They told us that some bank and agency staff did not have the required de-escalation and restraint techniques used by the trust which made it difficult for permanent staff to ensure the safety of people who used the service.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

One person told us that as they were admitted on a Friday but did not receive their epilepsy medication until after the weekend on the Monday evening. Staff told us that this was usually the case if the medication was not one they kept in stock or the person had not brought it to the hospital with them. Staff told us that the trust central pharmacy was not available at the weekend. The person had been transferred

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

from another hospital out of the area as when they were admitted there were no beds available in the trust. Their medication had not been transferred with them so they had to go three days without their epilepsy medication. They told us they had not had a seizure but had felt unwell which they thought was due to this medication being missed. Some staff told us that when medication was ordered it could take a number of hours or until the next day to arrive on the ward.

We found that the temperatures in the room and fridge where medicines were stored had not been consistently recorded. We saw that on three days the minimum fridge temperature was recorded as lower than it should have been. It was not clear whether action had been taken to ensure that the medicines were stored at a safe level for them to be effective. The ward manager reported this to the maintenance team during our inspection.

We looked at the environmental risk assessment which stated what action was taken to reduce the risks of people harming themselves. We saw that ligature risks had been identified in some bedrooms and bathrooms. The ward manager told us and the risk assessment stated that these were being refurbished to reduce this risk. We saw that some items that belonged to people who used the service were locked away to reduce ligature risks. Two staff supported people when they wanted to access these items and we observed people requesting this during the day and staff responded to this. This meant that people could access their belongings but staff took action to ensure that the risks to people harming themselves were reduced.

Assessing and monitoring safety and risk

The ward manager told us that they were recruiting for staff to fill the vacant posts. There were seven staff on duty on the day of our inspection, three staff were permanent and four were bank or agency staff. The ward manager told us that they tried to use regular bank and agency staff to provide consistent care for people who used the service. Agency staff spoken with told us there was an induction checklist which gave them the information they needed about the ward. They also said they had a handover so they had the information they needed about the risks to people who used the service.

Understanding and management of foreseeable risks

Staff told us that there were often difficulties in getting support from physical healthcare doctors in evenings and weekends. There was no doctor out of hours cover or nurse prescribers based at the ward.

Bruce Burns

Track record on safety

All safeguarding incidents had been recorded. Staff spoken with demonstrated a very good understanding of how to identify and report abuse. They told us they would feel comfortable to raise any concerns of abuse and that they could seek guidance from the trust safeguarding lead if needed. All people who used the service spoken with told us that they felt safe and knew how to report any concerns of abuse.

Learning from incidents and improving safety standards

Incidents were recorded and analysed. Staff were given feedback following incidents so that lessons could be learnt as to how incidents were responded to. All staff spoken with told us they had been debriefed following an incident and they could also access the trust staff support system for this.

We looked at restraint records and saw that this was not used often. When restraint had been used this was clearly recorded with the length of time used to restrain the person, how this was done and which staff were involved. Records showed and staff spoken with confirmed that all staff had received training in the trust method of physical intervention AVERTS.

Reliable systems, processes and practices to keep people safe and safeguarded from abuse

We found that the temperatures in the room and fridge where medicines were stored had been consistently recorded. However, staff had not recorded what the minimum and maximum temperatures were so it was not clear whether the medicines were stored at a safe level for them to be effective.

We saw that emergency life support equipment had been regularly checked to ensure it would work if needed.

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse* and avoidable harm

We observed some ligature points on the taps in people's bathrooms. This had been clearly identified in the robust ligature risk assessment. We saw that work had started to change all ligature points to ensure that the risk of people who used the service harming themselves was reduced.

We saw that the ward was clean and staff practiced good infection control procedures. The ward worked closely with the infection control specialist nurse to ensure that appropriate action was taken to minimise the risk of cross infection.

Staff reported some delays in obtaining medicines for people when they were being discharged from the unit.

Assessing and monitoring safety and risk

We saw that care plans and risk assessments clearly identified how staff were to support each person when they behaved in a way that could cause harm to them or to others. All people spoken with told us they had been involved in these. We saw that these were regularly reviewed and monitored through the multi-disciplinary team.

We saw that there were six staff on duty during the day and five staff at night. There was one part time occupational therapist. We saw that at least one or two bank or agency staff were employed on each shift. Staff told us that this was due to the recent increase in staffing levels. There was no evidence that agency staff completed an induction form when they started work on the ward. The ward manager told us that agency staff were orientated to the ward but induction forms had not been completed. Agency staff spoken with told us they did not always have time to go through people's care plans and risk assessments and were not aware of these. This meant that they might not know how to safely support people who used the service.

We saw that rapid tranquillisation was used and there was a trust policy on this to guide staff to use this safely. Staff told us that they had excellent medical support which ensured that if rapid tranquilisation was used people would have the medical support they needed.

We saw that all staff had received training in the Mental Capacity Act 2005 and the deprivation of liberty safeguards. We saw that this legislation had been used appropriately in a person's best interests to ensure their safety and welfare.

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Summary of findings

The physical health needs of people who used the service were assessed on admission and monitored to ensure people's health and wellbeing.

Staff received the training they needed to meet the needs of people who used the service. We found some gaps in the recording of induction for some agency staff.

Staff from all professions worked together to ensure that the needs of people who used the service were met. We found some inconsistencies in compliance with the requirements of the legislative requirements of the Mental Act 1983 on Bruce Burns unit, Magnolia, Newbridge and George units when people were detained for treatment. This could have an impact on people's legal detention under the Act.

We saw that activities were not offered to all people who used services and some people told us that they were bored.

Our findings

Oleaster - Magnolia

Assessment and delivery of care and treatment

We saw in records that care plans were in place and agreed by the person who told us they had a copy of these.

