Dudley and Walsall Mental Health Partnership NHS Trust

Bloxwich Hospital

Quality Report

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This report describes our judgement of the quality of care at this location. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Summary of findings

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Summary of findings

Overall summary

Cedar Ward
Core service provided: Older People

Male/female/mixed: mixed

Capacity: 20 beds

Linden Ward
Core service provided: Older People

Male/female/mixed: mixed

Capacity: 20 beds

Bloxwich Hospital is a purpose-built facility providing inpatient mental health services for older people. It has two mixed gender inpatient wards, each with 20 beds.

We found that the services provided were mostly safe and there were enough staff on the wards. Most staff knew the needs of the people who use services they were caring for, who received continuity of care.

There was evidence of good risk assessment taking place and every patient record we saw had a completed assessment. However, there was not always a plan in place to manage the identified risks.

Staff were not always trained to meet people's specific needs, and this increases the risks of them not receiving suitable care.

Some of the care we observed being provided was based on national guidance.

People who use services were treated with dignity and respect and we saw staff and patients interacting positively with each other.

The Mental Health Act responsibilities were discharged appropriately, although actions from previous Mental Health Act monitoring visits were not fully resolved.

Staff worked with other providers to ensure that people were transferred and discharged effectively. People's physical healthcare needs were assessed and monitored and any deterioration was acted on.

Staff were unaware of the future plans for the service at the hospital. However, staff did know about the trust-wide redesign of services.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Mental Health Act responsibilities

We found that Mental Health Act documentation was complete across both wards and reasons for people's detention were clear. The numbers of detained patients were very small across the hospital.

Older people's services

Care was provided in a safe environment and there were enough staff to meet the needs of the people who use services on the ward.People who use services were assessed when they were admitted to establish if they were a risk to themselves or others, although plans were not always in place to describe how these risks should be managed.We saw evidence of 'positive risk management', which protected patients' rights and protected their safety.Incident reporting was not completed in a consistent manner.We saw that the ward was locked and that informal patients may not have understood their rights to leave the ward.

Are services effective?

Mental Health Act responsibilities

We found that detention papers were properly scrutinised, attempts were made to inform people of their rights at regular intervals and rules around consent to treatment were followed. The trust had identified a need to improve the quality and uptake of Mental Health Act training.

Older people's services

Some of the care and treatment provided was based on national guidance.Staff had not received specialist training in order to meet the needs of the people using the services.

Are services caring?

Mental Health Act responsibilities

We saw that staff made regular attempts to help patients to understand their rights. However, there was no system in place to record that some patients, due to severe and ongoing cognitive impairment, will never fully understand their rights.It was not clear that all relevant patients were being referred to the Independent Mental Health Advocate (IMHA).We saw that staff were caring for people in the least restrictive way.

Older people's services

We saw that people who use services were consulted with about their care and treatment.Staff in both wards followed the principles of the Mental Capacity Act where people were unable to make decisions about their care and treatment.People who use services and staff interacted positively with each other. However, staff did not always have the right information about patients' needs.The wards were mixed gender which meant there was a risk that patients' privacy and dignity could be compromised.

Are services responsive to people's needs?

Mental Health Act responsibilities

Summary of findings

Detention was regularly reviewed at ward rounds and patients were encouraged to attend these reviews.There was good liaison and transfer between Bloxwich Hospital and the local general hospital when dealing with people's physical healthcare issues.

Older people's services

Patients on the wards had their cultural needs considered.Care records contained personal preferences for each patient.We saw that emergency medical equipment was available on both wards.Systems were in place to enable patients to be transferred and discharged from the ward.

Are services well-led?

Mental Health Act responsibilities

There were good systems in place for receiving and scrutinising people's detention papers.Levels of engagement with IMHA's were inconsistent.Audits of Mental Health Act issues were taking place, but they were limited and did not include audits against the Code of Practice.A number of issues raised on previous Mental Health Act monitoring visits had not been fully resolved.Lay managers said that they were given support and training to help them carry out their role.

Older people's services

Staff were unclear about the future of the older people's services at Bloxwich Hospital.Staff were encouraged to attend meetings to discuss service improvements.All staff knew how to report concerns about quality, but a few of them did not feel they could discuss this with senior managers.Staff told us immediate managers responded well to concerns raised.

Summary of findings

What we found about each of the main services at this location

Mental Health Act responsibilities

We checked whether the hospital staff and managers were meeting their responsibilities under the Mental Health Act 1983 and adhering to the Mental Health Act Code of Practice. We could not speak to detained patients to ask them about the care they received and their detention because they refused to speak with us, or they did not have capacity to understand our role or our questions.

When we visited the service on this occasion, we saw that there were a very small number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward. We found that, where it was necessary to use the Mental Health Act, people were lawfully detained and that the staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights when they were admitted but, where patients lacked capacity to understand their rights, staff were not always as proactive as they could be – for example by referring people to specialist advocates. There were only a few people who had been receiving treatment for mental disorder for long enough for special rules in the Mental Health Act to be followed, but where this was the case, the appropriate certificates had been completed to ensure that treatment was properly and legally authorised.We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective and responsive ways. However, we felt that improvements were needed to ensure that the Mental Health Act responsibilities were managed in better ways by improved audits and policies, and by ensuring that appropriate action was completed following our Mental Health Act monitoring visits and the trust's own audits.

