

Coventry and Warwickshire Partnership NHS Trust

Caludon Centre

Quality Report

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Date of publication: 17/04/2014

Date of inspection visit: 21-24 January 2014

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 this inspection

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Summary of findings

Overall summary

The Caludon Centre in Coventry is a purpose built facility providing inpatient mental health and learning disability services for adults of working age and mental health services for older people.

Sherbourne

Core service provided: Psychiatric Intensive Care Unit

Male/female/mixed: mixed

Capacity: 11

Spencer

Core service provided: Acute Admission

Male/female/mixed: female

Capacity: 14

Beechwood

Core service provided: Acute Admission

Male/female/mixed: mixed

Capacity: 20

Hearsall

Core service provided: Acute Admission

Male/female/mixed: mixed

Capacity: 20

Swanswell

Core service provided: Older People

Male/female/mixed: mixed

Capacity: 22

Quinton

Core service provided: Older People

Male/female/mixed: mixed

Capacity: 16

Gosford

Core service provided: Services for people with learning disabilities and autism

Male/female/mixed: mixed

Capacity: 9

We found a number of inconsistencies across the different services and good practice within wards had not been shared with other wards.

Some wards were regularly short of substantive staff and there was a heavy reliance on bank or agency workers. Some staff did not know the ward routines and as a result, people did not always receive the care they required. There was little continuity of care for individuals. Some staff did not know about the person they were caring for and had not had an opportunity to read the person's care plan records.

On some wards, staff were not trained specifically to meet people's needs and this increased risks to both staff and people using the service. Some staff told us that they had direct contact with their managers while others had little face-to-face contact and had not received supervision or attended team meetings.

There was a system for staff to report incidents that were then reviewed and acted on by managers. However, we found that regular incidents had taken place on Quinton ward, but there was nothing to show that learning from these incidents had taken place to prevent them happening again.

We found the Caludon Centre did not always adhere to the Mental Health Act's Codes of Practice. Some records did not show that people had been told about their rights under the Mental Health Act which could have impacted on their understanding of how to appeal against their detention and how to obtain the services of an independent Mental Health Advocate to support them.

Some wards were better managed than others and on those wards, there was a lack of support for ward staff.

A risk assessment process was in place; however much of the documentation seen in people's personal files was incomplete to demonstrate personal risk and been considered. We were told that the doors in place were specially commissioned doors to be 'anti-ligature' but the closure was visible when the door was open.

Summary of findings

On some wards, people had detailed care plans that showed staff how they should be supported and we saw they were involved in these. Other records were unclear and had not been updated regularly. This meant that staff might not know how to support people to reduce risk and meet their needs.

On some wards, staff worked with the team of professionals involved in each person's care to ensure that all their needs were met. Staff worked with other providers so that when the person was discharged they received the support they needed.

In outpatients, doctors talked with people and gave them, and others involved in their care, opportunities to raise and discuss issues. The doctors responded to these issues, such as side effects relating to medication.

There was the potential of a risk of harm for the people on Quinton Ward which had a number of breaches in regulations.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found a number of inconsistencies across the different services for the Caludon Centre in regards to safety.

Services for older people

There was good practice within wards but this had not always been shared with other wards.

We identified a number of concerns about the service for older people. Regular incidents had taken place on one ward for older people, but there was nothing seen to demonstrate that lessons had been learned to reduce incidents and keep people safe.

We found the ward was regularly short staffed from its planned staffing rota and relied heavily on bank or agency workers to fill gaps and undertake observations. This had an impact on continuity of care.

Some staff had not received training specific to the needs of some people on the ward. This increased the risk to both staff and people receiving a service.

Outpatients department

We found that there were systems in the department to ensure a safe environment for people who use services and for staff. Staff reported incidents, which were looked into, ensuring actions were taken to prevent them happening again.

Risk assessments to consider people's needs and areas where they needed support were a core part of the doctor's intervention. These took place at initial referral, during treatment and when people did not attend. These mostly considered people's vulnerability in their community and if there were any safeguarding issues.

Staff and people told us there was sufficient staffing and time for their appointments.

Services for people with learning disabilities or autism

Incidents where a person had been placed at risk of harm were investigated appropriately and action was taken to safeguard a person from harm and abuse.

Staff had received the training they needed to meet people's complex medical needs. We saw staff were confident in how to support this person and their needs.

Risk assessments had not always been fully updated despite the need for regular review.

There were six vacancies for staff and these vacancies were covered by regular bank and agency staff. We were told there was a delay in recruiting.

Acute admission wards

We found that people were not always protected from risks, for example some ligature points had not been eliminated from all areas within the acute admission wards. There was a risk assessment process in place, however, much of the documentation seen was not fully complete.

There was an incident reporting system for staff to report incidents. Incidents were then reviewed and acted on by managers.

We saw there were enough staff on duty; however, many of these were either from the provider's nursing bank or from nursing agencies. This meant that some staff on wards did not know the ward routines or many of the people using the service. This had an impact on continuity of care.

Summary of findings

Are services effective?

Services for older people

We saw there was no identified female only lounge on Quinton Ward and that there were mixed sex bedroom corridors. This meant Caludon Centre did not adhere to the Mental Health Act's Codes of Practice.

Records made of people who had been identified as needing close observation because of their behaviour or they were at risk, were not recorded at the time and completed retrospectively. Some observation records were not available.

Outpatients department

Staff demonstrated effective working as a multi-disciplinary team, and with other disciplines such as people's community care coordinators and external services, to ensure they were kept informed about changes to people's care and treatment. Reviews took place with people giving them opportunities to give feedback on the service and any changes needed.

Staff had opportunities for training to ensure they were competent and confident in their work with people.

Services for people with learning disabilities or autism

People's records included a detailed health plan so staff knew how to support each person to meet their physical and mental health needs. Records for the use of restraint, where needed, were not fully completed to guide staff effectively.

Care plans were in an easy-to-read format so that people could understand and be involved.

Staff had received the specialist training to be able to support a person with complex medical needs.

Some records for patients detained under the Mental Health Act had not been fully completed to show that they, or their relative, had been involved in decisions. Records were unclear as to whether or not a person had the mental capacity to consent to their treatment.

Acute admission wards

Staff had completed mandatory training in areas such as risk assessment; fire evacuation procedures and management of potential aggression (MAPA). All of the acute wards had activity workers in place; however, many had only been in place for a few weeks and had not received formal training in providing activities.