People told us and we saw in records we sampled that they had checks completed of their physical health needs on admission to the ward. We saw that a physical health link nurse was employed in the ward that was responsible for health promotion and maintaining contact with other health professionals.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored through for example; the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

We saw the activity time table that showed all the group activities provided. We did not see any individual activity timetables. However, staff told us that if people requested one to one activities these were provided. We saw that people went off the ward to do activities in the community and at the activity centre on site. People were also involved in activities on the ward. They told us that they enjoyed the activities offered but would like to do more.

Staff, equipment and facilities

We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal.

Multi-disciplinary working

In records we sampled there was evidence that the multi-disciplinary team worked together. Staff told us that input from psychology services was limited. People told us and we saw that they attended their review meetings.

Mental Health Act (MHA)

We saw that most people who were detained there under the Mental Health Act 1983 had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent because they did not have the mental capacity to do so or had refused to, we saw that a second opinion appointed doctor had seen them and stated that it was appropriate for treatment to be given. However, we saw that one person who was detained did not have their second opinion appointed doctor form completed appropriately.

We saw that people's mental capacity to consent to their treatment was assessed and where people were able to they had consented to this. We saw that people had access to an Independent Mental Health Advocate (IMHA).

We saw that information was not available for people who were not detained there under the Mental Health Act 1983 to state that they had a right to leave the ward when they wanted to.

Barberry - Jasmine

Assessment and delivery of care and treatment

Records showed that assessments were completed on admission of the person's physical and mental health needs. We saw that a physical health link nurse was employed in the ward that was responsible for health promotion and maintaining contact with other health professionals.

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored through for example; the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

We saw that there was an activity time table for group activities. The psychologist told us that people who used the service on this ward benefitted more from group activities rather than one to one sessions. We saw some people watched television with the subtitles on, some people accessed activities within the local community and others took part in art, craft and computer activities in the activity room provided. All people spoken with told us that they enjoyed the activities offered.

People told us they were involved in their care plans and attended their review meetings. We saw that the ward had a close working relationship with other mental health hospitals for deaf people in England and shared best practice with them to improve the quality of the service. We saw that literature provided by the Royal National Institute for the Deaf was available on the ward and was used to develop people's care plans.

Staff, equipment and facilities

We saw that all staff were appropriately qualified and competent in their job role. All staff that worked there had achieved at least British Sign Language (BSL) level one training and some were working towards higher levels. One member of staff was deaf and proficient in communicating using BSL.

Multi-disciplinary working

We saw that multi-disciplinary meetings were recorded and there was evidence that the team worked together. In two people's records that we looked at we saw that the discussions held in the person's meeting did not reflect their needs stated in their care plan.

Mental Health Act (MHA)

We saw that people's capacity to consent to their treatment was assessed and where people were able to they had consented to this. We saw that people had access to an Independent Mental Health Advocate (IMHA).

Oleaster – Melissa

Assessment and delivery of care and treatment

Records sampled showed that assessments were completed of the person's needs and risks when they were admitted. From this a care plan was developed that showed staff how to support the person to ensure their needs were safely met. All people spoken with told us that they were involved in their care plans and they were reviewed and updated regularly.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored, for example through the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

Staff told us that there was a weekly session with an art therapist held on the ward. We saw that an activity room was provided and staff told us that activities included art and crafts, using the foot spa, board games and listening to music. They said that people also went to activities at the activity centre on site. People spoken with told us there was not enough to do at the weekends. They said that some people were not able to go to activities off the ward so there was nothing for them to do. One person said they had been to the park with staff recently which they enjoyed.

Staff, equipment and facilities

All staff spoken with told us that they had received an induction when they first started working there. We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal. Staff also told us that during the day handovers between shifts lasted for an hour. They used this time to discuss clinical issues and to update their knowledge and skills so they were more effective in meeting all the needs of people admitted to the ward.

Multi-disciplinary working

In records we sampled there was evidence that the multi-disciplinary team worked together. People spoken with told us and we saw that they attended their review meetings. We saw and staff spoken with told us that people had been referred to other agencies and specialists where needed who supported the person to meet all their needs.

Mental Health Act (MHA)

Records we sampled showed that where people were detained under the Mental Health Act 1983, staff had informed them of their rights. People had access to an Independent Mental Health Advocate (IMHA) and had been supported to appeal against their detention where they had wanted to.

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Oleaster - Japonica

Assessment and delivery of care and treatment

Records sampled showed that detailed assessments had been completed of the person's needs and risks. From this a care plan was developed that showed staff how to support the person to ensure their needs were safely met and they had an opportunity to develop their skills and independence. People spoken with told us that they were involved in their care plans and they were reviewed and updated regularly.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored, for example through the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

People told us that they had asked for staff to sit with them during mealtimes to make it more of a social occasion and this had been listened to and two staff were provided at each mealtime.

During school term time teachers were employed on the ward during the day to help people to continue with their education or do educational courses. People spoken with told us that this helped them. People told us that there were a wide range of activities provided on the ward including jewellery making, cake baking and themed days to celebrate things like national nurse's day and cultural celebrations. Therapeutic activities were also provided and people said that there was a psychology group every week but they also had one to one sessions. Some people told us that they would like more activities during the evening when they often got bored. We discussed this with the ward manager who told us that they tried and encouraged people to relax. Therefore, in the evenings too many activities that would over-stimulate people were not organised as it could disrupt their sleep pattern. However, they said they would discuss this comment with the multi-disciplinary team and the people who used the service to see if improvements could be made.

Staff, equipment and facilities

All staff spoken with told us that they had received an induction when they first started working there. We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal. Staff told us they also attended reflective practice sessions which helped to improve their practice and benefitted people who used the service.