Services for older people

We saw that care was provided in a safe environment and there were enough staff to meet the needs of the patients on the ward. Staff knew how to report safety concerns. This meant that people who use services were cared for in a safe environment by an appropriate number of staff.People were assessed when they were admitted to establish if they were a risk to themselves or others, but plans were not always in place to describe how risk to people who use services should be managed. The staff told us, and records confirmed that adequate training was not always provided to enable them to follow best practice in managing challenging behaviour. This meant that some people who use services were at risk of receiving unsafe or unsuitable care.Some of the care and treatment provided was based on national guidance, and was therefore current and followed good practice.We saw that people who use services were treated with dignity and respect and care and treatment was provided in a caring and compassionate manner. However, effective systems were not in place to ensure that all the staff consistently understood individual's needs. This meant that, although people who use services were treated in a caring and compassionate manner, staff did not always have the information required to support them in a safe and consistent way.Systems were in place to enable people who use services to be transferred and discharged from the ward. We saw that staff worked well with people who use services, their representatives and other professionals to discharge people from the wards.Some staff told us they felt frustrated and anxious about the lack of clarity over the future of the two wards. Despite this, the staff told us they felt supported within their teams and by their managers.The trust told us they had recently implemented a new management structure within older people's services in response to quality concerns. This meant that the trust had taken appropriate action to address the concerns that had been raised.

Summary of findings

What people who use the location say

We left comment cards at Bloxwich Hospital and some people completed these before and during the inspection. The results were analysed at trust level, and included three hospital sites and community locations

- Of the 72 comment cards returned 16% (12) were illegible.
- 81% (59) mentioned the staff in a positive way, for example comments included 'staff are lovely', 'staff always treat me well', 'staff are good to me'.
- Of the 59 comment cards that spoke of staff positively, 71% (42) also stated that they thought there should be more staff available.
- One card expressed a negative opinion about the service and this person felt that not enough notice was taken of people who use services' opinions and there was not enough to do

We also spoke to a very small number of people who use services and relatives during our inspection at Bloxwich Hospital. People told us they were involved in planning their care and treatment. Relatives told us how they are involved in decision making about care and treatment.

Areas for improvement

Action the provider SHOULD take to improve

- Develop a clear vision for older people's services and share it with staff, people who use services, relatives and stakeholders.
- Ensure that specialist training is provided to all staff working in specialist areas of the trust.
- Ensure that the mixed gender units comply fully with the national guidance.
- Risk management plans should be developed and implemented from individual risk assessments. People should be involved in developing these plans, and 'advance decisions' included where appropriate.
- Develop and implement audits to check practice against the Mental Health Act Code of Practice, as well as the legal documentation in use. Ensure the Mental Health Act scrutiny committee are informed of the outcomes of these audits and develop action plans where needed.

Action the provider COULD take to improve

- Identify ways for informal patients to leave the ward and understand their rights to leave.
- Improve levels of engagement with the Independent Mental Health Advocate service.

Good practice

Our inspection team highlighted the following areas of good practice:

We saw evidence of positive risk management in relation to patient safety.

We found that Mental Health Act documentation was complete across both wards and reasons for detention were clear.

There was good liaison and transfer between Bloxwich Hospital and the local general hospital when dealing with people's physical healthcare issues.

We saw people who use services' cultural needs were considered in the wards.

Bloxwich Hospital

Detailed Findings

Services we looked at:
Mental Health Act responsibilities; Services for older people;

Our inspection team

Our inspection team was led by:

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

Team Leader: Jenny Wilkes, Mental Health Act Operations Manager, CQC

The team included CQC Inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers, senior managers and a GP.

We were additionally supported by two Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

Background to Bloxwich Hospital

Bloxwich Hospital has two inpatient wards offering specialist assessment, care and treatment to people who are experiencing mental health problems over the age of 65, or in the case of organic illness may be under 65. The wards are mixed gender.

Cedars ward is a 20 bed ward and cares for people with functional mental health conditions. Linden ward also has 20 beds and cares for people with organic conditions such as dementia.

Why we carried out this inspection

We inspected this hospital as part of our in-depth hospital inspection programme. We chose this hospital because they represented the variation in hospital care according to our new intelligent monitoring model. This looks at a wide range of data, including patient and staff surveys, hospital performance information and the views of the public and local partner organisations. One reason for choosing this provider was because they are a trust that has applied to Monitor to have Foundation Trust status. Our assessment of the quality and safety of their services will inform this process.

How we carried out this inspection

To get to the heart of people who use services' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?

Detailed Findings

- Is it responsive to people's needs?
- Is it well-led?

The inspection team always inspects the following core services at each inspection:

- Mental Health Act Monitoring
- Acute admission wards
- Health-based places of safety
- Long stay services
- Child and adolescent mental health services
- Services for older people
- Adult community-based services
- Community-based crisis services
- Specialist eating disorder services

Before visiting, we reviewed a range of information we hold about the provider and asked other organisations to share what they knew about the provider.

We held a public listening event on the 12 February 2014 and also met with groups of detained patients on 12 and 13 February at all the hospital locations.

We carried out an announced visit on 25 and 26 February 2014. We undertook site visits at all the hospital locations. We inspected all the acute inpatient services and crisis teams for adults of working age and older people. We also visited the specialist inpatient services and a sample of the community teams.

During the visit we held focus groups with a range of staff in the location, such as nurses, doctors, therapists, allied health professionals. We talked with people who use services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences receiving services from the provider.

Mental Health Act responsibilities

Information about the service

Bloxwich Hospital provides assessment and treatment for older people with mental health needs. It has two wards. Linden ward provides assessment and treatment for people living with dementia and has 20 inpatient beds. Cedars ward provides assessment and treatment for older adults with mental health issues and has 20 in-patient beds. This location is registered with us to assess and treat people under the Mental Health Act 1983 (MHA), so both wards can accept detained patients if needed and both serve the community of Walsall.

Cedars and Linden wards were last visited by our Mental Health Act Commissioner in July 2012 and September 2013 respectively to monitor the use of the MHA. We saw positive practice but also raised issues on compliance with the Mental Health Act Code of Practice which we report on in the well-led section.

Summary of findings

We checked whether the hospital staff and managers were meeting their responsibilities under the Mental Health Act 1983 and adhering to the Mental Health Act Code of Practice. We could not speak to detained patients to ask them about the care they received and their detention because they refused to speak with us, or they did not have capacity to understand our role or our questions.

