CareQuality Commission

Good ●

Bradford District Care Trust

Psychiatric intensive care units and health-based places of safety

Quality Report

New Mill
Victoria Road, Saltaire
Shipley
West Yorkshire
BD18 3LD
Tel: 01274 228300
Website:
www.bdct.nhs.uk

Date of inspection visit: 17-19 June 2014
Date of publication: 02/07/2014

Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
Airedale Centre for Mental Health	TAD54	Health-based place of safety	BD20 6PD
Lynfield Mount Hospital	TAD17	Health-based place of safety and Clover Ward, psychiatric intensive care unit	BD9 6DP

This report describes our judgement of the quality of care provided within this core service by Bradford District NHS Care 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.

Summary of findings

Where applicable, we have reported on each core service provided by Bradford District NHS Care Trust and these are brought together to inform our overall judgement of Bradford District NHS Care 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 psychiatric intensive care unit and health-based places of safety	Good	🟢
Are psychiatric intensive care unit and health-based places of safety safe?	**Requires Improvement**	🟠
Are psychiatric intensive care unit and health-based places of safety caring?	**Good**	🟢
Are psychiatric intensive care unit and health-based places of safety effective?	**Good**	🟢
Are psychiatric intensive care unit and health-based places of safety responsive?	**Good**	🟢
Are psychiatric intensive care unit and health-based places of safety 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

Contents

Summary of findings

Overall summary

Clover Ward is a psychiatric intensive care unit (PICU) for people detained under the Mental Health Act 1983. It is a mixed gender unit that provides a safe and secure environment for people who cannot be safely assessed or treated in an open acute inpatient facility. The health-based places of safety are units where people arrested under section 136 by the police are taken for an assessment of their mental health.

We found that there were clear procedures for reporting incidents, and that they were investigated and reviewed to prevent them happening again. Learning from incidents was shared with all staff and there were systems in place to cascade it to staff. There were also clear systems in place for reporting safeguarding concerns and staff understood their responsibilities in this area.

However, we found that the two health-based place of safety were not fit for purpose. The environments were not safe because they posed a risk to people and compromised people's privacy and dignity. In addition, we saw that people were not always observed closely enough in the PICU when they were using the shared communal areas.

There were also health and safety issues in the activities of daily living kitchen where, for example, temperatures for fridges with people's food were not monitored.

We found that there were enough staff and they were flexible enough to meet any patient's needs, such as increased observations.

Assessments for risk and patient's needs were carried out on admission, and we found them to be comprehensive. These were also followed up by detailed care plans.

The multidisciplinary team in the PICU comprised of psychiatrists and nurses only. This meant that other health professionals, such as psychologists and occupational therapists, were not integrated into the team providing people's care.

We saw that staff received training required to perform their job roles and were supported through regular supervision and annual appraisals.

The staff we observed were polite, compassionate and treated people with respect and dignity. People who used the service also told us that they felt safe and were happy with the care they received. We found that people were involved in their care, but that there were limited activities for them.

People received the right care at the right time from the nursing and medical team, and had regular reviews. They were also able to receive care for their physical health needs from other specialist health professionals when needed.

Complaints were taken seriously, investigated, responded to promptly, and lessons were learnt.

There were strong links with other internal and external agencies to help people move between services from referral, to admission and discharge.

We found that there was good local leadership in place and that staff were proud to work for the trust. Staff said that they felt supported by their managers and were pleased to work on Clover Ward.

Summary of findings

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

Are services safe?

The psychiatric intensive care unit (PICU) and health-based places of safety (HBPoS) were not effective in providing safe care and treatment. In particular, the environments of the two HBPoS did not meet current standards, according to regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists (RCP). This put people who used the service and others at risk. We also observed that staff did not always observe people closely enough while in the shared communal areas.

We found that fridge temperatures in the activities of daily living kitchen were not monitored.

However, incidents were reported and investigated. Lessons were learnt and shared to prevent the incidents happening again.

Requires Improvement 🟠

Are services effective?

People received treatment in line with current legislation, standards and national guidance. Assessments of risk and needs were carried out on admission and we found them to be comprehensive. These were also followed up by detailed care plans. Staff worked well as a team and had good links with both internal and external agencies. However, the multidisciplinary team in the PICU comprised psychiatrists and nurses only.