Multi-disciplinary working

We saw that multi-disciplinary meetings were recorded and there was evidence that the team worked together. Staff told us each person that attended the meeting was able to speak and was listened to. They said that the people who used the service were always involved in these meetings.

Staff and people who used the service told us that when the psychologist was on leave that psychology support was not provided. The ward manager told us that they were aware of this and the difficulty it caused the young people who used the service.

Mental Health Act (MHA)

Records we sampled for a person detained under the Mental Health Act 1983 showed that staff had tried to inform the person of their rights under the Act, however, it was recorded that they often refused to listen.

We saw that Section 17 leave forms had been appropriately recorded to ensure the safety of the person and others when on leave from the ward.

Mary Seacole House

Assessment and delivery of care and treatment

We saw in records that care plans were in place and people told us they had agreed to these and had a copy.

People told us and we saw in records we sampled that they had checks completed of their physical health needs on admission to the ward. We saw that a physical health link nurse was employed in the ward that was responsible for health promotion and maintaining contact with other health professionals.

People's mental capacity to consent to their care and treatment was assessed. We saw that where people were able to they had consented. People were informed of their right to access an Independent Mental Health Advocate (IMHA) if they were detained there under the Mental Health Act 1983.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored through, for example the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We saw the activity time tables that showed all the group activities provided. We did not see any individual activity timetables. However, staff told us that if people requested one to one activities these were provided. In ward one we saw that people were not engaged in activities on the ward. Two people we spoke with told us that they did not enjoy the activities offered. We saw that surveys completed by people who used the service and assessments completed by the occupational therapist showed that people had requested different activities. However, these had not been provided. We saw that people did go out in the community and had activities in the activity centre provided in the hospital. In ward two we saw that people were actively engaged in activities on the ward and all people spoken with told us they enjoyed the activities offered.

Staff, equipment and facilities

We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal.

A system was in place to record that agency staff had received an induction however this was not detailed to ensure that agency staff had the information they needed to support people who used the service. Records had not always been completed to show this had been done.

Multi-disciplinary working

In records we sampled there was evidence that the multi-disciplinary team worked together. Staff told us that input from psychologists was limited. People told us and we saw that they attended their review meetings.

Staff told us that there was a lack of medical team support particularly when required in an emergency. One person who used the service told us they did not see a doctor when they wanted to see them.

Mental Health Act (MHA)

We saw that Section 17 leave forms for people who were detained there under the Mental Health Act 1983 had been completed appropriately to ensure the person's safety and that of others.

We saw that people who were detained there under the Mental Health Act 1983 had the appropriate documentation in place for consenting to their treatment including medicines. Where people had been prescribed treatment without their consent because they did not have the mental capacity to do so or had refused to, we saw that a second opinion appointed doctor had seen them and stated that it was appropriate for treatment to be given.

Eden

Assessment and delivery of care and treatment

Records we sampled showed that an assessment of the person's needs had been completed when they were admitted to the ward. From this a care plan was developed so that staff would know how to support the person to meet their needs. People told us they had been involved in their care plan.

People told us and we saw in records we sampled that they had checks completed of their physical health needs on admission to the ward.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored through for example; the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

People told us that there were plenty of activities provided. Staff told us that they would like to be able to provide more activities but this was not always possible. They said that they had supported people to do some baking, make smoothies, do quizzes and art activities. We saw that people spent time playing board and card games with staff. Where people were able to they went out into the local community either on their own or supported by staff. People told us that the ward was always clean. One person told us that they felt much better since they had been on the ward.

Staff, equipment and facilities

We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal.

Multi-disciplinary working

In records we sampled there was evidence that the multi-disciplinary team worked together. People who used the service and staff told us that input from psychologists was limited. The psychologist based on the ward was on maternity leave and had not been replaced during this time. People told us and we saw that they attended their review meetings.

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Mental Health Act (MHA)

Records we sampled showed that where people were detained under the Mental Health Act 1983, staff had informed them of their rights. People had access to an Independent Mental Health Advocate (IMHA).

We saw that a sign was displayed following our last inspection, which informed people who were not detained under the Mental Health Act 1983, that they could leave the ward when they wanted to.

George

Assessment and delivery of care and treatment

We saw in records we sampled that care plans were in place. Most of the people spoken with told us they had not been involved in their care planning. Staff spoken with told us that people were involved however this was not always clearly recorded. We saw that some care plans and risk assessments did not record people's current needs. For example, one person's risk assessment stated that they were to be observed by staff every five minutes but another of their records stated that this was to be done every hour. Staff confirmed that this person was observed every hour. Another person had a care plan that was completed on their admission to the ward and was to be reviewed after 72 hours. We saw that this should have been reviewed eight days before our inspection but had not been. This could mean that staff did not know how to support people to meet their current needs.

People told us and we saw in records we sampled that they had checks completed of their physical health needs on admission to the ward. We saw that one person had been admitted to another hospital to meet their physical health needs. There was good communication between the other hospital and staff on George Ward to ensure that the person's physical health needs were met.

People's mental capacity to consent to their care and treatment was assessed. We saw that where people were able to they had consented. People were informed of their right to access an Independent Mental Health Advocate (IMHA) if they were detained there under the Mental Health Act 1983.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored, for example, through the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

We saw that as a result of listening to people who used services, a pool and table tennis table had been purchased for the ward. Some people told us they enjoyed using these.

An occupational therapist was employed to work on the ward and they arranged group and individual activities. Some people told us they had been asked what activities they liked to do and some of these had been provided. Some people told us they would like more activities provided as they sometimes got bored. An activity worker had been recruited but was waiting to start working there. Staff told us that an art psychotherapy group was held once a week on the ward as was a pottery group.

Staff, equipment and facilities

We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal.