When we visited the service on this occasion, we saw that there were a very small number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward. We found that, where it was necessary to use the Mental Health Act, people were lawfully detained and that the staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights when they were admitted but, where patients lacked capacity to understand their rights, staff were not always as proactive as they could be – for example by referring people to specialist advocates. There were only a few people who had been receiving treatment for mental disorder for long enough for special rules in the Mental Health Act to be followed, but where this was the case, the appropriate certificates had been completed to ensure that treatment was properly and legally authorised.

We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective and responsive ways. However, we felt that improvements were needed to ensure that the Mental Health Act responsibilities were managed in better ways by improved audits and policies, and by ensuring that appropriate action was completed following our Mental Health Act monitoring visits and the trust's own audits.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

Learning from incidents and improving standards of safety:

We reviewed the detention papers for three current or recently detained patients across the two wards. The detention papers were easily accessible in each file and included the full set of detention papers. We saw that there was a copy of the report by the Approved Mental Health Professional (AMHP) included with the detention papers which detailed the reasons for compulsory admission. This helped to ensure that ward staff caring for detained patients had information about individual patient risks, why compulsory detention was necessary and were aware of any incidents relating to the assessment or conveyance of patients.

Safe and proportionate systems

We saw that the vast majority of the patients were informal on each ward. This was because they had made the capacitated decision to stay informally or they lacked capacity to understand fully that they were in hospital but were not actively attempting to leave the ward. The wards were regularly locked to keep people safe. We spoke with one of three Consultant Psychiatrists and were given assurance that people were regularly reviewed in terms of observations and detention status to ensure that the staff kept people safe and ensured that people were cared for in least restrictive ways.

Risk management

We saw that when people were admitted under the Mental Health Act, they had a medical examination which considered any risks to people's physical health and a mental state examination which considered if people's mental health presented a risk to themselves or others. Staff would also use information from community staff where people were using community services. The Consultant Psychiatrist we spoke with stated that they cared for people in the community and in hospital so they got to know people well and this also helped manage risks. We saw that the ward staff had a range of measures to address disturbed and aggressive behaviour and manage risk. These measures included engaging patients in activities, making best use of the ward environment (for example by using the quiet areas of the ward), verbal de-escalation and where necessary Pro Re Nata (PRN) medication was used.

We saw that patients were risk assessed and this was reviewed regularly. The risk assessments we saw identified risks that people faced or posed but the risk assessments could have provided more detail in terms of managing those risks. For example only one detained patient had leave to go out of the hospital, this person's risk assessment included the need for escorts but did not identify the risks this person may face when they were conveyed to the acute hospital and how those risks could be managed, for example use of safety locks on the car doors.

We looked at the figures for detained patients going absent without leave at Bloxwich Hospital and saw that there were no significant numbers of AWOLs for this location. This showed that where people needed to be detained in hospital, staff were keeping people safe.

We could not speak to detained patients to ask if they felt safe on the wards we visited because they refused to speak with us or they did not have capacity to understand our role or the questions we asked of them.

Are Mental Health Act responsibilities effective?

(for example, treatment is effective)

Adherence to the Mental Health Act Code of Practice

We found that staff were working in accordance with the MHA Code of Practice. Detention papers were properly scrutinised, attempts were made to ensure that patients were informed of their rights and the rules around consent to treatment were followed, including locally devised standard forms to record consent to treatment, rights and urgent treatment decisions. There were appropriate flagging systems to ensure that staff worked within the MHA Code of Practice for example to remind clinicians when the three month rule for consent to treatment would be reached and appropriate notices to ensure staff were aware

Mental Health Act responsibilities

of when the detention would lapse. We saw that where there were shortfalls these were picked up by the trust's own audits but some of these issues remained persistent and had not been fully addressed or completed.

There were a small number of people who had been receiving treatment for mental disorder with special rules under the Mental Health Act to be followed. Where this was the case, the appropriate safeguards were in place to ensure that the legal certificates had been completed to ensure that treatment was properly and legally authorised. For example one person had been prescribed electro-convulsive therapy and clinicians had ensured that the treatment was initially recorded as meeting the threshold for urgent treatment on a locally devised form and for ongoing treatment a Second Opinion Appointed Doctor had authorised the treatment as being appropriate.

The Consultant Psychiatrist we spoke with had a very good knowledge of the Mental Health Act and told us that clinicians had the opportunity to keep up to date with case law relating to the Mental Health Act through training sessions hosted by the medical director. The trust had identified the need to improve the quality and uptake of MHA training for all staff.

Are Mental Health Act responsibilities caring?

Choices in decisions and participation

Under the Mental Health Act detained patients must be informed about their rights whilst they were detained. We saw that the hospital had a pro-forma to record that these rights had been given. We saw that nursing staff made regular attempts to assist patients to understand their rights. We saw that on occasion's patients still did not understand their rights despite these attempts. It was not clear from the records what different or other ways that staff had utilised to aid patient understanding. For those patients with severe and ongoing cognitive impairment there was no proper system to record that the patient will never fully understand their rights.

Detained patients have a right to access Independent Mental Health Advocacy Services (IMHA). We saw that the detained patients currently on the wards would not have instructed an IMHA because they did not fully understand the role of the IMHA. In these circumstances the hospital has a duty to refer the detained patient to an IMHA if the staff feel the patient would benefit from the IMHA. In such cases the IMHA would work with the detained patient to aid understanding or work on a non-instructed basis. There was evidence that not all relevant patients were assessed as benefiting from an IMHA service and it was not clear that a referral to the IMHA had been made. This meant incapacitated detained patients were not fully safeguarded because staff were not ensuring detained patients were referred to be seen by independent advocacy services.

People or their representatives were involved in decisions about their care where this was possible. Assessments of people's capacity to give consent had been made regarding specific decisions through a two stage test for capacity. For example, a person had been assessed as not having the capacity to make a decision about ECT and a decision was made in the person's best interests and this was documented in the record. However we saw some forms to assess capacity which were not decision specific.