Policies and guidelines were in place; however, staff were not always following them. Correct safeguards had not been put in place to protect adolescents admitted to the service. The seclusion policy was not robust enough, and resulted in some people spending long periods in seclusion without appropriate independent medical reviews.

Are services caring?

Some staff were not supported by training and supervision of their care practices, to be caring and compassionate with people.

We found that due to the high use of agency or bank staff, there were concerns about the ability to provide continuity of care. Some staff did not know about the person they were caring for and had not been given the opportunity to read the person's care plan records.

People's privacy and dignity was not always respected.

Outpatients department

Doctors encouraged people to talk about their needs. Staff clearly communicated with people and checked their understanding. Treatment and care was planned and delivered to ensure that people received the support they needed. We observed staff treat people with care, dignity and respect.

Services for people with learning disabilities or autism

The trust had not contracted the advocacy service to provide regular support.

Summary of findings

People and their relatives told us that staff were caring and treated them well. Staff spent time with people ensuring they understood their care and treatment. Flexible working hours meant people received treatment when they needed it

Staff were aware of the need to offer single sex accommodation, but this was not always possible.

Acute admissions

People had individual bedrooms and could store personal items and keep their valuable items secure. For safety reasons clothes rails are not provided as they can be used as weapons against patients / staff. Grooves are present on the edge of shelves which can be used to hang clothes from, however people did not seem able to hang their clothes which were on the floor.

Care plans and risk assessments were not personalised. People were not involved enough in care planning and assessments.

Staff engaged well with people and gave them explanations and reassurance. All of the adult acute admission wards had a 'Welcome Pack' with a range of information for new people. People told us that staff were very helpful but were very busy most of the time.

Are services responsive to people's needs?

Services for older people

Due to the number of agency or bank staff in use the service was not responsive to people's needs. Staff did not clearly communicate with people to identify the needs of the person. There was no ward round held for three weeks which meant that people's treatment was not reviewed.

Outpatients department

Doctors talked with people about their individual needs and how best to meet them. People were referred to other professionals or agencies for further assessment or care to meet these needs.

We found the trust had systems and information for people to give feedback on the service and for these to be reviewed and actions taken.

Services for people with learning disabilities or autism

Staffing levels were adjusted to enable people to be observed to ensure their safety and wellbeing. People were supported to effectively communicate their needs. People told us that there was not enough choice of food, and in one case this meant someone's cultural background could not be respected.

Appropriate action had been taken when a person was identified as being at risk of harm. The situation had been handled well to ensure the person's safety and wellbeing.

Acute admission wards

Bed occupancy was often over 100%, which meant that people had to move to a ward for older people to enable new people to be admitted.

We found that when people or their families raised concerns these were often dealt with at ward level, therefore reducing the need to formalise the complaint.

People were not given enough access to suitable activities and exercise.

Are services well-led?

Services for older people

Some wards were better managed than others and there was a lack of support for staff particularly on Quinton Ward. Staff did not understand how incidents were to be reported and learning from incidents was not shared with staff. Staff were not always supported within their role through training or supervision sessions with their line manager.

Summary of findings

Staff were not clear on their responsibilities under the Mental Health Act 1983.

Outpatients department

We found that staff were given information and had an understanding of the governance framework, with systems for feedback after incidents.

Staff told us they were supported by their teams and line managers. Although they had direct contact with their managers, they did not meet the trust's executive team members.

Some staff said that changes took time to be implemented after they had given feedback.

Services for people with learning disabilities or autism

People were involved in the 'ward vision' so knew about its purpose and what people should experience.

Staff had attended specialist training to provide specialist care to people with a learning disability.

Acute admissions ward

Many staff said that the provider's senior managers were not visible and they had not regularly seen members of the senior management team around the hospital.

Summary of findings

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

Mental Health Act responsibilities

We found the Caludon Centre did not always adhere to the Mental Health Act's Codes of Practice. Some records did not show that people had been told about their rights under the Mental Health Act which could have impacted on their understanding of how to appeal against their detention and how to obtain the services of an independent Mental Health Advocate to support them.

We reviewed the care and treatment of people detained under the Mental Health Act on the wards. Documentation relating to aftercare arrangements, required under the Mental Health Act, were poorly completed and there was no evidence that copies had been given to people or their relatives.

Acute admission wards

The general ward areas were well presented and clean. However people's bedrooms were poorly decorated and the facilities for people living on the ward were not always adequate. Occupancy levels were high and this meant that people were moved at short notice to sleep out on wards for older people, while newly admitted people were given their bedrooms.

Care plans were generic and we found no evidence that people using the service were involved in their care planning process. We found a risk assessment system in place; however the records we looked at during our inspection were not properly completed.

A risk assessment process was in place; however much of the documentation seen in people's personal files was incomplete to demonstrate personal risk and been considered. We were told that the doors in place were specially commissioned doors to be 'anti-ligature' but the closure was visible when the door was open.

Psychiatric intensive care units and health-based places of safety

The unit was airy with a good amount of open space. There were facilities for women to ensure they had access to private space. People we spoke with told us that they felt safe and there were a variety of activities for them to participate in.

The unit was well staffed but used high levels of bank and agency staff due to the number of close observations needed. Staff were well supported and regularly received supervision and support.

Services for older people

We found a number of inconsistencies across the older people services for the Caludon Centre. For example, where there had been good practice within wards this had not been shared with other wards.

We also identified a number of concerns for the older people's service. We had concerns for the care and welfare of people on Quinton Ward. Regular incidents had taken place but there was no indication that learning from these incidents had taken place to prevent them happening again.

There were no robust systems in place to protect people from harm. The ward was regularly short staffed and relied heavily on bank or agency workers. Staff were not trained specifically to meet people's individual needs. This increased the risks to both staff and people living on the wards.

The provider had identified the need for increased staffing on Quinton Ward, but no additional substantive staff had yet been employed. Following a staffing review for Quinton Ward, it was identified that an increase of staffing was needed for the ward. A recruitment plan was implemented and whilst the vacancies have not yet been fulfilled with substantive staff, there is a floating support team available to assist with staffing on the ward when required.

Summary of findings

We found that not all wards at the Caludon Centre adhered to the Mental Health Act's Codes of Practice. There was no identified female only lounge on Quinton Ward and they could not provide properly segregated accommodation for men and women.