There were systems in place for people to provide feedback, which was acted on. Staff were well trained and received regular supervision and appraisals. There were appropriate policies and procedures for people detained under the Mental Health Act.

Good 🟢

Are services caring?

The psychiatric intensive care unit and the health-based places of safety were caring. People were complimentary about the quality of the care and treatment they received and how they were treated by staff. We observed that staff treated patients with dignity and respect. People also told us that they were involved in their care and were given information that helped them to make informed decisions. However, activities were limited and there was no input from psychological and occupational therapy.

Good 🟢

Are services responsive to people's needs?

On the whole, the psychiatric intensive care unit and health-based places of safety were responsive to people's needs. People received the right care at the right time, and had regular reviews from nursing and medical team. People were able to receive care for physical

Good 🟢

Summary of findings

health needs from other specialist health professionals when needed, and their preferences were taken into account. There were links with other internal and external agencies, which helped people move between services from referral, to admission and discharge. Complaints were taken seriously, investigated, responded to and lessons learnt.

Are services well-led?   **Good** 🟢

We found that there was good local leadership and that staff were proud to work for the trust. Staff felt supported by their managers and peers, and said that senior managers in the trust were accessible and open. There was a good system of governance in place, which cascaded learning from incidents and information about risks to staff. There were good systems in place to monitor the service in order to improve its performance.

Summary of findings

Background to the service

Clover Ward is a psychiatric intensive care unit (PICU) that offers a safe and secure environment for people to receive the necessary support and treatment, who cannot be safely assessed or treated in an open acute inpatient facility. Clover Ward is a mixed gender unit with 10 ensuite bedrooms that a split into in gender-specific male and female areas. It has an outdoor garden and seating area, an activity room with access to a computer, a family visiting room, and access to sports and recreation. All people admitted are detained under the Mental Health Act 1983.

The health-based place of safety (HBPoS) is a unit where people arrested under section 136 by the police are taken for an assessment of their mental health. From that unit people may be admitted to the acute ward or to the PICU. People who do not need to be admitted may be referred to an appropriate community team for support with their mental health difficulty.

Our inspection team

Our inspection team was led by:

Chair: Angela Greatley, Chair, The Tavistock and Portman NHS Foundation Trust

Team Leader: Jenny Wilkes, Head of Inspection – Hopsitals Directorate (Mental Health), Care Quality Commission

The team included CQC mental health inspectors, inspection managers, consultant psychiatrist, Mental Health Act commissioner, specialist advisors in mental health nursing, specialist advisors in occupational therapy.

Why we carried out this inspection

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

How we carried out this inspection

We carried out an announced visit on 17, 18 and 19 June 2014. Before visiting, we reviewed a range of information we hold about the core service and asked other organisations to share what they knew. During the visit, we held focus groups with a range of staff who worked within the service, such as nurses, doctors, and therapists. We talked with people who use services, carers and/or family members. We observed how people were being cared for reviewed their care or treatment records.

What people who use the provider's services say

Before our inspection, we spoke with people who used the service through focus groups. During the inspection, we spoke with people who used the service and they were complimentary about the care they received. We found that people were very positive about their experiences of care and we observed that staff were polite, respectful, and kind with people on the ward. People told us that staff were friendly, treated them with respect and involved them in their care. They also told us that they felt safe, that the food was good and they were involved in their care.

Summary of findings

Good practice

- People received care which they found to be kind and compassionate.
- Complaints were taken seriously, investigated, responded to promptly and lessons were learnt. There was good adherence to the Mental Health Act 1983 and Mental Health Act Code of Practice
- The trust's response time to health based places of safety was always met within six-hour target.

Areas for improvement

Action the provider MUST or SHOULD take to improve

- The trust must make sure that the health-based places of safety are safe and fit for purpose.
- The trust should make sure that close observations are maintained on people while in the shared communal areas.
- The trust should make sure that fridge temperatures are monitored, in line with food hygiene guidelines.