Dignified care and avoiding restrictive practices

We could not speak to detained patients to ask them if they were treated with dignity and respect because they refused to speak with us or they did not have capacity to understand our role or the questions we asked of them. We saw that people had individualised care plans including care plans relating to detention under the Mental Health Act.

The wards were locked which restricted people's movements with the aim of keeping people safe. We saw that there was improved understanding of Deprivation of Liberty Safeguards (DoLS) which were used on occasions. DoLS are used where restrictions were placed on someone's daily life to make sure that they get the care and treatment they need. These restrictions amount to depriving that person of their liberty but safeguards are put in place to ensure that the person's rights are upheld and to ensure that the restrictions are reviewed regularly. For example we saw that a DoLS authorisation was used when someone was placed on higher levels of observation but it became necessary to use the Mental Health Act because there were concerns whether the person was refusing treatment for mental disorder. This meant that staff were considering how people were supported in being cared for in least restrictive ways

Mental Health Act responsibilities

Are Mental Health Act responsibilities responsive to people's needs?
(for example, to feedback?)

Responding to people's needs and reviewing care

We saw that where people were admitted into hospital or assessed under the Mental Health Act, their detention was regularly reviewed at ward rounds. We saw that these reviews included representatives of the medical and nursing teams, family and patients were encouraged to attend and to a lesser degree there was also involvement of community teams. We saw that one person had been taken off a section because their condition had meant they were no longer actively making attempts to leave the unit.

We observed the care provided to detained patients and saw that there were a range of activities to encourage and support people provided by staff with a designated role to undertake activities.

People were able to access an inpatient bed in the relevant older person service, in the locality from which they came, in most circumstances. The detained patients on the ward at the time of our inspection were appropriately placed and were not awaiting transfer.

Providers working together during periods of change

We saw examples of good practice where there was good liaison and transfer between Bloxwich Hospital and the general hospital where people required physical health care. For example one detained patient was given escorted section 17 leave to treat developing physical health problems and returned to Bloxwich Hospital when these symptoms were treated.

We heard that there were issues in relation to accessing primary and community services because there were no service level agreements with appropriate services such as the physiotherapy and chiropody departments. This impacted on people's access to physical health care for non-urgent conditions across both wards.

Are Mental Health Act responsibilities well-led?

Governance arrangements and effective leadership in relation to the Mental Health Act

We saw that there were good systems in place for the receipt and scrutiny of detention papers when patients were first admitted under the Mental Health Act including good checklists. The senior nurse on duty held responsibility for checking and receiving detention papers and there was good evidence of administrative and medical scrutiny to ensure that people were detained lawfully and appropriately in accordance with the Mental Health Act. Compliance with the statutory requirements of the Mental Health Act was well supported by experienced and committed MHA administrative staff and managers. The regular Mental Health Law sub group also supported compliance and good practice.

We saw that on occasion's patients' still did not understand their rights despite repeated attempts. It was not clear from the records what different or other ways that staff had used to aid patient understanding. For those patients with severe and ongoing cognitive impairment there was no proper system or policy to record that the patient will never fully understand their rights. It was not clear what the current trust policy was in these areas.

We spoke with the IMHA provider and heard that levels of engagement and referrals with statutory advocacy services for detained patients across the trust were inconsistent. We heard that the trust did not have an agreed comprehensive engagement protocol with the IMHA provider setting out expectations on each side, for example such as the sample engagement protocol outlined in the most recent guidance document IMHA: Guidance for Commissioners produced by NIMHE.

We found that there were audits carried out to consider how well the Mental Health Act was being implemented at the hospital. Audits undertaken included detention papers, information on rights, consent to treatment, section 17 leave arrangements and care planning. The audit pro-forma was limited in scope and did not include many items we would expect when carrying out robust audits of MHA activity. For example it included whether the appropriate legal certificate was attached to the medicine chart but did not include whether the medication

Mental Health Act responsibilities

prescribed matched the medication detailed on the medicine chart. The audit looked at section 17 leave in terms of whether risk assessments were carried out and superseded forms had been crossed out but did not look at other aspects of Code of Practice requirements, for example ensuring clear parameters were recorded, whether a CTO had been consider if seven days leave had been granted and whether the patient had been given a copy of the form. There was no mention in the audit pro-forma about the duty to inform and refer to independent mental health advocacy services.

We saw that although we had pointed out issues and the trust MHA audits were continuing to identify similar issues, when we returned the issues had not been properly resolved or progressed. Cedars and Linden wards were last visited by our Mental Health Act Commissioner in July 2012 and September 2013 respectively to monitor the use of the MHA. The commissioner saw positive practice in relation to working within the Mental Health Act, multi-disciplinary working, activities for detained patients and dignity issues, appropriate involvement of family members in people's care, staff to patient interactions and dignity issues.

The commissioner raised issues which included limited evidence in relation to repeating patient rights and informing detained patients about the Independent Mental Health Advocacy Service; limited evidence in relation to setting out reasons why compulsory admission was necessary, patient participation in care planning and risk assessments for leave decisions as well as the public pay phone not being in use on Cedars ward.

The audit carried out by the trust at this location in January and February 2013 to look at progress against the issues we had raised showed that these items had not been fully progressed. For example the trust audits identified that both patients on Linden ward at the time of the audit had a Section 132 rights form stating they lacked capacity to understand their rights but it was still not clear if an IMHA referral had been made or considered. It was unclear why this was the case especially given the low numbers of detained patients and this issue had been highlighted by CQC. The audit did not detail what specific and measurable action would be taken in these two cases to ensure compliance with the MHA and Code and to prevent reoccurrence in the future. We saw this issue reoccurring on this inspection. The trust had identified the need to improve the quality and uptake of MHA training for all staff.