Not all staff were supported by training and regular supervision of their practices, to be caring and compassionate with people, which meant they did not always receive the care they required. People's privacy and dignity was not always respected and due to the high use of agency or bank staff there was no continuity of care. Some staff did not know the person they were caring for and had not been given an opportunity to read their care plan records or discuss their care needs.

Engaging and involving people and their family or carers in the planning of their care and treatment did not happen consistently. People had not signed their ward round or care plan records.

We were told that on one ward, a ward round had not taken place for three weeks, which meant that people's treatment had not been assessed.

Some wards were better managed than others inspected. There was a lack of support for staff on the wards, staff told us that they had not received supervision with their manager or had team meetings.

Services for people with learning disabilities or autism

Staff confidently raised concerns about the practice of other staff and action was taken as a result of this. This meant that people were safeguarded from harm and abuse.

Staff received the training they needed to meet people's individual needs, ensuring their wellbeing.

Some records were unclear and had not been updated regularly. This meant staff might not know how to support people to reduce their current risks and meet their needs.

There were six staff vacancies, which were being covered by bank and agency staff. Regular staff covered most shifts, but sometimes new staff did not know the person they were caring for or how to meet their needs.

People had detailed care plans that included their involvement, and showed staff how they would like to be supported. We saw that people had regular physical health checks to ensure their wellbeing.

Staff worked with the team of professionals involved in each person's care so that their needs were met. Staff worked with other providers so that when a person was discharged they received the support they needed.

Some records did not show that people had their rights under the Mental Health Act explained to them. This could have an impact on their health and wellbeing.

Staff had an understanding of what they needed to do to make improvements to benefit people.

Community-based crisis services

This service was responsive to the needs of the people using it. People were seen up to four times each day for both medication management and psychological support while at home. The team planned in detail the type of intervention needed during each visit and fed back to the team at the next handover.

Other specialist services inspected

We found that the Caludon Centre was providing a specific service reviewing the needs of people living in the community. The outpatient department in the hospital provided safe and effective care. They had sufficient numbers of competent staff in place to meet people's needs.

Summary of findings

Staff demonstrated a caring approach and people spoke positively about the care they received. We saw staff delivering compassionate care. Care was planned and based on people's individual needs. The service was responsive to feedback.

Summary of findings

What people who use the location say

We left cards at the Caludon Centre and people completed these before and during the inspection.

Comments about the Centre included, “Named doctor is absolutely brilliant, very caring and compassionate. Doctors are stretched, overworked and under resourced. There is little talking therapies or any therapy available” and “Fantastic service, really helpful, understanding and supportive.”

We received one comment about Hearsall Ward which stated, “Sometimes lower level staff were the ones that treated patients with the most respect. System did not make sense. Had to raise voice or felt opposing the staff to make one be heard. Unsure whether believed by staff – on the whole a varied experience.”

Areas for improvement

Action the provider **MUST** take to improve

- Ensure that planning and delivery of care meets people’s individual needs, safety and welfare.
- Ensure effective arrangements are in place to identify, assess and manage risks consistently across services.
- Ensure that suitable arrangements are in place to ensure the dignity, privacy and independence of service users.
- Ensure that suitable storage, recording and monitoring systems are in place to ensure medications are handled safely and appropriately.
- Ensure that accurate records are maintained that hold appropriate information about people’s care and treatment.

Action the provider **SHOULD** take to improve

- Ensure consistency in the learning from incidents across the organisation to give consistent message.
- Ensure consistency in the learning from incidents across the organisation to give consistent message.
- Ensure that specialist training (for example dementia, autism training and rapid tranquilisation) is provided to all staff working in specialist areas of the trust.

- Ensure consistent use and knowledge of safeguarding practices is developed and implemented information concerning vulnerable adult and children’s safeguarding reporting processes are available.
- Ensure all staff are given equal access to supervision and processes are in place to monitor these arrangements.
- Review the use of agency staff and casual staff to ensure continuity of care.
- Ensure staff are given equal opportunity to ‘de-brief’ following incidents and that learning is cascaded throughout the trust.

Action the provider **COULD** take to improve

- Staff could share ideas of best practice to make the service more effective for people who use it.
- People who use the service could be supported to express their views about the service provided and be given feedback on actions taken.
- More staff support could be given to ensure that ways to measure the quality of care that people experience is effective and that people receiving a service can make changes where possible.

Good practice

- The ward manager for the adults’ service within Swanswell Ward had systems in place to ensure the ward was suitably staffed.
- In the outpatients department, we saw that doctors interacted with people in a person-centred way. People were welcomed by staff and treated with dignity and respect.
- The crisis team operated a patient survey that fed back into the service and was used to improve practice.

Summary of findings

- The Lakeview ECT Clinic and Gosford Ward are all AIMS accredited, and rated excellent, with the Royal College of Psychiatrists. AIMS is a standards-based accreditation service designed to improve the quality of care in psychiatric wards. Standards are drawn from authoritative sources and cover all aspects of the inpatient journey. Compliance is measured by self- and peer-review.

Caludon Centre

Detailed findings

Services we looked at:

Mental Health Act responsibilities; Acute admission wards; Psychiatric intensive care units and health-based places of safety; Services for older people; Services for people with learning disabilities or autism; Community-based crisis services; Other specialist services inspected

Our inspection team

Our inspection team was led by:

Chair: Professor Patrick Geoghegan OBE

Team Leader: Jackie Howe, Care Quality Commission

The team included CQC inspectors, Mental Health Act commissioners, a variety of specialists and experts by experience.

- Learning Disabilities Outpatient Service
- Community based crisis services
- Assessment and Treatment Service

The Trust has a total of 21 active locations. There are three hospitals sites: Brooklands, St Michael's Hospital and Caludon Centre. Nine of these locations provide mental health services.

Coventry and Warwickshire Partnership Trust was formed in 2006 and integrated with community services from NHS Coventry in April 2011. The organisation now provides services from more than 80 locations with an income of about £200 million, and employs more than 4,200 staff.

The trust provides a wide range of mental health and learning disability services for children, young adults, adults and older adults as well as providing a range of community services for people in Coventry.

The trust also provides inpatient, community and day clinics as well as specialist services to a population of about 850,000 living within Coventry and Warwickshire, and also to a wider geographical area in some of their specialist services.