- The trust should make sure that people receive care from a full range of professionals in the multidisciplinary team.
- The trust should make sure that people's privacy and dignity is maintained while they are using the health-based place of safety.
- The trust should make sure that people using the service have access to a wide range of activities.

Q CareQuality Commission

Bradford District Care Trust

Psychiatric intensive care units and health-based places of safety

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Health-based place of safety	Airedale Centre for Mental Health
Health-based place of safety	Lynfield Mount Hospital
Clover Ward, psychiatric intensive care unit (PICU)	Lynfield Mount Hospital

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.

The Mental Health Act (MHA) records we reviewed were comprehensive and in order. Reports from the Approved Mental Health Professionals (AMHP) involved in assessment and detention were available People's mental health capacity was assessed and recorded. All medication administered was authorised under section 58 in accordance with the code of practice. There was evidence of rights being presented to people appropriately in

accordance with the rights under the MHA. The MHA manager kept the ward staff up-to-date and any actions that may be required, such as mental health review tribunals.

There were posters displayed in the ward informing people of the Independent Mental Health Advocacy service (IMHA). We spoke with the ward manager who told us that any person detained under a section of the MHA would be referred for an Independent Mental Health Advocate.

Leave was authorised through a standardised system. Ward staff had a thorough process for ensuring leave was authorised before each person left the ward.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We found that nursing staff and managers had a broad understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) on the ward and had attended training to ensure that they had the required knowledge. This training was completed part of the mandatory trust training. The trust had a MCA and DoLS lead person who could be contacted for any support.

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

The psychiatric intensive care unit (PICU) and health-based places of safety (HBPoS) were not effective in providing safe care and treatment. In particular, the environments of the two HBPoS did not meet current standards, according to regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists (RCP). This put people who used the service and others at risk. We also observed that staff did not always observe people closely enough while in the shared communal areas.

We found that fridge temperatures in the activities of daily living kitchen were not monitored.

However, incidents were reported and investigated. Lessons were learnt and shared to prevent the incidents happening again.

Our findings

Clover Ward/PICU

Track record on safety

Staff we spoke with had a good understanding of the current risks in the service. Past incidents were discussed at team meetings to ensure that safety issues were addressed by the staff and that staff were aware of them. Meetings were held at all levels within the team to ensure that information regarding safety and previous safety concerns were addressed at local and central level. Clinical governance meetings took place for divisional services within the trust and incidents were reported. Serious untoward incidents were a standing agenda item for these meetings which ensured that they were raised through the division.

Learning from incidents and improving safety standards

We saw that there was an effective system to record incidents and near misses. All the staff we spoke with clearly demonstrated how they would identify and report incidents. We saw that incidents were reported, investigated and analysed. Staff told us that they received feedback following incidents through meetings and information was circulated within the team.

We saw evidence that learning from incidents took place and where there were lessons to be learnt, we saw that they were shared through handovers and team meetings. This meant that the provider was able to identify, investigate and learn from incidents.

We looked at restraint records and saw that it was rarely used. There was no seclusion room in use at the time of our inspection, this was being renovated. The ward had employed strategies to reduce aggressive incidents that may lead to people being restrained. An example of this was through the training of staff in de-escalation skills. We saw that all staff had been trained in the physical intervention method used within the trust and all staff spoken with confirmed this. All staff told us that they received a debrief session following an incident and they could also access the trust's reflective group ran by psychologists.

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

We saw that regular health and safety checks were completed on the ward and identified risks were put right to ensure the safety of people using the service. The ward was clean and tidy when we visited. Cleaning schedules were in place to ensure cleaning was undertaken.

We saw that staff training was planned to ensure staff were skilled and trained to provide safe care and treatment. The training included safeguarding vulnerable adults and staff knew how to raise any safeguarding concerns. Staff we spoke with demonstrated they had the knowledge to ensure people were protected from abuse and harm whilst they were on the ward.

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

We found that medicines were stored appropriately and safely in locked cupboards and in fridges. Safety checks on

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

the management of medicines were performed regularly. We saw that the trust rapid tranquillisation policy had been followed by staff who prescribed medicines to be given in an emergency.