A Mental Health Act Commissioner visited Cedars ward in July 2012 and saw that the public pay phone was not in use which meant that detained patients could not maintain family contact. After that visit we were given assurances that the ward phone would be fixed. On this inspection, the ward phone had been disconnected. Staff we spoke with had not been told that the ward phone would be disconnected although there was a promise of a replacement phone facility this was not available. Staff told us that patients would be allowed to use the ward office phone but there were no notices to inform detained patients of the availability of the alternative arrangements. The trust's recent audit did not consider the availability of the phone for detained patients.

We met with representatives of the lay hospital managers who considered the renewals of detention and also heard appeals from patients who wanted their detention formally reviewed. The lay managers were clearly committed to ensuring they carried out their responsibilities appropriately and provided challenge to medical, nursing and management staff where necessary. We heard that the lay hospital managers were provided with support and training relevant to their role and held regular meetings. Hospital managers were not routinely informed or given copies of our Mental Health Act monitoring reports to help them ensure that the responsibilities under the Act were properly delegated and discharged by staff employed by the trust.

Services for older people

Information about the service

Cedars ward has 20 mixed gender beds. Care and treatment is provided to people over the age of 65 who have a functional mental health condition, such as depression or schizophrenia.

Linden ward has 20 mixed gender beds. Care and treatment is provided to people with an organic mental health condition such as dementia.

Patients on both wards were either informal or detained under the Mental Health Act 1983.

Summary of findings

We saw that care was provided in a safe environment and there were enough staff to meet the needs of the people who use services on the ward. Staff knew how to report safety concerns. This meant that people were cared for in a safe environment by an appropriate number of staff.

People who use services were assessed when they were admitted to establish if they were a risk to themselves or others, but plans were not always in place to describe how risk to people should be managed. The staff told us, and records confirmed that adequate training was not always provided to enable them to follow best practice in managing challenging behaviour. This meant that some people who use services were at risk of receiving unsafe or unsuitable care.

Some of the care and treatment provided was based on national guidance, and was therefore current and followed good practice.

We saw that people who use services were treated with dignity and respect and care and treatment was provided in a caring and compassionate manner. However, effective systems were not in place to ensure that all the staff consistently understood individual's needs. This meant that, although people who use services were treated in a caring and compassionate manner, staff did not always have the information required to support them in a safe and consistent way.

Systems were in place to enable people who use services to be transferred and discharged from the ward. We saw that staff worked well with people who use services, their representatives and other professionals to discharge people from the wards.

Some staff told us they felt frustrated and anxious about the lack of clarity over the future of the two wards. Despite this, the staff told us they felt supported within their teams and by their managers.

The trust told us they had recently implemented a new management structure within older people's services in response to quality concerns. This meant that the trust had taken appropriate action to address the concerns that had been raised.

Services for older people

Are services for older people safe?

How are people's risks assessed and managed?

We looked at six care records across the two wards. We saw that staff completed a risk assessment on admission for every person. This assessment included the risks posed to their physical health and the risks they posed to themselves and others. Staff told us that they communicated with other professionals, such as GP's and care coordinators to ensure that people who use services previous and current risks were shared on admission. Care records showed that risks were discussed and reviewed regularly by the multi-disciplinary team during patient reviews. This meant that an effective system was in place to identify and monitor potential risks.

The staff told us that on occasions people were admitted to the ward outside of standard working hours when care coordinators and GP's were not available. On these occasions it was difficult to access information about previous and current risks. This was because the staff on the ward did not have access to peoples computerised community care records. This meant that on occasions there was a delay in the ward receiving information to help them to effectively assess some people who use services risks.

We saw that where risks had been identified plans were not always in place to describe how risks should be managed. We saw that one person had been identified as at risk of exhibiting behaviours that placed them or others at risk of harm. These behaviours can be known as behaviours that challenge. The persons care records showed that staff had intervened to manage these behaviours on three occasions, but no plan was in place to guide staff on how they should intervene. Another patient was at risk of falling from a chair. We saw this patient almost fall from their chair whilst we were observing care and treatment. The staff intervened when they observed the patient almost fall and they assisted the patient to move to a more suitable chair. We spoke with two staff members who confirmed the patient was at risk of falling from the chair, but we saw no management plan in the persons care records that provided staff with guidance on how to manage this risk. This meant that the two people were at risk of receiving inconsistent or unsafe care because there were no plans in place to inform staff on how to manage their identified risks.

We saw evidence of positive risk management in relation to how people who use services' safety was monitored. For example, we saw that peoples observation levels were reduced appropriately to enable the staff to assess, monitor and evaluate people's risks. This meant that people who use services risks were managed in a controlled manner that protected their rights but protected their safety.

We saw that people who use services were protected from the risks associated with the use of medicines. Pharmacists regularly visited the ward to check that medicines were prescribed safely and systems were in place to ensure that the risks associated with medicines were considered and discussed with the patient, their representatives and the multidisciplinary team. An example of this was the use of an antipsychotic medicine checklist. Antipsychotic medicines are one type of medicine used to treat some mental health conditions. Using a checklist showed that the risks associated with the medicines had been assessed and a review date to identify if the medicine was effective had been set.

Do the staff and staffing levels protect people who use services from harm?

The staff we spoke with demonstrated an understanding of the signs of abuse and were able to tell us how they would report any safeguarding concerns in accordance with local policy and procedures. All the staff we spoke with told us they felt confident to share information relating to patient safety. This meant that ward staff had the knowledge, understanding and confidence to identify and report any safeguarding concerns.

Ward managers told us that staffing numbers were flexible and were adjusted to meet the changing needs of the people who use services. One ward manager said, "There were inadequate staffing numbers and skill mix here initially, but senior managers have been very supportive and we now have safe staffing levels". Staff rotas reflected that there had been an increase in staffing to accommodate peoples care needs.

Following incidents is action taken to improve the standards of safety for people who use services who use the service?