Coventry and Warwickshire Partnership NHS Trust has been inspected 21 times since registration. Out of these, there have been 10 inspections covering five locations which are registered for mental health conditions. The Caludon Centre is a location which has previously been inspected by the Care Quality Commission.

Background to Caludon Centre

The Caludon Centre is a purpose built facility, based on the University Hospital Coventry and Warwickshire (UHCW) site, providing inpatient and outpatient adult mental health care and learning disability inpatient and outpatient services.

Services

- A Place of Safety
- Psychiatric Intensive Care Unit
- Older Adult Mental Health Inpatient Service
- Older Adult Mental Health Outpatient Service
- Adult Mental Health Inpatient Service
- Adult Mental Health Outpatient Service
- Learning Disabilities Inpatient Service

Detailed findings

Why we carried out this inspection

We inspected Coventry and Warwickshire Partnership NHS Trust during our wave 1 pilot inspection. The Trust was selected as one of a range of Trusts to be inspected under CQC's revised inspection approach to mental health and community services.

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?
- 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 responsibilities
- Acute admission wards
- Psychiatric intensive care units and health-based places of safety
- Long stay/forensic/secure services
- Services for older people
- Services for people with learning disabilities or autism
- Adult community-based services
- Community-based crisis services

Before visiting we reviewed a range of information we hold about the location and asked other organisations to share what they knew about the location. We carried out an announced visit on 21 and 22 January 2014. During our visit we held focus groups with a range of staff across the trust; nurses, consultants; junior doctors and therapists. We talked with people who use services and staff from all areas of the 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 also met with people who use services and carers, who shared their views and experiences of the location.

We undertook an unannounced visit, at night, on 22 January 2014.

Mental Health Act responsibilities

Information about the service

The Caludon Centre provides services to adult and older people.

We visited the following wards.

- Sherbourne Ward a psychiatric intensive care unit providing 11 beds for men and women. These people are too acutely unwell for their care to be managed on an acute admission ward.
- Beechwood is an acute admission ward with 20 beds for men and women.
- Hearsall Ward is an acute-adult 20 bedded mixed-sex ward
- Spencer Ward is a 14 bedded adult female acute ward
- Swanswell Ward is a 22 bedded functional acute assessment and treatment service for older men and women.
- Quinton Ward is a 16 bedded organic acute assessment and treatment service for older men and women. The ward provides a multidisciplinary assessment for people with a suspected dementia-type illness.
- Gosford Ward has nine beds for men and women with a learning disability.
- The Place of Safety (Section 136) is situated at the Caludon Centre has capacity to hold and assess two people. A “Place of Safety”, is a location where the police may take someone they believe is suffering from a mental illness and is in need of immediate treatment or care. This is either for their own protection or for the protection of others, so that their immediate needs can be properly assessed.

Summary of findings

We reviewed care and treatment of people detained under the Mental Health Act. We found the Caludon Centre did not always adhere to the Mental Health Act's Codes of Practice. We found there was a lack of consent to treatment and some records did not show that people had been told about their rights under the Mental Health Act which could have impacted on their understanding of how to appeal against their detention and how to obtain the services of an independent Mental Health Advocate to support them.

Section 17 forms were poorly completed and there was no evidence that copies had been given to people or their relatives.

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We found that people did not always receive information that ensured they understood their rights as detained patients under the Mental Health Act.

We found that people were not always protected from risks, for example, ligature points had not been eliminated from all areas.

We saw that doors to all the wards were locked from inside to prevent entry by anyone not authorised to enter the ward. All visitors to the wards were required to sign in and out to create a record of who was on the ward at any given time of the day. We were told that people admitted through the place of safety during the night, may be placed in the bed of a current person who was awake and willing to move to another ward for the night. Alternatively they could remain in the place of safety until the morning when a bed would be located.

People went out on leave with conditions, but we saw there were inconsistencies with records or logs to demonstrate that either they or their carer/ relative had agreed to or understood the conditions of their detention.

Are Mental Health Act responsibilities effective?

(for example, treatment is effective)

We looked at people's care records and found inconsistencies on whether capacity to consent had been assessed to ascertain if the patient was agreeable to, or had the capacity, to consent to medication required for their mental health treatment.

We looked at the files of people who were detained under the Mental Health Act and could find no record of them being told their rights under the Mental Health Act or that they understood or accepted their formal detention.

We looked at section 17 leave forms and found most were completed. However we found they contained limited information about the conditions applied, and that forms were hard to read. Forms did not always contain the

signature of people or carers to demonstrate their agreement of conditions and their understanding of contingency plans. We did not see records that copies had been given to the person or their carer/ relative.

The seclusion policy was not always followed, and people spent long periods in seclusion without an appropriate independent medical review.

In the learning disability unit we saw in one record of a detained person that the use of two medicines, used to manage their anxiety, had not been authorised by their doctor as required under the Mental Health Act 1983. The person's care plan stated they were an informal patient but we saw in other records that they were detained there under the Mental Health Act 1983. We saw that their current section 17 form had not been fully completed to show that they, or their relative, had been involved in decisions made.

Are Mental Health Act responsibilities caring?

People were given information on admission about their formal detention but did not always understand or read the information. We found staff did not always explain people's rights in a way they understood.

People's privacy and dignity was not always respected. Staff were aware of the need to offer single sex accommodation, but this was not always possible.

Are Mental Health Act responsibilities responsive to people's needs?

(for example, to feedback?)

We found the use of Mental Health Act was not always responsive to people's needs. Some people were unable to understand the information given to them and had not had their legal status explained to them in a way they could understand.

People admitted during the night to the Place of Safety suite, a temporary unit for people in crisis to access mental health services quickly, may be placed in the bed of a current person who was awake and willing to move to another ward for the night. Staff told us people could remain in the place of safety until the morning when a bed would be located.

Mental Health Act responsibilities

Correct safeguards had not been put in place to protect the adolescents admitted to the service as required by the Mental Health Act Code of Practice.

We found staff on the adult acute admission wards did not know how to manage and safeguard anyone under the age of eighteen admitted to an acute admission unit. We saw on Spencer Ward two adolescents had been admitted. There was nothing to demonstrate what, if any, special arrangements had been made to safeguard them whilst on the ward.

Are Mental Health Act responsibilities well-led?

There are Mental Health Act administrators within the trust, who monitor the legality of the detention and treatment paperwork. They prepare for Mental Health Review Tribunals and Hospital Managers Hearings.