Assessing and monitoring safety and risk

Risk assessments were carried out for all visits to the ward to ensure that all staff and people were safe. 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. People's needs were appropriately assessed. We saw good examples of completed needs assessment, followed by detailed care plans and behavioural management plans. However, relational security was not always adhered to. We saw that in the last three weeks there had been two incidents of indecent assault on females who used the service in the shared communal area. We observed that staff did not always maintain close observations on people while in the shared communal areas. This meant vulnerable females were at risk of harm from males while in shared communal area. All people spoken with told us that they felt safe on the ward and would approach staff if they had any concerns.

We saw that fridge temperatures in the activities of daily living kitchen were not monitored, but they followed appropriate food labelling and storage in line with food hygiene guidelines.

We saw that nursing staffing levels were appropriate with a good skill mix. We found that staffing arrangements ensured that people's needs could always be met safely with staffing levels consistently maintained. The manager told us that there was flexibility within staffing resources for additional staff to meet the people's needs where this was assessed as requiring one-to-one observations. The unit had a ward based consultant and a junior doctor.

Understanding and management of foreseeable risks

The service had systems to deal with foreseeable emergencies. Most staff were trained in intermediate life support techniques. Training records confirmed this and staff told us they felt confident in dealing with medical emergencies.

Airedale and Lynfield/HBPoS

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

We looked at the HBPoS at the Airedale Centre for Mental Health and at Lynfield Mount Hospital. We found that the suites did not meet the current standards according to regulations around the safety and suitability of premises and guidance on good practice published by the Royal College of Psychiatrists (RCP). We observed that people who used the service and others may be placed at risk because each HBPoS suite environments had ligature points and did not meet fundamental standards within the good practice guidance of the RCP to assure against the risks of unsafe or unsuitable premises. For example, at both locations there were ligature points in the toilets used, which meant potential self-harm and ligature risks to people who used the service. Toilets were located in the corridors that were used by visitors which meant people were escorted to toilets through the corridors and could put other people at risk.

Furniture was not fixed to the floor and that could potentially be used as weapon, and there were no clocks for people to orientate themselves to time. We saw that the one at Airedale did not have an observation window and there was no notice to inform people that a CCTV was used. This meant that the two rooms which were used for HBPoS were not fit for purpose. We found that there wasn't an environmental risk and ligature risk assessment which identified these high risk areas to ensure that people's safety is ensured. The second one at Lynfield Mount was suitable for the purposes of HBPoS.

We asked the trust to look at the safety of the HBPoS environment immediately following the inspection. They provided assurance of the plans and improvements they would make to ensure people could be cared for safely.

Staff had attended training on safeguarding children and adults and the staff we spoke with were aware of the procedures to escalate and report concerns when they had them. Staff told us that they worked with local social services to make referrals related to safeguarding and any concerns that they had.

Good arrangements were in place to transfer people to the units and when staff were concerned about people they were able to request support from the police. The units had good arrangements to contact an Approved Mental Health Professional (AMHP), good contact arrangements with doctors and good access to section 12 approved doctors. (A

Are services safe?

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

section 12 approved doctor is a medically qualified with an expertise in mental disorder and has been recognised under the Mental Health Act to examine people for detention.)

Assessing and monitoring safety and risk

The units were always contacted by police before bringing a person to the unit. We saw that the units were not staffed in readiness for people to be brought in for assessment. Staff were taken from the acute wards to assess people brought to the unit.

Information was gathered from a variety of sources to inform the assessment of people admitted. If a person was known to services, their community team were contacted for details about their care and risk assessments and they were able to access these from the electronic records system. General practitioners (GP) were contacted for any relevant information relating to people's risk and care.

We checked records on both locations and saw that risks were assessed and identified. We observed that identified risks were discussed with people in a clear way to ensure their involvement. We saw that records of close observation and monitoring of people were maintained to ensure that practice in this area was safe.

Understanding and management of foreseeable risks

There was a duty nurse at all times who was available to attend to the assessment of a person admitted to HBPoS. The units had access to emergency medication and equipment when it was necessary. We saw that staff had training in basic life support and this was mandatory in this service.

Are services effective?