Multi-disciplinary working

In records we sampled there was evidence that the multi-disciplinary team worked together. People who used the service and staff told us that input from psychologists was limited. People told us and we saw that they attended their review meetings.

Mental Health Act (MHA)

We found that one person had their Community Treatment Order (CTO) revoked and they were being treated in hospital. However, they had not been legally detained in hospital under Section 62 for urgent treatment until six days after their CTO had been revoked. This meant that there was not the legal authority to treat the person during this time. We did not see that a referral had been made for a Second Opinion Appointed Doctor (SOAD) to assess this person to ensure they agreed that the person needed to be detained for treatment. The Mental Health Act Administrator told us they had not received a copy of the SOAD referral request for this person.

Newbridge House

Assessment and delivery of care and treatment

We saw in records we sampled that a care plan was in place that showed staff how to support the person to meet their needs. We saw that people had been asked to sign to show they agreed with their care plan and where they had refused this was recorded.

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

People told us and we saw in records we sampled that they had checks completed of their physical health needs on admission to the ward. We saw that people's physical health was regularly monitored during their stay to ensure these were met.

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored, for example, through the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

People spoken with told us that there were activities provided that they enjoyed and there was something to do every day. One person told us and we saw that people were supported to do their own laundry which helped to promote their recovery.

Staff, equipment and facilities

Staff told us that they received the training they needed and we saw that where updates were required, dates had been set. Staff told us they received regular supervision however, sometimes due to the number of bank and agency staff, they were not always supervised during each shift. They said that this could be difficult and increased the risks to the safety of people who used the service.

An activity worker was provided to co-ordinate regular activities for people who used the service. They told us that they sometimes worked at weekends so that activities were available throughout the week.

A gym was provided however staff told us that there were only a few staff trained to be able to supervise people who used the service when using this. People told us that they would like to use the gym more often but staff were not always available to support them to do this.

We saw that a weekly art psychotherapy was held in the ward. Some people told us they really enjoyed this and it helped them in their recovery. One person told us that they had recently started attending a therapy group which was part of their treatment and they found useful.

Multi-disciplinary working

In records we sampled there was evidence that the multi-disciplinary team worked together. People spoken with told us and we saw in records sampled that they attended their review meetings.

Mental Health Act (MHA)

People who were not detained there under the Mental Health Act 1983 told us that they knew they could leave the ward when they wanted to. We saw during the day that several people went out when they wanted to.

Records we sampled showed that where people were detained under the Mental Health Act 1983 that staff had informed them of their rights and ensured they understood these. People told us that they had access to an Independent Mental Health Advocate (IMHA).

Bruce Burns

Assessment and delivery of care and treatment

We saw records that care plans were detailed and people told us they were involved in and had agreed to these.

We saw and people told us that they received a physical health check on admission.

We saw that where people were able to, they consented to their care and treatment. People's capacity to consent was assessed. Where people were detained under the Mental Health Act 1983, they had access to an Independent Mental Health Advocate (IMHA).

Outcomes for people using services

The outcomes of care and treatment plans for people were being monitored, for example, through the HoNOS (Health of the National Outcome Scale) and person reported outcome measures (PROM).

We saw that an activity time table had been developed by the occupational therapist and all sessions were offered in groups. We saw that people were engaged in a variety of activities and that some people went out to participate in community activities. People spoken with told us they enjoyed the activities offered.

Staff, equipment and facilities

We saw that staff received the training they needed and where updates were required dates had been set. All staff spoken with told us that they received regular supervision and had an annual appraisal.

A newly qualified nurse was concerned that they did not have a preceptor ship programme in place to support and mentor them. We discussed this with the ward manager who told us that this was implemented by the trust but not at ward level.

Are services effective?

Requires Improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Multi-disciplinary working

We observed that the multi-disciplinary team worked together. People told us and we saw that they attended their review meetings. Staff told us that input from psychologists was limited. Staff told us that they worked closely with Solihull local authority and care co-coordinators attended meetings when required. The home treatment team was based within the building and worked closely with staff on the ward to ensure that people's care and treatment was continued when they were discharged.

One person had to be transported to another hospital that only offered their special mental health treatment twice a week. An ambulance was used for all trips as they had several physical health needs. The ward manager told us that the multi-disciplinary team had discussed transferring this person to the other hospital with the person's family. However, it had been agreed that it was in the person's best interests to remain at Bruce Burns. This showed that the staff had worked with the person and their family to ensure they received the care and treatment they needed in the most effective way.

Mental Health Act (MHA)

We saw that one person was on Section 17 leave from the ward but their forms to consent to their care and treatment under the Mental Health Act 1983 were not available. The ward manager told us they were unsure where this would be kept as the person was referred from a community team. We saw in other records sampled that consent to care and treatment had been appropriately documented.

We found that some people's Section 17 leave authorisation had expired. The ward manager told us that this was in the diary to be done and it had only recently expired. This could mean that people were on leave that had not been authorised which could impact on their safety and that of others.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Summary of findings

Staff were caring and showed compassion to the people who used the service. Staff were genuinely motivated to ensure that people were supported to recover and to rehabilitate within the community.

People who used the service were treated with dignity and respect. People's mental capacity was assessed and, where people lacked the mental capacity to make decisions about their care and treatment, decisions were made in their best interests.

Our findings

Oleaster - Magnolia

Kindness, dignity and respect

People told us that staff were helpful and they had been treated with dignity and respect. We observed that the interactions between staff and people who used the service were good and staff treated people with respect.

People using services involvement

People told us they were involved in their care and were given choices about food and medication. People had access to advocacy services.

Emotional support for care and treatment

People were supported to maintain independence where they were able to and to participate in social, leisure and community activities.

We saw that there was a room where people could make telephone calls in private and another room where they could have visits from family and friends.