The Mental Health Act Administrators have recently been awarded an internal quality award for their work. They undertake audits on the wards in relation to consent to treatment, and the giving of rights under section 132 and section 17 leave arrangements of the Mental Health Act.

The provider had a Mental Health Act Legislative Group which reports to the 'Safety and Quality Committee', which makes exception reports to the trust Board. The groups review themes emerging from the reports made by CQC Mental Health Act monitoring visits and monitor action plans, as well as sharing relevant findings with other governance subgroups.

We found that despite the systems in place the groups identified to monitor the application of the Mental Health Act there were issues with the management and recording of procedures required by the Mental Health Act Code of Practice. We found there was a lack of recording about consent to treatment and no evidence that patients accepted or understood their detention. Section 17 forms were poorly completed and there was no evidence that copies had been given to people or their relatives.

Acute admission wards

Information about the service

The Caludon Centre has four acute admission wards. The wards provide in-patient care and treatment for people admitted informally and people detained under the Mental Health Act.

- Beechwood is an acute admission ward with 20 beds for men and women.
- Hearsall Ward is an acute-adult ward with 20 beds for men and women.
- Spencer Ward is a 14 bedded adult female acute ward.
- Westwood Ward is a 20 bedded mixed sex acute admissions ward.

Summary of findings

The general ward areas were well presented and clean. However people's bedrooms were poorly decorated and the facilities for people living on the ward were not always adequate. Occupancy levels were high and this meant that people were moved at short notice to sleep out on wards for older people, while newly admitted people were given their bedrooms.

Care plans were generic and we found no evidence that people using the service were involved in their care planning process.

We found a risk assessment system in place; however the records we looked at during our inspection were not fully completed.

Acute admission wards

Are acute admission wards safe?

Patient safety

We saw that doors to all the wards were locked from inside to prevent entry by anyone not authorised to enter the ward. All visitors to the wards were required to sign in and out to create a record of who was on the ward at any given time of the day. We saw that not all ligature risks had been eliminated from patient areas, although risk assessments were in place. This meant that some systems were in place to protect people from the risk of abuse however not all potential risks had been eliminated from the environment.

All wards had a systematised approach to check the whereabouts of people and to ensure that they were safe. We found that based on risk assessments vulnerable people were nursed in bedrooms located close to the nursing station for monitoring and observation purposes.

Equipment /Environment

All areas of the ward were clean and tidy. There were wall mounted alcohol rubs to assist with infection control. Staff had access to protective personal equipment such as gloves and aprons. There were visible notices on hand hygiene.

We looked at equipment used and found some equipment maintenance was overdue. We also found that some safety equipment, such as the fire extinguisher in one kitchen area, missing.

Electronic reporting system

We saw the Incident reporting system that was completed following incidents allowed ward managers to review and grade the severity of incidents. All staff spoken with were able to describe the system and how to use it.

Risk assessments

We found that individual risk assessments had not been fully completed to identify the risks to a person's safety and wellbeing whilst in hospital. We looked at ligature points in all the wards and found examples of potential environmental risks. The trust told us that the doors were commissioned 'anti-ligature'. We saw that the doors to people's bedrooms had door closures that were exposed when the door was open. Windows had restrictors which are a legal requirement against opening too far, however there is the potential that these could be used for self-harm.

The ward management board displayed information about people and that some people were identified as having a history of fire setting. These people were left with lighters and matches and there was no recognition in the risk assessments seen that people were unsafe to keep these items.

Bed management

We visited four acute admission wards. Three wards were 20 bedded wards for men and women and one 14 bedded female ward. All four wards had more people than beds. For example Hearsall Ward had 20 beds but during our inspection we found that they had 30 people registered to the ward. This example was found across all the other acute wards we inspected. Some people slept out on older people's wards because there was no bed for them to sleep in at night on their ward. They then spent the day on their own wards.

We were told that people admitted through the place of safety during the night, may be placed in the bed of a current person who was awake and willing to move to another ward for the night. Alternatively they could remain in the place of safety until the morning when a bed would be located.

Staffing levels

We found that staffing levels for the acute admission wards were consistently maintained at six staff for the early shift, six staff for the late shift and three staff for the nights. We were told those were the minimum numbers of staff for each ward. Where there were level three observations, someone needing a member of staff at all times, additional staff were brought in.

During our inspection we were told there was a high usage of bank and agency staff throughout the hospital. We re-visited Spencer Ward; the place of safety suite and Beechwood Ward at night. During this night visit there were 49 staff on duty across the four acute admission wards and the PICU, 18 of whom were bank or agency staff. We were told that on a night in the previous week over 50% of the staff were from bank and agency. We spoke to two staff from an agency who told us they regularly worked on the acute admission wards at the hospital. On Beechwood we saw that out of seven staff on duty, four were from bank and agencies. This meant people may receive inconsistent care from staff that may not know them or their needs.

Acute admission wards

We were told that there was a lack of substantive consultant psychiatrists and consequently the posts were covered by locum consultants. Staff told us they saw regular changes of doctors which meant that people's care pathways were negatively affected. The effects were in medication management; risk management and often required people to retell their stories several times.

Safeguarding

We found staff on the adult acute admission wards did not know how to manage and safeguard anyone under the age of eighteen admitted to an acute admission unit. There was nothing to demonstrate what, if any, special arrangements had been made to safeguard them whilst on the ward. CQC found that the trust had failed to notify us of young person's being admitted to adult ward.

This was submitted to the CQC at the time of the inspection.

Are acute admission wards effective? (for example, treatment is effective)

We found care plans were generic without evidence of the person being involved in the process. We saw documentation used had not been fully completed and did not contain signatures or dates. We did not find evidence of formal care programme approach (CPA) reviews. The CPA is the system that is used to organise people's mental health care.

We looked at people's notes and did not find evidence that the capacity of the person to consent to their care or treatment had been assessed. Capacity assessments should be undertaken to ascertain if the person was agreeable to or had the capacity to consent to medication required for treatment of their mental health.

We looked at the files of several patients who were detained under the Mental Health Act and could find no evidence that they had their rights explained to them or that they understood or accepted their formal detention.

Physical Health

We found that all people had a physical assessment completed by a doctor on admission. When people had on-going physical health needs, we saw that referrals to other health professionals were made and staff accompanied people to their appointments and reported back the outcome of those appointments.