We saw that some patient incidents had been formally recorded and reported to enable managers to identify and analyse incident trends. However, we saw that incident reporting was not completed in a consistent manner. For

example one patient's care records showed that they had required staff intervention to manage their behaviours that challenged on three occasions over a three day period. We asked the ward manager to show us the three incident reports so that we could see how the staff had intervened. No incident forms had been completed. During our inspection we identified that two staff members on Linden ward did not have a personal alarm allocated to them as there were not enough alarms on site. We asked the ward manager if they were aware of this incident, but they told us they had not been made aware. The ward manager also confirmed that no incident form had been completed to highlight this potential risk to the staff. This meant that incidents were not consistently or effectively recorded and reported, so action to reduce further incidents could not always be made.

Staff told us they learned about action taken as a result of serious incidents through staff meetings. We looked at the minutes of the four most recent staff meetings for the two wards. In October 2013 the minutes recorded that managers had received an email from the clinical governance team about incidents and their causes. We saw the contents of the email had not been discussed or shared due to time restraints. This item was then carried forward to be discussed at the next meeting, but again the minutes of that meeting recorded there was no time to share this information. This meant that the system in place to share information about learning from incidents had not been effective and the staff were not informed of changes made in response to the incidents.

Are people who use services cared for in a safe environment that protects their rights?

Both the wards could only be accessed and exited via the use of a swipe card. Only staff could use the swipe cards, therefore access to and exit from the wards had to be facilitated by the staff. The staff told us that both wards were locked to provide a safe environment. A locked door policy was in place that confirmed this. Signs were found on the exits which explained informal patients could request to leave the ward by speaking to a member of staff. The trust may wish to note that the signs were not written in an easy read format to help patients' understand their rights to leave the ward. For example, during our inspection we observed three people unsuccessfully pushing on the door in an attempt to leave the ward. None of these people sought help from staff to exit the ward. This meant that people who use services were cared for in a secure environment, where informal patients may not have understood their right to leave the ward.

Are services for older people effective?
(for example, treatment is effective)

Are national standards and guidelines followed to ensure patient care is based on evidence based practice?

We saw that medical staff followed guidance from the National Institute of Health and Care Excellence (NICE). This meant that people who use services received medical assessment and treatment that was based on the best available evidence of good practice.

We saw 'getting to know you' information sheets in peoples care records. These sheets recorded information about peoples individual likes and dislikes. This meant that NICE guidance was followed to enable staff to provide patient centred care.

Nursing staff told us they did not receive training or updates on the NICE guidance. Nurses were aware of the term NICE, but were unable to tell us how they used the guidance when they provided care and treatment. One nurse said, "NICE guidance is not discussed in staff meetings. It is our own responsibility to ensure we are updated with this". This meant that some staff groups were not aware of how they could apply national guidance to improve patient care and treatment.

The NICE guidance for dementia care recommends involvement of allied health professionals in their assessment and treatment. Allied health professions include professions such as occupational therapists and physiotherapists. The ward managers told us they had limited access to allied health professionals. This meant that people who use services may not have received the right assessment and treatment at the right time.

Do the staff work in partnership with others?

Pre discharge meetings took place where other professionals pertinent to patient discharge were invited to attend. This could include the people who use services

care coordinator, social worker, relatives and advocate. This meant that the staff worked with other professionals and people that were important to the patient in order to facilitate effective discharges from the wards.

Staff told us that they shared information about other agencies and organisations with people who use services and their relatives. An example of this was the provision of information about community support services in a leaflet format.

How is the quality of care assessed and managed?

We saw that Cedars ward was in the early stages of implementing the use of the outcomes star model. This model provides a framework for the assessment and monitoring of people who use services progress to recovery. This meant that patient outcomes were beginning to be monitored to enable staff to identify if care and treatment had been effective.

Patient meetings were regularly held on the wards and these focused on gaining people who use services opinions about the quality of the service. This meant that people's opinions were sought in the assessment and monitoring of quality on the wards.

Both wards had been accredited by the Royal College of Psychiatrists. This accreditation is called the Accreditation for Inpatient Mental health Services (AIMS). AIMS is a standards based programme designed to improve the quality of care in inpatient mental health wards. The process involves a review of quality. This meant that the trust sought opportunities to have the quality of their service reviewed by others.

Are the staff suitably qualified and competent to meet people who use services' needs?

Staff told us they received regular mandatory training which included moving and handling, infection control and safeguarding adults. We were unable to confirm that all staff were up to date with their mandatory training by looking at staff records, but those we spoke with were able to give us information demonstrating they understood moving and handling, infection control and safeguarding subjects. The staff also told us that they were required to undertake regular training in the Management of Actual or Potential Aggression (MAPA). During our inspection we asked eight staff if their MAPA training was in date. Six out of the eight staff told us it was not and their staff records confirmed this. This meant that although staff had received some mandatory training, some staff were not suitably trained to safely manage and support people who exhibited behaviours that placed them or others at risk of harm. These behaviours can be known as behaviours that challenge.

One of the ward managers showed us a copy of a list of staff who had been allocated a date for training in the management of behaviours that challenged. We saw that some staff still had no training date allocated. This meant there was no effective plan in place to ensure the staff received the training they required to manage people who use services behaviours that challenged.

Linden ward provided care and treatment to people with a diagnosis of dementia. Staff told us they had not received recent dementia training from the trust. One staff member said, "It's not brilliant here for specialist dementia training, actually it's very poor". This meant that staff were not aware of best practice guidance to enable them to provide care and treatment to people who use services with dementia.

We spoke with an activity coordinator who worked across both wards. They told us they had received training to enable them to facilitate chair based exercise sessions on the wards. This meant that the activity coordinator had received appropriate training to enable them to provide care and treatment specific to older people who use services.