Barberry - Jasmine

Kindness, dignity and respect

We observed that the interactions between staff and people who used the service were good and staff treated people with respect. Staff spent time communicating with people in a positive manner. We saw that staff responded to people's requests in a timely way and showed a clear understanding of people's needs.

People using services involvement

People who used the service told us they were involved in their care planning and reviews. People said they could invite their relatives and friends to be involved in their care planning if they wanted to. People had access to advocacy services.

Emotional support for care and treatment

People were supported to maintain independence where they were able to and to participate in social and community activities.

We saw that there was a room where people could make telephone calls in private and another room where they could have visits from family and friends.

Oleaster - Melissa

Kindness, dignity and respect

People told us that staff were caring and non-judgemental. One person told us that staff looked after them very well.

We saw that privacy film had been put on people's bedroom windows so that they could see out but nobody could see into their bedroom, which respected their privacy and dignity.

People using services involvement

We saw that weekly meetings were held on the ward with people who used the service. There was a board that displayed what action had been taken following the meetings. For example, it stated that people had said they would like more jigsaws provided and as a result seven jigsaws had been ordered for the ward. Some people spoken with told us that they had asked if they could do some gardening and that staff were going to support them with this.

Emotional support for care and treatment

People were supported to maintain independence where they were able to and to participate in social and community activities.

We saw that people had access to a small kitchen where they could make their own drinks. People told us they could help themselves to a drink whenever they wanted to.

Oleaster - Japonica

Kindness, dignity and respect

People told us that staff treated them well. We observed that staff were caring and compassionate to people who used the service. We saw staff spent time talking with and listening to people.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

People using services involvement

People told us that community meetings were held each week on the ward where they could talk about the positive and negative things which helped to make things better. They also said that there was a ward communication book where they could write their comments down.

This was read by staff twice a day and things written were addressed to make improvements. There were small chalk boards around the ward that people and staff were encouraged to write positive quotes on to promote people's wellbeing.

One person showed us that they had helped to design a board to help people when they were admitted to the ward. This explained to people what they would need to know and where things were. They said that each person admitted also received a welcome pack to help orientate them to the ward and settle in.

People told us that three times a day there was a tuck shop on the ward which they ran. They said this helped them to learn how to deal with money and gave them some responsibility.

Emotional support for care and treatment

People told us that they could have visits from their family and a room was provided for this. There was a system for their family to book visits so that all families did not visit together and people's therapeutic activities were not disrupted.

Mary Seacole House

Kindness, dignity and respect

We observed care provided and we saw that the interactions between staff and people who used the service were good. Staff were polite and treated people with respect and dignity. One person told us that staff were very respectful and treated them with dignity. Staff responded to people's requests in a timely manner and showed an understanding of people's needs.

People's privacy was respected. We saw that there was a cordless phone for people to use when making calls and a pay phone was provided.

People using services involvement

People told us, and records showed that they were involved in their care planning and review meetings. People who wanted to involve their relatives and friends were supported to do so. People had access to advocacy services.

We saw that staff respected people's individual preferences, religion, culture and background.

Emotional support for care and treatment

We saw that people were supported to maintain their independence where they could do and to participate in social and community activities.

Eden

Kindness, dignity and respect

People told us that staff respected their dignity and that staff treated them well. We observed staff to be caring and compassionate towards people who used the service.

People using services involvement

People told us that they had a meeting every week where they could talk about what they wanted and any concerns they had. People told us that they knew how to access advocacy services. One person told us that they saw their advocate regularly.

Emotional support for care and treatment

People told us that staff talked to them like a person and were not judgemental. One person told us that if they were upset staff sat with them and talked about it. We saw that staff spent time talking with and listening to people. Staff spoken with showed an understanding of people's emotional needs and how they needed to support people to meet these.

George

Kindness, dignity and respect

People told us that staff respected their dignity and that staff treated them well. People spoken with told us that staff were caring and we observed this during our inspection. We spoke with a professional visiting the ward who spoke positively about the care and attitude of staff to people who used the service.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

People using services involvement

People told us that they had a meeting every week where they could talk about what they wanted and any concerns they had. Most people told us that they knew how to access advocacy services, however some people did not know about how to do this.

Emotional support for care and treatment

People told us that staff were non-judgemental and that staff spent time talking with and listening to them. People told us that their relatives and friends could visit if they wanted them to.

We saw that staff respected people's individual preferences. They were supported to maintain their independence as much as they were able to and to participate in social and community activities.

Newbridge House

Kindness, dignity and respect

We observed that staff were caring towards people who used the service and interacted with them in a positive manner. People spoken with told us that the staff were friendly.

Staff spoken with were motivated by the satisfaction of seeing people who used the service get better during their time on the ward.

Some people told us that bank and agency staff did not always listen to them and did not respond in a caring way. They told us that this affected their health and wellbeing.

People using services involvement

Some people spoken with told us that weekly community meetings were held which an advocate attended. People told us that they were asked for their views and improvements were made as a result.

Staff told us that people were asked what they wanted to eat by the chef and the menu had been revised following this. People told us they had a choice of what they wanted to eat.

Emotional support for care and treatment

Staff told us that they supported the families of people who used the service as well as the person which helped to reassure people who used the service.

One person told us that permanent staff were very good and often spent time listening to them and tried to understand how they were feeling. Staff told us that there was a weekly drop in session provided by a psychologist and that where needed people were referred to psychology for one to one sessions.

We saw and people told us that they were supported to maintain their independence where they could do and to participate in social and community activities.

Bruce Burns unit

Kindness, dignity and respect

We observed that the interactions between staff and people who used the service were good and staff treated people with respect. Staff spent time communicating with people in a positive manner. We saw that staff responded to people's requests in a timely way and showed a clear understanding of people's needs.