We saw care plans were in place across all four wards to monitor people's physical health. We spoke with staff about people on their ward and they were able to tell us about people's physical health and the plan of care. Staff told us that they had access to one day physical health training, however this was optional and there was poor uptake due in part to ward pressures.

Staff training and competence

Staff spoken with had completed, and were up to date, with their mandatory training. One member of staff we spoke with told us they had had good training opportunities and had undertaken training in caring for people with autism, personality disorder, domestic violence and safeguarding of vulnerable adults. Another staff member told us they were encouraged to take courses to aid their development.

We saw that staff were trained in MAPA and had yearly refresher training to ensure they were skilled and knowledgeable in the technique for the management of violence and aggression. All of the wards had access to an activity worker who organised a variety of activities for people on the wards. However they were unable to cover any activity in the kitchens, such as cooking, because they had not received training in food hygiene. This meant that activity workers were unable to provide people with activities that would help them regain lost cooking skills.

Policies and clinical guidelines

Policies and clinical guidelines were in place across the trust, available to staff via the trust intranet, however staff did not always follow the policies and guidelines. We saw that adolescents were admitted and not been managed according to the trust's policy by failing to provide one to one observation and notifying the regulator (CQC) of their admission. This meant that children were placed on adult acute wards without the appropriate safeguards in place.

Quality of care and treatment

We followed the care and treatment of some of the people on acute admission wards at the time of our inspection. People's care and treatment needs were discussed at the time of referral and decisions were made among professionals following a review of the person's needs. There were timetabled reviews with people regularly being seen by the medical team.

Acute admission wards

What people told us

We checked people's care plan records and found conditions had been made regarding them leaving the ward. Section 17 leave forms were being used for people who were not detained under the Mental Health Act. We found there was no guidance for how staff should respond to people if they requested to go home.

Are acute admission wards caring?

Person-centred care

We found that people had care plans and risk assessments in place however we found care plans were generic repeating the same areas of needs with the same intervention for all people on the ward. The only difference between each care plan was the name of the person. We also found risk assessment documentation to be poorly used. Forms were in people's files but were not fully completed. We asked staff about the care of individual people and they were able to describe the risks to people and the level of observation they were on.

Staff engagement

We saw that the interaction between staff and people on the ward was good when staff had time to do so and we saw examples of good staff engagement. We saw that staff gave explanations and reassurance to people in their interactions. Most of the engagement was initiated by people on the ward because staff were very busy with other tasks in the office or working with individual people. We saw that a number of people were in their bedrooms lying on beds. Some of those people remained in their bedroom for the duration of our time on wards but were regularly checked by the staff undertaking observation rounds.

Information available

The adult acute wards had a 'Welcome Pack' which included a range of information such as named nurse, contact numbers for advocacy services and information about their formal detention. We spoke with people who had received copies of the 'Welcome Pack'. One person told us they had not read the pack and no one had gone through the information with them meaning people were given 'Welcome Packs' about their admission, but staff had not checked they had been read and understood.

What people told us

People we spoke with told us staff were very helpful but were very busy most of the time. One person who had been

admitted the night before said they had been left on their own since admission but understood that other people were in greater need than them. They said, "When you need attention you can't get any because they are so busy." Another person said, "Staff do an amazing job."

We checked people's care plan records and found conditions had been made regarding them leaving the ward. Section 17 leave forms were being used for people who were not detained under the Mental Health Act. We found there was no guidance for how staff should respond to people if they requested to go home.

A person told us their wishes had been ignored by staff in relation to an intimate situation they had with another person. The event was an intimate contact with another person which staff became aware of. The first person confirmed they had consented to the intimate contact and did not want the contact to be raised as a concern; however, staff ignored their wishes and made a referral to the safeguarding team.

Are acute admission wards responsive to people's needs? (for example, to feedback?)

Privacy and dignity

People had individual bedrooms and could store personal items and keep their valuable items secure. For safety reasons clothes rails are not provided as they can be used as weapons against patients / staff. Grooves are present on the edge of shelves which can be used to hang clothes from, however people did not seem able to hang their clothes which were on the floor.

We were told that the design of shower rooms sometimes caused water to run into bedrooms when the walk-in shower was being used.

All wards except Spencer Ward were wards for both men and women. We saw that people's rooms were in separate corridors with separate facilities such as toilets and lounges.

People did not have direct access to drink making facilities but could ask staff for drinks outside of the set meal times. This was a blanket approach to minimising risk. Users of the service told us that they were able to get drinks when they wanted one.

Acute admission wards

Persons experience and outcomes

We found the community crisis resolution/home treatment team attended the ward reviews working with the ward team to facilitate discharge. We were told by the bed manager that they liaised closely with the wards so they knew when people were ready for early discharge, allowing them to know where beds could be accessed when demands for admissions increased. This meant people were often sent on home leave to allow new people to be admitted. We found, and were told, that when demand for beds increased, particularly at night and weekends, people often slept out on older adults wards in order for a new acutely ill person to be admitted and sleep in their rooms.

There were games available for people to use with others, with staff or with activity workers. There were mini libraries with a good selection of books that people could access whenever they wished. During our inspection we did not see anyone using the library however we saw people participating in group activities with activity workers.

Response to feedback and complaints

We were told by staff there was a complaint, suggestions and compliments policy in place that was monitored and managed by a head of complaints in the trust. In addition to this the Complaints and Person Advisory Service (PALS) was promoted within the hospital. People also had access to an independent mental health advocate' (IMHA) should they wish. Staff told us that they tried to resolve complaints at a local level before it became formalised. We spoke to three people about concerns they had had and they confirmed that staff had resolved these on the wards without them having to formally complain. This showed that staff worked with people to resolve issues at an early stage before it became a formal complaint.

Patient feedback

We were told by staff that people wanted to have more physical activities on the wards, such as those who could not have ground leave, and who had requested an exercise bike and cross trainer. Staff told us that the provider responded that these items were ligature risks so would not purchase them. Three people complained to us during our inspection that kitchens on their wards were not open and available for them to use.

Are acute admission wards well-led?

Leadership

We found the ward managers were visible and accessible to their staff. They were knowledgeable about the people using the service and the challenges they faced on a day to day basis. Some staff we spoke with said they regularly saw the matron/hospital manager visiting the wards. Whilst we were inspecting we saw the matron/manager visiting wards and interacting with staff.

The majority of staff said that senior management of the trust were not visible and not regularly seen by members of the senior management team around the hospital. We found that some of the more junior staff on the wards did not know the names of the executive team.