Both wards used agency staff to ensure there were sufficient staff numbers to deliver patient care and treatment. Student nurses also worked on the wards. Agency staff and students we spoke with confirmed they had received suitable ward inductions to enable them to work effectively on the wards.

Do patients receive care and treatment in a manner that protects their rights under the Mental Health Act 1983?

We looked at one person's care records who was detained under the Mental Health Act 1983. Care records relating to their detention, care and treatment showed that the principles of the Act had been followed and adhered to. For example, there was evidence demonstrating a second opinion authorised doctor (SOAD) had been requested and their opinion was clearly documented. The role of the SOAD is to decide whether the recommended treatment is clinically defensible and whether due consideration has been given to the views and rights of the patient.

Services for older people

Are services for older people caring?

Are people who use services involved in making decisions about their care and treatment?

We saw that people who use services were consulted about their care and treatment. Two people were able to tell us they were involved in planning their care and treatment. One person said, "I am being sent home for one week with a care plan. I've been involved with the planning".

Some people on the wards were unable to make decisions about some aspects of their care and treatment. Care records showed that the principles of the Mental Capacity Act 2005 were followed. This meant that people's abilities to make specific decisions were assessed and appropriate professionals and representatives were consulted with to make decisions in people's best interests. One relative confirmed this by saying, "X cannot communicate. We have a meeting this week to discuss the care plan. We have been well informed and well involved in decision making".

Are people who use services needs reviewed regularly?

We saw that people who use services received regular reviews by nursing and medical staff. With patient consent we observed two peoples reviews. We saw the medical team gained feedback from the nursing staff about the persons progress and the following issues were discussed; Medication, mental capacity, risks, physical health and discharge planning.

How do staff ensure people understand their care and treatment?

Throughout our inspection we observed the staff helping people who use services to understand information in a manner that reflected their level of understanding. For example, we saw staff used gestures and actions to assist people to understand verbal information. We also observed staff communicating with people who had hearing difficulties in an appropriate manner to enable them to hear more effectively.

Do people who use services receive the support they require?

We spent time observing the care on both wards. We saw positive interactions between staff and the people who use services. We observed three people who became distressed due to their mental health conditions. We saw that staff spent time reassuring the people and stayed with them until their distress reduced. This meant people who use services were treated with care and compassion.

We saw that care was delivered in line with peoples support plans. For example, where people required assistance with eating and drinking; and monitoring of their food and drink intake, they had received this.

We saw that peoples physical health needs were assessed and monitored. Any deterioration in physical health was acted upon. For example, we saw advice had been sought from a tissue viability nurse for a person who required treatment for a pressure ulcer.

We asked six members of staff about three people's needs. We found that five of the staff knew the persons likes and dislikes and they understood the person's needs. This meant that most of the staff had the knowledge required to support the three people.

One staff member could not provide us with information about the three people as they were agency staff, new to the ward and had not received a handover. The trust may wish to note that this staff member had been on shift for 70 minutes and had not received a handover.

We also found that staff were not aware of people who use services' resuscitation or Deprivation of Liberty Safeguarding (DoLS) status. These safeguards should ensure that a care home or hospital only deprives someone of their liberty in a safe and correct way, and that any restrictions are only made when it is in the best interests of the person and there is no other way to look after them.

We asked six staff if any patients had a do not resuscitate order. Only one of the six staff we asked gave us an accurate answer. We also asked staff if any people who use services had DoLS authorisations in place. Again, only one staff member gave us an accurate answer. This meant that the systems in place for handing over information about people's needs was not always effective and people who use services were at risk of receiving unsafe or unsuitable care.

During our inspection we observed the activity coordinator discussing the day's newspaper with people who use services and we also saw them encouraging people to participate in a quiz. We saw these activities were appropriate to the person's age and understanding. The

trust may wish to note that some people reported that there were often no activities during the evenings and weekends. One person said, "There are things going on, but I sometimes get bored at weekends". We also observed a member of agency staff facilitating a newspaper discussion group. This was not done in an effective manner as people were not encouraged to be involved in a purposeful way. This meant that leisure based activities were not consistently promoted on the wards.

We saw that staff enabled people to access support from an advocate if required. Advocates ensure that people who use services can speak out, express their views and defend their rights. Information was available on the wards promoting the use of advocates and we saw that referrals were made as required.

Are people who use services treated with dignity and respect?

People who use services and their relatives told us they were treated with dignity and respect. One patient said, "I think my dignity is well kept". One person's relative said, "X is able to express their wishes and these are respected". This meant that people who use services and their relatives felt they were treated with dignity and respect.

We saw that the environment placed people at risk of receiving care that compromised their privacy and dignity; this was because the wards were mixed gender. For example the male and female bathrooms were located next to each other. We requested a formal risk assessment around this, but were told one was not available. However, staff we spoke with told us they always supervised people accessing bathroom areas, by going into the bathroom with them or by standing outside the door. Staff said they did this to ensure peoples safety and to ensure other people did not access the bathrooms whilst they were in use. This meant that staff were aware of the risks around patient dignity and they took appropriate action to protect people who use services from these risks.

People who use services we spoke with did not report any concerns relating to the mixed gender environment. One patient told us, "I think the ward is safe, private and comfortable. It's a very nice place".

Are services for older people responsive to people's needs?

(for example, to feedback?)

How do the staff meet the diverse needs of people who use services?

We saw that the wards had considered the diverse cultural needs of the people who use services with notices in the patients lounge on Cedars ward describing the religious books available such as the Bible, the Quran and the Dhammapada. These notices were available in five languages. Staff told us that special diets required for health or cultural reasons were catered for. This meant staff had considered the cultural and spiritual needs of the people who use services.

We saw that care records contained information about peoples preferences, such as what time they would like to go to bed. The trust may wish to note that these preferences were not always met. One person told us they liked to go to bed early, but could not because they needed to wait for their medicines at night. They said, "I feel tired because I have to wait up for my medication". This meant that individual preferences could not always be met.