We observed that on bedroom doors there was an observation window that had been covered by a curtain. However this could be opened by other people who used the service and staff told us that this had happened. This could impact on people's privacy and dignity.

People using services involvement

People told us they were involved in their care planning and review meeting. Where people chose to involve their relatives and friends in these this was supported. People told us they had access to advocacy services.

Emotional support for care and treatment

Staff told us that they supported the families of people who used the service as well as the person which helped to reassure people who used the service.

People were supported to maintain their independence as much as they were able to and to participate in social and community activities.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Summary of findings

Staff worked with community teams to ensure people's discharge from hospital was planned. We saw that assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures.

We saw that people's preferences and wishes were considered. A choice of menu was available that catered for people's specific dietary needs and reflected their cultural and religious needs**.** We found that people who used the service knew how to make a complaint and told us that when they had done so, action had been taken to resolve these and make improvements.

Our findings

Oleaster - Magnolia

Planning and delivering services

We found that staff on the ward worked with the Home Treatment Teams in the community to plan people's discharge. Staff told us that most people were discharged within the expected time of 90 days. They said that only one person had exceeded 90 days and this would be raised with bed management.

Right care at the right time

We saw that staff responded to concerns from a relative about their relatives discharge and amended the discharge plan to meet the person and their relative's wishes.

Care Pathway

We saw that comprehensive assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures.

We saw that there was a range of choices provided in the menu that catered for people's dietary, religious and cultural needs.

Learning from concerns and complaints

A complaints, suggestions and compliments box was available on the ward and information on how to make complaints was displayed. All people spoken with knew how to complain and when they had done so, felt that these were listened to. They told us that they received feedback from their complaint and were satisfied with how these were handled and resolved. All staff spoken with knew how to support people who used the service and their relatives to complain, if they wanted to.

Barberry - Jasmine

Planning and delivering services

Staff told us that two months before our inspection people who were not deaf had been admitted to Jasmine when there was a shortage of beds on other wards. Staff told us that this had been difficult to manage. However, they had raised this with the trust Chief Executive and resolved quickly.

We saw that staff worked with community teams to plan for people's discharge and community nurses attended ward review meetings prior to their discharge. We saw that separate areas were provided in the ward for men and women to respect people's privacy and dignity.

Care Pathway

We saw that assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Evidence was seen of admission assessments and discharge procedures.

We saw that there was a range of choices provided in the menu that catered for people's dietary, religious and cultural needs.

Learning from concerns and complaints

Information about how to make a complaint was provided on a user friendly touch screen and explained in British Sign Language. A complaints, suggestions and compliments box was available on the ward. All people spoken with told us they knew how to make a complaint and that when they had, they were listened to. Staff knew how to support people who used the service and their relatives to make a complaint if they wanted to.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Oleaster - Melissa

Planning and delivering services

Staff told us how they worked with community teams to prepare for people's discharge. This showed that planned discharges took place so that people were supported when they left hospital.

Care Pathway

We saw that assessments of people's needs were in place. This meant that the care plans reviewed reflected the specific care and treatment needs of the people who used this service. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures.

People told us, and we saw, that their cultural and religious needs were met during their stay in hospital.

Learning from concerns and complaints

People told us that they knew how to make a complaint. They said that when they had made a complaint this had been investigated and action was taken to resolve their concerns. People told us they had the information they needed to know how to access an advocate.

Oleaster - Japonica

Planning and delivering services

People spoken with told us that their discharge plan was discussed with them 72 hours after admission and they were supported to work towards this. Records we sampled showed that discharge plans were in place and staff liaised with community teams and other providers to ensure people were discharged with support.

Care Pathway

We saw that assessments of people's needs were in place. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures. People told us they had choices of food that met their preferences and needs.

Learning from concerns and complaints

We saw that a feedback board was displayed in the ward for people who used the service. People told us that they wrote what they wanted to on there, including negative things, and that these were listened to. People told us they knew how to make a complaint and staff supported them to do this.

Mary Seacole House

Planning and delivering services

We saw that people's discharge was planned for during their stay and staff worked with the community teams to ensure that people had the support they needed. We saw that most people were discharged within the expected length of stay of 90 days. One person had been there for over three years due to their complex needs.

Care Pathway

Evidence was seen of admission assessments and discharge procedures. Care plans had been reviewed by the multi-disciplinary team.

We saw that people's preferences and wishes were considered. A choice of menu was available that catered for people's specific dietary needs and reflected their cultural and religious needs.

Learning from concerns and complaints

All people spoken with told us that they could raise complaints when they wanted to and they were listened to and given feedback from these. We saw that information on how to make a complaint was easily accessible. A complaints, suggestions, compliments and comments box was provided on the wards. All staff spoken to knew how to support people who used the service and their relatives to make a complaint.

Eden

Planning and delivering services

We saw that people's discharge was planned for during their stay and staff worked with the community teams to ensure that people had the support they needed. We saw that the trust employed social workers to ensure that people had support with their housing and benefits when they were discharged. This meant that people's discharge was not delayed as they were supported to meet all their needs.

Care Pathway

We saw that assessments of people's needs were in place. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures.

We saw that people's preferences and wishes were considered. A choice of menu was available that catered for people's specific dietary needs and reflected their cultural and religious needs.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Learning from concerns and complaints

All people spoken with told us that they could raise complaints when they wanted to and they were listened to and given feedback from these. We saw that information on how to make a complaint was easily accessible. A complaints, suggestions, compliments and comments box was provided on the wards. All staff spoken to knew how to support people who used the service and their relatives to make a complaint.

George

Planning and delivering services

We saw that discharge plans were implemented during the person's stay on the ward so that this was well planned. We saw that the ward staff worked with the home treatment team. This helped to ensure that people had the care and treatment they needed when discharged from hospital.