Good 🟢

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

People received treatment in line with current legislation, standards and national guidance. Assessments of risk and needs were carried out on admission and we found them to be comprehensive. These were also followed up by detailed care plans. Staff worked well as a team and had good links with both internal and external agencies. However, the multidisciplinary team in the PICU comprised psychiatrists and nurses only.

There were systems in place for people to provide feedback, which was acted on. Staff were well trained and received regular supervision and appraisals. There were appropriate policies and procedures for people detained under the Mental Health Act.

Our findings

Clover Ward/PICU

Assessment and delivery of care and treatment

Staff were aware of the most recent, relevant National Institute of Clinical Excellence (NICE) guidance. Information about up to date clinical guidelines and policy was shared amongst the team.

The physical health needs of people were routinely assessed and monitored and the team worked closely with GPs and secondary healthcare services to ensure that the identified needs were met during people's care with the team.

Outcomes for people using services

The provider carried out outcomes satisfaction survey where people gave a feedback of the care and treatment they received. The results showed that most of the people were happy with the care they received. We saw that people were encouraged to participate in a community morning meetings were they participated in how the ward is run.

The provider used some outcome measures to determine the effectiveness of the service which they provided. We saw that the team used Health of the Nation Outcome Scales-Care Pathways and Packages Project (HoNOS-CPPP.

This is an outcome measure that decided the progress of therapeutic interventions. We saw that people did not have long stays on the ward. They only had short length of stays before they were moved to acute wards.

Staff, equipment and facilities

Staff received the training they needed and where updates were required, this was monitored. All staff spoken with told us that they received regular supervision and had an annual appraisal and their personal and professional development goals were set.

The unit met national standards for mixed gender ward. It offered 10 ensuite bedrooms in gender-specific male and female areas. The building is well planned with a lot of space, allowed plenty of light and the bedrooms were large. People had lockers in a separate area for valuable belongings. There were a full range of rooms for required therapies and social activities. There was a dedicated family room. The unit had a clean medication room and well-equipped physical examination room. Part of the building was closed due to addition of a seclusion room being built.

Multidisciplinary working

All nursing staff we spoke with told us there is good support and involvement from medical colleagues during working hours and also out of hours. In records we sampled we saw that people attended their reviews with the multidisciplinary team at least twice a week. However, this team was only limited to nurses and doctors. Input from other health professionals such as occupational therapist and psychology was secured via referrals. This meant that people were not receiving collaborated care from a full multi-disciplinary team.

There was evidence of working with other external agencies, such as GPs, hospital teams and wards, intensive home treatment team (IHTT), mental health crisis team, independent sector and local authority. For example, staff told us that they also work closely with the IHTT for smooth admission and discharge planning. The ward would coordinate the care with the ward, and invite staff from IHTT to attend reviews to ensure that they were able to meet the needs of people when discharged.

Mental Health Act (MHA) 1983

We looked at five case notes and found that all records were in accordance with the mental health act code of practice. We saw that people's mental health capacity was

Are services effective?

Good ●

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.

clearly assessed and recorded. We saw that all detention papers were appropriate and people had their rights under MHA given to them. Section 17 leave was authorised through a standardised system. Ward staff had a thorough process for ensuring leave was authorised before each person left the ward.

Airedale and Lynfield/HBPoS

Assessment and delivery of care and treatment
Assessments were undertaken by nursing staff that perform a triage function in determining if the person needed admission and if they did where that admission should be.

Outcomes for people using services
We saw that people were able to give feedback about their care and treatment they received.

Staff, equipment and facilities
We saw that the units do not have staff based there, but they are managed through the acute wards.

Multidisciplinary working
We spoke with staff that regularly assessed people in the suites and the managers who oversee the area. We saw

that the units had access to doctors, AMHPs, Child and Adolescents Mental Health (CAMHs) and Learning Disabilities psychiatrists. We saw that these professionals had strong links and worked together to ensure that people's needs were met.

Mental Health Act (MHA) 1983
Under the MHA people were brought in to the HBPoS, under police powers, and must be informed about their rights whilst they were there. On this inspection, we saw there were leaflets and pro-formas to record that these rights had been given. We saw records that showed that people had their rights read to them.

