Black Country Partnership NHS Foundation Trust

# Macarthur Centre MH

## Quality Report

Heath Lane Hospital
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## Locations inspected

| Location ID | Name of CQC registered location | Name of service (e.g. ward/ unit/team) | Postcode of service (ward/ unit/ team) |
|---|---|---|---|
| TAJ11 | Heath Lane Hospital | The Macarthur Centre | |

This report describes our judgement of the quality of care provided within this core service by Black Country Partnership NHS 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 Black Country Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of Black Country Partnership NHS Foundation Trust.

### 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

This unannounced inspection focused on concerns raised to CQC by a whistle-blower. We did not therefore inspect all activities of all CQC key questions.

We could not find any evidence that supported any of the whistleblowing allegations. We shared our findings with the trust at the end of the inspection and at a multi-agency meeting after the inspection.

The CQC had undertaken a comprehensive inspection of Black Country Partnership NHS foundation Trust in November 2015. The Macarthur centre had been inspected as part of the core service 'Acute wards for adults of working age and psychiatric intensive care units' and rated overall as good.

Following our inspection, we did not identify any actions that the trust must make to improve services. We did identify areas in which the trust should take action to improve.

We found the following areas of good practice:

- The ward environment was clean and well maintained.
- Risk assessments and management plans were in place. Staff regularly reviewed risks and handed over comprehensive clinical information between shifts.
- Seclusion records were complete and documented in line with the trust policy.
- The staff team had developed regular debriefings session and used supervision to reflect on how they managed challenging clients and stresses of working in the psychiatric intensive care environment.
- The ward had good links with the advocacy service that visited the ward regularly and staff supported patients to attend weekly community meetings.

However, we also found areas that the service provider could improve:

- Staff vacancies and high use of bank staff were affecting the consistency in the working approach for both patients and the permanent staff team.
- Staff did not always keep patient information confidential.
- Patients could only use the ward phone once a day and only in the presence of staff. This was a blanket restriction and it had not been individually care planned.
- Staff did not keep a log of informal complaints, which would mean staff did not have an overview of informal complaints and actions from them.
- Staff did not always record patient observations accurately.

# Summary of findings

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

### Are services safe?

- We found that the ward was a safe, clean and well-maintained environment.
- Staff were aware of and understood their responsibilities to safeguard vulnerable adults and children.
- The ward were developing and incorporating 'Safewards' practice in line with guidance from the department of health.
- Risk assessments were in place and updated daily.
- Patients told us they felt safe.
- Managers reviewed all incidents reported by staff. Managers fed back any lessons learnt or themes that linked in from the wider trust.
- Staff said that debriefing after incidents and the weekly reflective practice group gave them a further opportunity to learn from incidents and manage the stress that working within a challenging environment brought.

However:

- There were six qualified nurse vacancies. This resulted in high use of bank staff, which led to inconsistency for patients and permanent staff.
- There was a blanket restriction in place over the use of the ward telephone.

### Are services effective?

- All care plans we reviewed were up to date, personalised and recovery orientated.
- We reviewed handover documentation that was detailed and comprehensive.
- Staff attended and valued the weekly reflective practice group.

### Are services caring?

- Staff interacted with patients in a positive, friendly, polite and respectful manner.

### Are services responsive to people's needs?

- Patients had access to food and drink throughout the day and night.

# Summary of findings

- Staff had organised a shop run to purchase items for patients who were unable to leave the ward due to their Mental Health Act status.

**Are services well-led?**

- The ward manager was working collaboratively with staff and senior colleagues to reduce stress and improve morale by implementing 'Safewards' initiatives designed to build relationships with patients and staff and make wards more peaceful places. Plans to protect time for supervision and clinical reflection were also in place.

However:

- Staff felt that they were pressured to accept admissions to the unit, even when they felt the admission was inappropriate. Although staff had shared concerns with the trust leadership, no review had been undertaken and they felt unsupported.

# Summary of findings

## Information about the service

The Macarthur Centre is a 12 bed psychiatric intensive care unit (PICU) for males. It is located at Heath lane Hospital. It has two outside areas, therapy rooms, a dining room, kitchen and two day areas located in the ward area. The Macarthur Centre also has a seclusion room.

The CQC inspected the Macarthur Centre in 2015 as part of the acute wards for adults of working age and psychiatric intensive care inspection. Overall, the services were rated as good.

## Our inspection team

The team was comprised of three CQC Inspectors and one CQC Assistant Inspector.

## Why we carried out this inspection

This was an unannounced focussed inspection after CQC had received a number of concerns from a whistle-blower, a person raising a concern about care that they have received or witnessed within an organisation.