The wards had equipment ensuring the needs of people with physical disabilities were met. An example of this was equipment to help people bathe safely. Staff told us they had received training in the use of the equipment. This meant that the ward was equipped to meet the physical needs of the people who use services.

We saw that emergency medical equipment was available, including a defibrillator. Staff told us they were trained in resuscitation techniques and the information they gave us about how they would respond to a medical emergency confirmed this. The trust may wish to note that staff told us that doctors were not based on site in the evening and night. Nursing staff also told us that poor access to doctors during the evenings and night meant they sometimes used 999 services rather than waiting for medical support from the trust's doctors. This meant that staff had a system in place to seek emergency medical support out of hours, but this support was not always available from the trust.

How does the trust facilitate transfers and discharges between services?

Staff told us that some people were admitted to the wards because a bed in their local area hospital was unavailable. They told us that when this situation occurred, they regularly communicated with the patient's local hospital

and people were transferred as soon as a bed was made available. This meant that if people who use services were admitted to the wards because beds were not available at their local hospital, a system was in place that ensured people who use services were transferred to their local area as soon as possible.

We saw that people were transferred to other hospitals if their physical health deteriorated. There were joint protocols in place between the trust and other local hospital trusts that outlined the transfer process. This meant there was guidance for staff to follow so that people who use services were transferred appropriately and safely between services.

How do the staff learn from feedback?

We saw that patient feedback was regularly sought through patient meetings. One staff member said, "We have patient meetings every week. Patients can discuss anything they want to". We saw feedback from the meetings was used to improve care on the wards. For example, peoples' food and activity requests were met as a result of these meetings.

There was a complaints system in place which people and their representatives could use. People who use services and their relatives told us they would be happy to share their concerns with staff if they needed to. The ward managers told us how they would manage a complaint to ensure that it was investigated and managed appropriately.

During our inspection of Linden ward we identified that one person's resuscitation status of 'do not resuscitate' had not been recorded in accordance with the trust's resuscitation policy. We shared our concerns with the nurse in charge who took responsive action to ensure the persons care records were updated. This meant that responsive action was taken to address the concern that we raised.

Are services for older people well-led?

Is there a clear vision for services for older people?

We spoke with five medical and nursing staff members about the future of older people's services at Bloxwich. All the staff told us they were unclear about the future of the services. One staff member said, "It's very frustrating. We are living under the umbrella of possible closure and there are lots of things up in the air at the moment". The minutes of the most recent staff meeting dated 31 January 2014 confirmed what the staff told us. These minutes stated, 'It has not been decided what older adults services will look like in the future'. This meant there was no clear vision outlining the purpose and future of older people's services at Bloxwich.

Are the staff engaged in service improvement?

The nursing staff were encouraged to attend staff meetings where service improvement ideas could be discussed. We saw that some areas for improvement were discussed and shared during staff meetings. For example, the need to improve the system where people who use services received their medicines covertly was discussed and actions were agreed. Allied health professionals and medical staff told us they also had regular meetings where service improvement was discussed. This meant that information was shared with staff at a local level in relation to service improvement.

We asked six members of nursing staff if they were aware of a service improvement plan for the services for older people. All six confirmed they were not.

In total we spoke with 25 members of staff who worked on the older people's wards at Bloxwich. Staff interviews were held on a one to one basis or through focus groups. All the staff were aware of the systems in place to report concerns with quality and standards. However, two of the staff felt that they were not able to share concerns about quality with senior managers. Two other staff members felt that they were not involved in service improvement. One staff member said, "I really don't feel fully engaged in service improvement or service redesign". This meant that a small group of staff felt they could not or were not able to participate in service improvement processes.

Is effective leadership in place to ensure high quality care and treatment?

Leadership teams met monthly to discuss quality issues. The minutes of the meetings confirmed that representatives from the wards and different professions were present. The minutes of the meetings showed that audits had been completed or were planned to be completed in a number of areas, such as; falls, infection control and record keeping. This meant that measurements of quality were taking place or were planned to take place.

However, we could not see evidence that the results of the audits were analysed and shared in a timely manner, for example the minutes of the older adults service standards

meeting dated 19 February 2014 recorded that a falls audit had been completed. The minutes stated, 'the audit was done during summer 2013 and the recommendations are still to be discussed and circulated'. This meant there had been a significant delay in sharing the recommendations to improve quality and reduce the risk of falls.

Staff told us and we saw that ward managers responded to staff concerns. For example, concerns had been raised about a member of agency staff. This had resulted in the manager sharing their concerns with the agency and the staff member was not used on the ward again. This meant that ward managers responded promptly to concerns where staff actions impacted negatively upon patient care.

The trust had recently identified concerns with the leadership and management of services for older people, and a new management structure had recently been put in place. This meant that the trust responded appropriately to address the concerns. At the time of our inspection it was too soon to identify whether the new structure was effective.

How are the staff supported?

Through one to one interviews and focus groups we spoke with 25 members of staff who worked on the older people's wards at Bloxwich. All staff told us they felt supported by their line managers and the teams they worked within. One staff member said, "I feel very supported on the ward. I had really good support following a period of sickness". Another staff member said, "I couldn't have asked for anything better. There is always someone I can approach for support". This meant that staff felt supported within their local teams.

All the staff told us they had opportunities to attend supervision or reflective practice sessions and annual appraisals. The staff told us they found these opportunities to be beneficial.

We looked at how staff safety was managed on the wards. Staff told us they were issued with personal alarms at the beginning of each shift. These alarms could then be used in the event of an emergency situation such as, if a patient exhibited threatening behaviours. The trust may wish to note that during our inspection we identified two staff members who had not been able to access an alarm. This was because there we no more alarms available at the beginning of their shift. Nurses in charge were not aware that these staff did not have alarms. This meant the system in place to enable staff to seek assistance in the event of an emergency was not always effective and staff were placed at risk of harm.