Care Pathway

We saw people's religious and cultural needs were responded to. We saw that assessments of people's needs were in place. However, we saw that some care plans did not record people's current needs and preferences which could mean that staff did not know how to support people to meet their needs.

Learning from concerns and complaints

Most people spoken with told us that they could raise complaints when they wanted to and they were listened to and given feedback from these. Some people told us that they did not know the formal complaints procedure but they had raised concerns with staff that they thought had been listened to.

We saw that information on how to make a complaint was easily accessible. A complaints, suggestions, compliments and comments box was provided on the wards. All staff spoken to knew how to support people who used the service and their relatives to make a complaint.

Newbridge House

Planning and delivering services

We saw that discharge plans were implemented during the person's stay on the ward so that this was well planned. We saw that the ward staff worked with the home treatment team which was based in the same building. This helped to ensure that people had the care and treatment they needed when discharged from hospital.

Care Pathway

We saw that assessments of people's needs were in place. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures.

We saw that information was available for people who used the service in different languages. Staff told us that interpreters were regularly provided to assist people whose first language was not English.

People told us that there were several choices of food which included those that reflected their cultural background. We saw that food was provided to meet people's religious needs where appropriate.

Learning from concerns and complaints

We saw that people who used the service had information about how to make a complaint and who to contact if they had any concerns about the service provided. People spoken with told us they knew how to make a complaint. One person told us that when they had made complaints these had been investigated and resolved to their satisfaction.

Some staff spoken with told us that they did not receive feedback from complaints that had been made. They said this affected their morale as they did not know if and what they needed to improve.

Bruce Burns Unit

Planning and delivering services

We saw that discharge plans were implemented during the person's stay on the ward so that this was well planned. We saw that the ward staff worked with the home treatment team and the local authority. This helped to ensure that people had the care and treatment they needed when discharged from hospital.

Most people were discharged within the expected length of stay of 90 days. We found that four people had been in the ward since November 2013. We saw that there were arrangements in place to discharge people or transfer people to other services that would meet their needs.

We saw that separate bedrooms, bathroom areas and communal areas were provided for men and women to ensure their privacy and dignity.

Are services responsive to people's needs?

Good

By responsive, we mean that services are organised so that they meet people's needs.

Care Pathway

We saw that assessments of people's needs were in place. Staff confirmed that these were reviewed regularly by the multi-disciplinary team. Evidence was seen of admission assessments and discharge procedures.

We saw that people's religious and cultural needs were responded to.

Learning from concerns and complaints

All people spoken with told us that they could raise complaints when they wanted to and they were listened to and given feedback from these. We saw that information on how to make a complaint was easily accessible. A complaints, suggestions, compliments and comments box was provided on the wards.

All staff spoken to knew how to support people who used the service and their relatives to make a complaint.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary of findings

Staff felt well supported by their managers and by the senior management within the trust. People who used the service were listened to and improvements made as a result of this. Staff spoken with told us that their views were listened to and they were valued by management. They said that changes had been made as a result of the trust's 'listening in action' initiative.

Staff told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety within the organisation. It was not clear how action was taken to ensure that outcomes from audits were addressed on every unit inspected so that improvements could be made to benefit people who used the service.

Our findings

Oleaster - Magnolia

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Responsible governance

We saw that audits were completed on monitoring the Mental Health Act and Mental Capacity Act, activities and incidents. Audits were held centrally by the trust including the service user surveys which were monitored by an independent organisation called Service User Voice. Staff told us that the clinical governance team analysed the risks within the trust and this information was shared with all staff to reduce risks to safety.

We saw that staff had been given roles of responsibility on the ward and staff leads had been identified, for example, for substance misuse or for involvement of carers. Staff told us that this had empowered them to be responsible for ensuring that high quality of care was delivered to all people on the ward.

Leadership and culture

Staff told us that regular staff meetings were held and minutes of these were available so that if they missed a meeting they knew what had been discussed and agreed.

Engagement

People spoken with told us that they were involved in how the ward was run and that some changes had been made as a result of the trust listening to their views.

Staff told us that senior managers within the trust had visited the ward and spoken with people who used the service and staff. All staff spoken with told us that their views were listened to and they were valued by management. They said that things had changed as a result of this.

Barberry - Jasmine

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Responsible governance

We asked staff to show us audits completed but these were not available. Staff told us that these were mostly done centrally through the trust. It was difficult to establish how actions from audits were followed if they were not available on the ward.

Leadership and culture

Staff told us that management was supportive and encouraged openness. All staff spoken with felt that they could approach management at any time with their concerns and get resolved quickly. They said senior management promoted fairness, a good learning environment and a diverse working environment without discrimination.

Engagement

People spoken with told us that they were involved in how the ward was run and that some changes had been made as a result of the trust listening to their views.

Staff told us that senior managers within the trust had visited the ward and spoken with people who used the service and staff. All staff spoken with told us that their views were listened to and they were valued by management. They said that things had changed as a result of this, particularly 'listening in action.'

Oleaster - Melissa

Vision and strategy

Staff told us that they were aware of the vision and values of the trust and that one member of staff had been awarded an award for quality and service user involvement.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Responsible governance

We saw that staff had been given roles of responsibility on the ward and staff leads had been identified, for example, for substance misuse or for involvement of carers. Staff told us that this had empowered them to be responsible for ensuring that high quality of care was delivered to all people on the ward.

Leadership and culture

Staff told us that recently there had been an improvement in communication from the trust Chief Executive which made them feel part of the trust and valued as such. Staff told us that they thought their concerns had been listened to.

Engagement

Staff told us that their views were listened to on the ward and also within the trust, which they felt a part of. People spoken with told us that they had a say in how the ward was run. Staff told us that when a person was discharged from the ward they were given an evaluation form to ask their views on the service provided. Improvements were made as a result of these being completed.