We did not complete a comprehensive inspection; instead, we focused on the specific issues raised by the whistle blower. The whistle blower had given detailed information that we reviewed alongside CCTV recordings, records, patient and staff interviews. The concerns shared were staff to patient physical and emotional abuse, falsification of records and inappropriate behaviours between staff whilst on duty.

## How we carried out this inspection

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

- visited the Macarthur Centre and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with four patients who were using the service
- interviewed the ward manager
- spoke with five other staff members; including doctors, nurses, psychologists and a housekeeper
- spoke with the head of mental health nursing and urgent care manager
- reviewed closed circuit television recordings
- looked at five care records of patients.
- reviewed two sets of observation records
- reviewed community meeting minutes
- reviewed 13 handover sheets.

# Summary of findings

## What people who use the provider's services say

Patients were generally complimentary about permanent staff at the Macarthur Centre. Two patients felt that staffing changed frequently and that some bank staff were not familiar with the ward or needs of patients.

## Areas for improvement

**Action the provider SHOULD take to improve**

**Action the provider SHOULD take to improve**

- The trust should recruit into staff vacancies to ensure consistency within the staff team and for patient care.
- The trust should ensure that staff do not compromise patient confidentiality when displaying information in multiuse rooms.
- The trust should review the blanket restrictions in place regarding patient telephone use.
- The trust should review the process of logging and reviewing informal patient complaints.
- The trust must ensure that staff record observations in line with trust policy.

Black Country Partnership NHS Foundation Trust

# Macarthur Centre MH

## Detailed findings

| Name of service (e.g. ward/unit/team) | Name of CQC registered location |
|---|---|
| The Macarthur Centre | Heath Lane Hospital |

# 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

# Our findings

### Safe and clean environment

- The MacArthur Centre had good lines of sight to observe patients on the ward. Staff viewed blind spots with the aid of strategically placed convex mirrors and the trust had fitted CCTV since the last inspection. There was a viewing monitor in the staff office. The CCTV we reviewed did not support any allegations that were made by the whistle-blower.
- The ward environment was visibly clean and tidy. We observed housekeeping staff working on the ward.
- The ward had an alarm and nurse call system in place. Staff and patients could use these to summon assistance in an emergency. Staff issued the inspection team with alarms when we requested. We observed staff responding to alarms in a timely and calm manner.

### Safe staffing

- The ward staffing establishment was 20.6 whole-time equivalent (WTE) qualified nursing staff and 11.5 WTE health care support workers.
- At the time of inspection, there were four band 5 nurse vacancies and one band 6 nurse vacancy as well as, one qualified nurse on long-term sickness and one qualified nurse on a career break.
- We reviewed staff rotas from 8 to 26 August 2016. The ward had met its establishment levels for all shifts and the inspection team noted when bank staff were booked to cover vacancies and unexpected leave. The ward manager confirmed that block booking of bank staff was useful in providing consistency for both patients and staff.
- The whistle blower alleged that there was an abusive culture amongst some staff who worked together regularly. However, after reviewing the rotas we could see that staff did not regularly work together on the same shifts. The ward manager confirmed this was the case.
- Patients and staff confirmed that escorted leave was cancelled infrequently. Staff had organised a shop run to purchase items for those patients who did not have access to section 17 leave.
- As this was an unannounced inspection, we had not requested numbers of incidents that required restraint or seclusion.
- Staff said that over the last twelve months there had been higher rates of incidents and use of seclusion on the ward. Staff reasons for this included; managing patients who needed more intensive treatment than they could offer, use of extended seclusion with one patient with challenging needs. For example, one patient who had needed a more secure environment than the Macarthur Centre could offer. The patient was nursed in seclusion until a suitable placement was found.
- We reviewed the seclusion records of two patients. Staff had kept seclusion records in line with the trust policy and reported on the trust electronic recording system.
- The five care records we reviewed had up to date risk assessments and management plans. Each patient had an individual shift handover sheet that staff wrote on a daily basis. We reviewed 13 of these. They all identified current and historic risks. Staff discussed these in all handovers, which meant that the staff joining a shift had updated information of individual patient risks and associated management plans.
- We reviewed two sets of observation records. We found one set of records were incomplete. On two separate days, staff had not recorded 4 hours of observations. From this we could not tell if the observations had been missed or the staff had forgotten to document them,
- All staff we spoke with had training in managing aggression and violence. Staff used verbal de-escalation where possible to manage aggression and violence, before using physical interventions. Staff also used 'Safewards' initiatives which included ''get to know you boards'' in attempt to reduce levels of tension on the ward and therefore challenging incidents.