We found that staff worked in accordance with the MHA Code of Practice in relation to the place of safety. There were appropriate pro-formas and systems to ensure staff worked within the MHA Code of Practice. For example, to record key issues, issues such as transfers between the police and place of safety and the outcome of the use of the place of safety.

Are services caring?

Good 🟢

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

Summary of findings

The psychiatric intensive care unit and the health-based places of safety were caring. People were complimentary about the quality of the care and treatment they received and how they were treated by staff. We observed that staff treated patients with dignity and respect. People also told us that they were involved in their care and were given information that helped them to make informed decisions. However, activities were limited and psychological and occupational therapy were accessed by referral.

Our findings

Clover Ward/PICU

Kindness, dignity and respect

People using the service were positive about the attitude of staff and the support they received. People told us that staff were friendly, polite and treated them in a respectful manner.

We observed the interaction between people who used the service and staff was positive and that staff responded to people with patience, kindness and ensured that they were treated with dignity and respect.

We observed many examples of staff engaging with people on the unit. For example, we saw that staff would sit with people on a one-to-one and discuss about any concerns in a therapeutic way.

People told us that they were happy with the food and had a variety of choices that met their needs and halal was also offered. We saw that people had access to hot and cold drinks when needed.

People using services involvement

People told us that they had a high level of involvement in their care and if they had any issues staff clearly explained to them how to address these. For example, when we spoke with one person they told us their care and treatment was clearly explained to them both individually with their named nurse and within their review meetings.

There was information on independent mental capacity advocates and independent mental health advocates available should people wish to talk with them. We saw that advocates had been involved in some decisions where appropriate.

Meetings took place on ward to gather the views of people. For example, people told us they felt the community meetings gave them a good opportunity to raise any concerns they have and to discuss issues.

Emotional support for care and treatment

We saw that staff demonstrated a high level of emotional support to people on the unit at an individual level and took time to explain and support them in a sensitive manner. We saw that people had limited activities taking place on the ward. One person told us that activities were valuable but did not happen enough. We saw and staff told us that the person allocated for activities was often pulled away to provide care. Psychological and occupational therapy input on the ward was via referral as the care team consisted of doctors and nurses only.

Airedale and Lynfield/HBPoS

Kindness, dignity and respect

We noted that at both Lynfield Mount and Airedale, people's dignity was compromised when people need to access the toilet they had to cross a public corridor to visit the toilet and due to the significant ligature risks in the identified toilet area would have to be supervised while in the toilet.

Staff we spoke with demonstrated a good understanding of how to treat people with respect and dignity and were polite and considerate.

People using services involvement

On the day of our inspection, there were no people admitted to the units so we did not see any interactions between staff and people. However, we saw records that showed people were involved in their assessments.

Emotional support for care and treatment

Staff told us that they would always remain with people to offer them one-to-one support and reassurance.

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

On the whole, the psychiatric intensive care unit and health-based places of safety were responsive to people's needs. People received the right care at the right time, and had regular reviews. People were able to receive care from other specialist health professionals when needed, and their preferences were taken into account. There were links with other internal and external agencies, which helped people move between services from referral, to admission and discharge. Complaints were taken seriously, investigated, responded to and lessons learnt.

Our findings

Clover Ward/PICU

Planning and delivering services

Referrals to the service were accepted from the single point of access or the lead nurse in charge of health based place of safety. The single point of access operated 24 hours each day and the intensive home treatment team (IHTT) would carry out an assessment where required and would decide the best place to meet a person's particular needs. The ward worked closely with the IHTT, the bed management team and acute wards to ensure smooth admission or discharge. If a person was admitted to PICU, IHTT would continue to be involved and attend reviews to plan discharge.

We saw that in assessments, the physical health needs of people were routinely assessed and monitored and the team worked closely with the duty doctor and secondary health care services to ensure that the identified needs were met. Specific care plans for people's physical health needs had been developed where appropriate. People were assessed for their health needs within six hours of admission by the duty doctor.

Right care at the right time

We found that people were able to see medical staff when they needed to. People told us that they could see a doctor when they want to and they are always available to give support. We saw that reviews were taking place regularly and people knew when their reviews were happening. People were able to access input from specialist teams, such as physical healthcare, when required. We saw from records sampled that a range of appropriate options had been discussed for the person's care. For example, access to dietician.