Staff feedback

We spoke with staff on the wards and they told us they knew how to escalate safety concerns. They were aware of procedures for safeguarding (protecting people from abuse) and whistleblowing (reporting wrong doing in the organisation) and they had received relevant training. They told us they would feel comfortable raising concerns with their managers; they felt their managers would take them seriously and they would take appropriate action.

Psychiatric intensive care units and health-based places of safety

Information about the service

Sherbourne is an 11-bedded mixed sex psychiatric intensive care unit (PICU). The unit provides care and treatment for people who experience mental illness and present behaviours that need to be managed in a specialist area with staff trained and experienced in restraint and de-escalation skills.

Summary of findings

The unit was airy with a good amount of open space. There were facilities for women to ensure they had access to private space. People we spoke with told us that they felt safe and there were a variety of activities for them to participate in.

The unit was well staffed but used high levels of bank and agency staff due to the number of close observations needed. Staff were well supported and regularly received supervision and support.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

We found the care unit (PICU) was well staffed with a good staff to patient ratio. The unit was calm during our inspection. People we spoke with told us they felt safe on the unit. One person told us, “I feel safe here; there’s that many staff on the ward I don’t really worry.”

We saw there was a high usage of bank and agency staff due to the high level of people who required close observations on the unit. All staff who worked on the unit were trained in how to restrain people safely. Staff told us this training enabled them to defuse potential aggression and they were able to safely manage incidents of aggression.

The unit had one woman who was on observation to ensure they were safe on the ward. We saw there was a female only lounge so they could sit quietly away from the male patients on the unit.

Staff told us they had regular support sessions from a clinical psychologist. The sessions were to review incidents that had occurred on the ward and to learn from incidents.

Are psychiatric intensive care units effective?

(for example, treatment is effective)

Seclusion is, because of their behaviour, the sole confinement of a person in a room which may be locked.

We reviewed the seclusion log and found that entries of seclusion episodes were not in date sequence. This meant an up-to-date and accurate record of all seclusion had not been kept.

We looked at the record for a person who had spent 81 hours in seclusion. We saw that, whilst in seclusion, checks on the person were made every ten minutes and recorded on the seclusion observation review sheets. We found that the review sheets were not completed accurately. The observation review sheets have a four hour cycle with hourly checks. Every four hours the person should be reviewed by a nurse and a doctor, but we found this did not always happen. We found 14 occasions where a review should have been completed after four hours by a nurse and a doctor but in fact was completed by two nurses. This

showed the person was not properly reviewed during their period of seclusion meaning that people could be secluded for longer periods than necessary without an independent review of their seclusion.

On the ward we saw the seclusion policy had an attached form which required staff to confirm by signing that they had read and understood the policy. There were 32 staff names on the confirmation sheet but only nine staff had signed. This indicated that most of the staff had not read and understood the trust policy and guidelines on seclusion.

Are psychiatric intensive care units caring?

During our inspection we saw positive interventions between people and staff. Staff responded to people’s requests promptly and appropriately. The unit had a weekly community meeting where people were able to raise issues and have a discussion with the staff.

We spoke with three people who told us that they had care plans and had discussed these with staff on the ward. One person told us, “I’ve got care plans, but I don’t keep them. What’s the point.” We found that people were able to choose the sort of food they wanted and were able to get drinks when they wanted.

We observed good interaction between staff and people living on the ward and staff maintained people’s dignity and treated them with respect.

People told us that they were able to talk to some staff on the ward and raise some of their concerns but there were some staff they were not comfortable talking to. One person told us, “Some of the staff can be nasty, but I can be nasty too but mostly staff are good to me.”

Are psychiatric intensive care units responsive to people’s needs?

(for example, to feedback?)

People told us that there were regular activities organised that stopped them being bored. The unit had an activity coordinator who worked with people to undertake the types of activities they enjoyed.

Psychiatric intensive care units and health-based places of safety

People had single bedrooms with en-suite facilities where they went when they wanted to have some time alone. People were aware they were under observation and this meant that staff regularly checked them whilst they were in their bedrooms.

We spoke to the activity coordinator who told us about the timetable of activities on the ward. Activities such as weekly community meetings where people are invited to discuss events and activities they wanted to do; reading and art groups. They told us about activity plans to have a cake sale on Valentine's Day to raise money to purchase materials for further activities. There are board games, a Wii console, a television and DVD player that people could use in the evenings and weekends. We also saw a pool table where people were able to play with other people or with staff.

We saw people had access to a courtyard where they were able to smoke and get fresh air. All trips to the courtyard were supervised by staff. Non-smokers were able to access the courtyard with staff escorting them.

We found the ward was supported by consultant and junior doctors. The ward manager told us the ward staff received regular support from a clinical psychologist however we found no evidence that there was clinical psychology support to the people on the ward.

Are psychiatric intensive care units well-led?

The manager had detailed knowledge of each person on the unit and was aware of their needs.

Staff had a formal supervision session every four to six weeks during which support was offered around their clinical work, risk and any management issues that may have arisen. One staff member we spoke with told us they found supervision very helpful.

We attended the handover between staff and found a very thorough process in operation covering all people living on the ward. The handover was written and the nurse in charge checked when staff were last on duty and the handover covered that period.

A clinical psychologist attended the unit to provide staff support because of the intensive nature of the work being done. We were told by one member of staff they found the support very helpful, particularly when they had had to manage some challenging situations.

Services for older people

Information about the service

- Swanswell Ward is a functional acute assessment and treatment service for older men and women from across Coventry.
- Quinton Ward is an organic acute assessment and treatment service for older men and women from across Coventry. The ward provides a multidisciplinary assessment for people with a suspected dementia-type illness.

We have not previously inspected these wards.

Summary of findings

We found a number of inconsistencies across the older people services for the Caludon Centre. For example, where there had been good practice within wards this had not been shared with other wards.

We also identified a number of concerns for the older people's service. Regular incidents had taken place on Quinton Ward, but there was no indication that learning from these incidents had taken place to prevent them happening again.

There were no robust systems in place to protect people from harm. The ward was regularly short staffed and relied heavily on bank or agency workers. The trust had identified the need for increased staffing, but as yet no additional substantive staff had been employed. Staff were not trained specifically to meet people's individual needs. This increased the risks to both staff and people living on the wards.