# Are services safe?

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

- One patient told the inspection team that they had seen staff only used physical interventions with very challenging patients and when required to keep the ward safe.
- Staff told us that the trust were in process of reviewing blanket restrictions. We did identify one blanket restriction in use. There was no patient phone on the ward. However, staff allowed patients to use a cordless staff phone, once a day in the presence of staff. Therefore, patients had restricted access to a phone, their privacy was compromised and the restrictions were not part of planned care.
- All staff we spoke to had received training in safeguarding vulnerable adults and children. They were able to give examples of what might constitute a safeguarding concern and how they would report it.
- All staff we interviewed said they would share concerns regarding untoward staff practice if they heard or viewed any. Staff said they would follow safeguarding procedures if they had concerns.
- We asked patients about alleged fights between patients and staff on the ward. All patients we spoke with said this did not happen.

### Reporting incidents and learning from when things go wrong

- Staff reported incidents on the trusts electronic recording system. We reviewed six incident report forms in detail that related to concerns shared by the whistle-blower. We found that staff documented incidents in detail and we could find no evidence to support allegations made by the whistle blower.
- Staff told us that they de-briefed patients and staff after any incidents on the ward.
- The staff team had identified a number of issues relating to an increase in incidents over the last twelve months. In response to this, a weekly reflective practice group was developed. The psychologist also offers one to one supervision to staff.
- The unit psychologist could refer staff involved in traumatic events for eye movement desensitisation and reprocessing therapy (EMDR). This is a form of psychotherapy to treat trauma related difficulties.

# Are services effective?

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.

## Our findings

### Assessment of needs and planning of care

- We reviewed five care records. They were up to date and included an assessment of need and care plan. Staff completed assessments in a timely manner and included a physical examination and ongoing monitoring of physical health problems.
- The care plans were personalised and recovery orientated.
- Care records were paper based and stored securely in the staff office.

### Skilled staff to deliver care

- All staff we spoke with said that they had regular supervision.
- Staff attended a weekly reflective practice group run by the psychologist

### Multi-disciplinary and inter-agency team work

- We reviewed documentation that confirmed that staff handover happened between all shifts. Housekeepers told us they also attended handover

### Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- All patients were automatically referred to the advocacy service on admission. The advocacy service visited the ward twice a week. The advocacy service had not raised any concerns similar to that of the whistle blower.

# Are services caring?

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

## Our findings

**Kindness, dignity, respect and support**

- During the inspection we observed staff interacting with patients in a positive, friendly, polite and respectful manner.
- We  saw staff acting in a calm manner when nursing agitated patients.

# Are services responsive to people's needs?

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

## Our findings

### The facilities promote recovery, comfort, dignity and confidentiality

- Patients and staff confirmed that food and drink were accessible throughout the day and night.
- Patients had limited access to the phone.
- We saw identifiable patient information on a notice board in multidisciplinary team room. This meant that when patients had meetings with staff in that room, they would be able to read information about other patients. This did not protect patients' confidentiality.

### Meeting the needs of all people who use the service

- Staff had organised a shop run to purchase items for patients who did not have access to section 17 leave, a means by which patients legally left the ward for short periods.
- Staff had obtained petty cash to spend on a variety of daily newspapers for the patients lounge.
- Staff told us meal times were at set times and 'protected'. This ensured patients had time to attend to nutritional and dietary needs.

### Listening to and learning from concerns and complaints

- Staff told us patients can complain informally to staff on the ward or formally through the patient and liaison service (PALS). Staff said they would log any informal complaints in patients' notes not on the electronic system. We felt that this would not allow the staff an oversight of all informal complaints that patients made, as they were recorded separately.
- The trust recorded formal complaints on the trusts electronic recording system. We reviewed eight complaints. We found staff had documented the complaint in detail and none related to concerns identified within the whistleblowing concern.
- One patient told us that staff had helped them write a letter of complaint to the CQC and PALS.
- We reviewed minutes from the ward community meetings. We saw that staff encouraged patients to attend this meeting on a weekly basis to discuss issues and concerns on the ward. Meeting minutes evidenced 'you said and we did' actions, which included the purchase of a pool table. There was no mention of concerns or events raised by the whistle blower.
- The ward had a number of mechanisms in place for patients to make complaints. Included regular 1;1's with staff, independent advocacy services, PALs and the community meeting.

# Are services well-led?

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.

## Our findings

### Leadership, morale and staff engagement

- The ward manager told us that since November 2015 staff morale had been low but due to some recent initiatives, the staff team were feeling increasingly supported. However, staff raised concerns around what they felt are inappropriate referrals to the PICU and did not feel their concerns are being heard by the trust leadership.