Oleaster - Japonica

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Leadership and culture

Staff told us that they had weekly briefings from the Chief Executive and knew that there were forums to contact him or other senior managers if they wanted to share their opinions about the leadership of the trust. They thought this was positive and encouraged an open culture.

Engagement

Staff told us they regularly met together to reflect on their practice and worked as a team. They told us that they had a staff away day last October which helped them to move forward and develop the service. Staff discussed with us the difficulties of having a young person's ward in a hospital for adults but felt they had worked together as a staff team to ensure that people who used the service were safe.

Mary Seacole House

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Responsible governance

We saw that audits had been completed however there was no evidence of what action had been taken as a result of these to make improvements where needed.

Staff spoken with told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety.

Leadership and culture

We saw that staff meetings were held regularly and minutes of these were made available to all staff. Action was taken as a result of listening to staff views to make improvements. All staff spoken with told us that their views were listened to and they felt that they were valued by management. Staff told us that senior management within the trust had visited the ward to talk with people who used the service and staff. They told us that the new Chief Executive had made a difference to the culture of the organisation which was now more open and positive.

Engagement

We saw that people who used the service were asked for their views in satisfaction surveys and in meetings on the ward. We saw that minutes were kept of these meetings and a newsletter was produced as to what action was taken following them. People spoken with told us that they were involved in how the ward was run and some changes had been made as a result of the trust listening to their views.

Eden

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Responsible governance

Staff spoken with told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety.

Leadership and culture

Staff spoken with told us that managers were approachable. All staff spoken with felt that they could approach the managers at any time with their concerns and these would be resolved quickly. We saw that regular staff meetings were held and minutes of these were made available to all staff.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Staff told us that the Chief Executive had visited the ward and they thought that recently the culture within the trust was more open.

Engagement

We saw that people who used the service were asked for their views during meetings on the ward and minutes were kept of these meetings. Some people spoken with told us that they were involved in how the ward was run and some changes had been made as a result of the trust listening to their views.

We saw that staff meetings were held regularly. All staff spoken with told us that their views were listened to.

George

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Responsible governance

Staff told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety within the organisation.

Leadership and culture

All staff spoken with told us that their views were listened to and they felt that they were valued by management. Staff told us that senior management within the trust had visited the ward to talk with people who used the service and staff. They told us that the new Chief Executive engaged with staff throughout the trust which they thought was positive.

Engagement

We saw that people who used the service were asked for their views during meetings on the ward and minutes were kept of these meetings. Some people spoken with told us that they were involved in how the ward was run and some changes had been made as a result of the trust listening to their views. We saw that staff liaised with the Patient Advice and Liaison Service (PALS) which helped to ensure that the views of people who used the service were listened to and action was taken as a result.

Newbridge House

Vision and strategy

Staff received updated information from the trust via team meetings and the trust's intranet.

Responsible governance

Staff told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety within the organisation.

Leadership and culture

Some staff spoken with told us that the new ward manager had made positive changes which meant the ward was now more controlled but relaxed which benefitted people who used the service. Staff told us that the ward manager was approachable and listened to their ideas.

Staff told us that permanent staff had been given an area of responsibility to lead on, for example, infection control. They said that this helped the ward to run better and empowered staff to take responsibility in leading the ward.

Staff spoken with told us that there were monthly wellbeing meetings that were led by the psychologist. Some staff told us they had not attended these but had received feedback which they found useful. Staff told us that senior management within the trust had visited the ward to talk with people who used the service and staff. They told us that the new Chief Executive engaged with staff throughout the trust which they thought was positive.

Engagement

People spoken with told us that they were involved in how the ward was run and some changes had been made as a result of the trust listening to their views. We saw that regular meetings were held with people who used the service. Minutes of these were kept which showed what action had been taken to make improvements for people who used the service.

Bruce Burns unit

Vision and strategy

All staff spoken with showed a good understanding of the values, vision and objectives of the trust.

Responsible governance

We asked staff to show us audits completed but most of these were not available. Staff told us that these were mostly done centrally through the trust. It was difficult to establish how actions from audits were followed if they were not available on the ward. Staff told us that the trust clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety within the organisation.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Leadership and culture

The ward manager told us that staff meetings were not held as it was difficult to get staff to attend these. However, the ward manager issued a monthly newsletter to staff which informed them of any changes, complaints, incidents and any information staff would need to keep updated. Staff spoken with told us that this was one way communication which did not give them an opportunity to share ideas as a team. However, they told us that the ward manager was approachable and listened to their views. They told us that they were supported by the management and things had changed as a result of their views being listened to.

Staff told us that senior management within the trust had visited the ward to talk with people who used the service and staff.

Engagement

People spoken with told us that they were involved in how the ward was run and some changes had been made as a result of the trust listening to their views. We saw that regular meetings were held with people who used the service. Minutes of these were kept which showed what action had been taken to make improvements for people who used the service.

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must ensure that people on the Bruce Burns unit are protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them by means of the maintenance of an accurate record in respect of each service user which shall include appropriate information and documents in relation to the care and treatment provided to each service user. Regulation 20 (1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must protect people on the Oleaster Centre, Mary Seacole House, Newbridge House and the Bruce Burns units against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording and safe keeping of medicines used for the purposes of the regulated activity. Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	The trust must ensure that people on Mary Seacole House are protected against the risks associated with unsafe or unsuitable premises; by means of suitable design and layout. Regulation 15 (1) (a)

Regulated activity	Regulation

Compliance actions

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

Diagnostic and screening procedures

Treatment of disease, disorder or injury

The trust must ensure that sufficient numbers of suitably qualified, skilled and experienced staff are employed to ensure that the physical health care needs of people at Mary Seacole House and New Bridge House are being met.

Regulation 22