In records we sampled, we saw that people attended their reviews with the multidisciplinary team. We saw some collaborated evidence of working as team following the Care Programme Approach (CPA) frame work. The ward worked closely with both mental health and local authority services to ensure that people who had been admitted to hospital as inpatients were identified and helped through their discharge. We saw that the ward maintained contact with these services.

Anyone being admitted always received a full assessment including using pre-admission information. This involved undertaking a range of mental and physical health checks. Where a risk was identified plans were put in place to support the person. People had a contingency plan in place which had details on what actions to take and services to contact in case of an emergency.

People were able to access interpreting services to meet their needs if they did not speak English well enough to express their needs. We found that people got their escorted section 17 leave.

People's preferences and wishes were considered and their care plans reflected their cultural and religious needs

Care pathway

Pre-admission information was obtained from the other wards, GPs or community teams, in advance of an admission to ensure staff knew of the risk areas to a person and how they could best support them during their stay. The service aimed to maintain contact with the community teams to ensure continuity of care and plan discharges as soon as a person is admitted. As a result, discharge arrangements began at the point of admission to limit the amount of time people spent on the ward. Care coordinators were brought in early to a patient's care to help facilitate their arrangements for discharge.

People were discharged to acute wards or in the community with IHTT support, depending on the level of risk. People would continue to get support from IHTT until they were discharged to CMHT or their GPs. Staff told us that discharges could be delayed due to unavailability of beds and this would be referred to the bed management team.

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

Information leaflets were available regarding the Patient Advice and Liaison service (PALs) and how to complain should people wish to. Feedback was also being collected from people using the service in feedback forms. When a complaint was received the staff were aware of the process for investigating it and identifying learning. People were supported to make complaints whenever they had issues but were encouraged to discuss those concerns first with their named nurse or the nurse in charge. Learning from complaints was circulated to all staff and other wards within the division.

Airedale and Lynfield/HBPoS

Planning and delivering services

A triage service for police was available, where police would phone before admission. People may be assessed in the community with a quick response from the Crisis Team or Community Mental Health Team (CMHT). When a person is brought to the unit staff from the ward carried out a joint assessment and decided the best place to meet the needs of the person. This could be the PICU, acute ward or community with support from intensive home treatment team (IHTT) or community mental team (CMHT). Out of hours the admission wards would accept a referral from the lead nurse.

Right care at the right time

There was evidence of good working relationships between the many parties involved in the place of safety, including IHTT, crisis team, AMHPs, and the doctors, the police service and accident and emergency (A&E) departments. This coordinated group of professionals ensured that people were receiving the care they would need at the right time. We saw that response times were short and good.

The arrangements to ensure people could be conveyed to a HBPoS were in place, including working arrangements for the police to phone in advance to ensure that the suite was available and to assist staff to coordinate a speedy assessment. We found that out-of-hours service had a good response in accessing AMHPs to complete the mental health act assessment.

People were provided with information about the service and what to expect. We saw that leaflets in different languages were available. People had access to advocacy services or interpreters through telephone.

Care pathway

Information we saw showed people were able to access an inpatient bed in the relevant acute ward or psychiatric intensive service when a decision was reached to admit to hospital. Where people were not deemed to require hospital stays we saw that they were offered follow up by the IHTT or CMHT with the level of support determined by the levels of assessed and manageable risk.

Learning from concerns and complaints

Information leaflets were available regarding the Patient Advice and Liaison service (PALS) and how to complain should people wish to.

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

We found that there was good local leadership and that staff were proud to work for the trust. Staff felt supported by their managers and peers, and said that senior managers in the trust were accessible and open. There was a good system of governance in place, which cascaded learning from incidents and information about risks to staff. There were good systems in place to monitor the service in order to improve its performance.

Our findings

Clover Ward/PICU

Vision and strategy

All staff spoken with showed a good understanding of the values, vision and objectives of the service. Staff told us that the aim of the service was to support people to deliver safe, high quality care and to keep them in hospital for the shortest possible time.

Staff told us that the team had a focus on person-centred care and would always work together to try and improve the way they worked.

Responsible governance

Regular team meetings were held with minutes of the meetings recorded. Areas of discussion included service updates, incidents, complaints, and any issues of concern raised by staff. Most of the staff spoken with told us the trust's clinical governance team analysed the risks within the organisation and this information was shared with all staff to reduce risks to safety.

All the staff we spoke with confirmed to us that they received regular communication from the board and their managers and were kept up to date with changes within the trust.

Staff were aware of the whistleblowing policy and that they would feel confident to report and refer concerns if it was needed. The whistle blowing policy was available on the trust's intranet site for staff to refer to.

Leadership and culture

All staff were happy to work for the trust and particularly proud to be part of the PICU team. Most staff spoken with told us they felt that the management of their team was

good and that they felt supported by their team manager. One staff member told us that there was one incident that they felt unsupported by their line manager when they raised concerns about another staff.

Staff told us that the manager was very approachable, had an 'open door' policy and encouraged openness. Staff felt that the unity within the team was very strong and that helped them with focusing on quality and achieving positive outcomes for people.

Engagement

Peoples' views were gathered through feedback from questionnaires and their views were taken into account. People and their families were routinely given questionnaires about the service provided. The results were analysed to provide an overview of the service and necessary changes were made to improve the service.

Staff told us that they had regular briefings from senior management to update them with changes and events within the trust. Staff told us that they felt well supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness. Staff told us that they had access to reflective groups and received debrief sessions when a major incident occurred.

Performance improvement

We saw that there were good systems in place to monitor the service in order to improve the performance. We saw that the performance management of service quality was through forums from the service governance group and monthly operational team meetings. All performance indicators such as medication errors, incidents of aggression, delayed discharges and clusters were discussed. Actions were drawn up to improve performance.

Airedale and Lynfield/HBPoS

Vision and strategy

Staff spoken with demonstrated a good understanding of vision and values of the service. They told us that they aim to provide high quality care as a cohesive service that includes police, other health teams and local authority. Their priorities were to improve people's lives through working in partnership across the varied communities and ensure that they were always available to meet people's needs in a person-centred way. Staff told us that they want to achieve positive outcomes for people they served.

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 regular Mental Health Legislation Committee team meetings were held with minutes of the meetings recorded. Areas of discussion included analysis of risks within the organisation and any risks identified were included on the committee's risk register and this information was shared with all staff to reduce risks to safety. This information was also shared with the clinical governance group.

Leadership and culture

The units do not have regular staff based there. The management of the units are shared between the ward managers on the acute wards linked to the place of safety. The adult place of safety has good links to intensive home treatment team (IHTT) and has seen a reduction in the number of people regularly brought to the unit.

Engagement

We saw that there was a system in place to gather people's views through feedback from questionnaires about the service provided. Staff told us that results were analysed to provide an overview of the service and necessary changes were made to improve the service if needed.

Staff told us that they felt well supported by their managers and peers and that senior managers were accessible, approachable and encouraged openness.

Performance improvement

We saw that there were good systems in place to monitor the service in order to improve the performance. We saw that the Mental Health Legislation Committee included Mental Health Improvement Group which monitored the performance of the service quality that were part of the performance dashboard. We observed that the group regularly reviewed performance indicators, such as six-hour wait time, the number of times Section 136 was used, liaised with the services involved in assessments and reviewed the effectiveness of the HBPoS. The service monitored age and gender of people who used the service, however, there was a lack of routine ethnic monitoring.

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
Treatment of disease, disorder or injury	People who use services and others having access to premises must be protected against risks associated with unsafe or unsuitable premises, by means of suitable design and layout and appropriate measures in relation to the security of the premises. Regulation 15. (1) (a) (b).
	People who used the service and others may be placed at risk because each HBPoS suite environment had ligature points and did not meet fundamental standards within the good practice guidance of the RCP to assure against the risks of unsafe or unsuitable premises. There were ligature points in the toilets used which meant potential self-harm and ligature risks to people who used the service. Toilets were located in the corridors that were used by visitors which meant people were escorted to toilets through the corridors and could put other people at risk. Furniture was not fixed to the floor and that could potentially be used as weapons.