We found Quinton Ward did not adhere to the Mental Health Act's Codes of Practice. There was no identified female-only lounge on Quinton Ward and they could not provide properly segregated accommodation for men and women.

Staff were not supported to be able to be caring and compassionate with people, which meant they did not always receive the care they required. People's privacy and dignity was not always respected and due to the high use of agency or bank staff there was no continuity of care. Some staff did not know the person they were caring for and had not been given an opportunity to read their care plan records.

Staff did not adequately include and engage people and their family or carers in the planning of their care and treatment. People had not signed their ward round or care plan records.

We were told that a ward round had not taken place for three weeks, which meant that people's treatment could not be assessed.

Some wards were better managed than others inspected. There was a lack of support for staff on the wards. Staff told us that they had not received supervision or had team meetings.

Services for older people

There was a potential risk of harm for the people on Quinton Ward which had a number of breaches in regulations.

Are services for older people safe?

Medication

The storage of medicines on Quinton Ward was not of a safe standard. The medication cupboard was untidy which meant staff found medication difficult to locate. A member of the nursing staff told us, “Sometimes staff call to say we have not got a medicine but the pharmacy know it has been sent. Due to chaotic storage the medicines are not easy to find.”

We found the refrigerator temperature record form was not completed on a daily basis, although the temperatures which had been recorded were within the appropriate temperature range. Water for injections was stored in the refrigerator when this was not required meaning a person would receive an injection with refrigerated water which would feel cold and unpleasant. A member of staff told us, “I keep taking it (water) out of the fridge but every time I come back it is back in the fridge” and “It (water) is always in there.”

We looked at the medication administration records (MAR) and found there was not a robust system for recording when medication had been administered. We found a system was in place where the use of a red pen was used to circle boxes with a signature within the circled box. A nurse explained to us, “I will put my initials in a box and circle in red and write ‘R’ in red. This shows the patient refused medication.” We asked the nurse what the policy was for recording when medication was refused and they told us, “I don’t know.”

We spoke with a nurse about the storage of medicines. They told us how medication was not easy to find and this had been fed back to their line manager. They told us their manager would feedback to the medicine management team; however no action had been taken following the feedback.

There was a different system used for other MAR records and there was no consistency for recording when someone had refused medication. For example, we saw gaps in medication records with no signature to confirm whether the medication had been administered or refused. The records did not follow the policy that the trust had in place.

We saw three people on Quinton Ward had their medication administered covertly. This meant the

Services for older people

administration of medication was hidden in food or drinks. We found details of how the medication was administered recorded within people's care plans but not recorded on the drug chart or MAR record. This meant nursing staff would not be aware that the person's medication would need to be covertly administered.

Safeguarding

We spoke with a variety of staff who told us they were unclear on how to report any potential abuse and what the safeguarding procedure was. Staff we spoke with were not able to identify when a safeguarding referral should be made to ensure people were protected from harm or abuse. We saw where safeguarding referrals had been made to the Safety and Quality team; these had not been completed with full details of the incident.

We looked at incident reports issued by the trust on a monthly basis and these did not identify safeguarding incidents. We spoke with one manager on one of the units. They told us that they did not always identify an incident as a safeguarding concern when completing their monthly returns using the trust's 'dashboard' system. They said they were not able to 'run' a report which identified safeguarding incidents enabling them to identify themes and to take action to protect people from a safeguarding incident occurring again. This meant the trust did not have a system in place to enable individual ward managers to monitor safeguarding incidents and take appropriate action to safeguard people.

We saw that doors to all the wards were locked from inside to prevent entry by anyone not authorised to enter the ward. All visitors to the wards were required to sign in and out to create a record of who was on the ward at any given time of the day.

We asked staff about their knowledge of deprivation of liberty (DOLS). We found the majority of staff were unclear on how DOLS should be implemented or recorded and would not know what to do if someone who was not detained wished to leave the ward. We looked at staff files which confirmed staff had not received training. The manager told us that training was being arranged by the Trust.

We saw the training matrix for staff on Swanswell Ward. This showed that out of 26 staff only 12 had received Management of Actual or Potential Aggression (MAPA) training in 2013. This meant that some staff had not

received the specialist training to look after people safely. We noted there were incidents where MAPA training would have been required. Staff told us there were regular incidents where people or staff had been assaulted. They told us they did not always feel safe as there were not enough personal alarms for staff.

Staff on Swanswell Ward told us they had regular supervision meetings with their manager and an annual appraisal although a record of these meetings was not always on staff files. We saw one manager had a supervision schedule in place which identified dates of supervision for staff on the ward. The managers on both wards told us they had not been able to conduct these supervision meetings due to time constraints and recognised they were behind.

Staffing levels

During November and December 2013, Quinton Ward bank and agency hours were significantly higher than that used on Swanswell Ward. In December 2013 there were a total of 1159 agency hours used on Quinton Ward compared to 218 on Swanswell Ward.

Following a staffing review for Quinton Ward, it was identified that an increase of staffing was needed for the ward. A recruitment plan was implemented and whilst the vacancies have not yet been fulfilled with substantive staff, there is a floating support team available to assist with staffing on the ward when required. Staff told us that an increase of three nursing staff per shift had been recommended. They told us that one staff member had been recruited since November 2013, but had not started due to a delay in their suitability to work with vulnerable people check. The manager told us they were not involved with the review of the staffing for the team and was not aware of which workforce design model was being used. We noted the unit manager had provided feedback for five agency workers and they had not been used again on the ward due to their performance.

We looked at staff files to see if they had received training in how to protect vulnerable children and adults. We saw staff had received awareness training as part of their mandatory training. We were told all staff were booked to receive further training in protecting vulnerable people in 2014. We saw some of this training had not been booked until

Services for older people

October 2014. This meant people may be at risk, as staff were not receiving training until ten months after our inspection and were not clear on how they should report safeguarding concerns.

We looked at the 24 hour ward report to identify the staff actually on duty compared to the planned rota between 2 January 2014 and 21 January 2014. We found the staff mix was made up of at least 50% agency or bank staff, whilst on some days there could be 75% agency or bank staff for a week. Ward staff told us they tried to use the same agency to gain some consistency but this was not always possible.

A member of staff told us, “It is getting better as they have tried to employ new staff. The regular staff are under pressure as you need to remind agency staff about personal care needs and diets.”

Diary entries for the 30 days prior to us visiting the ward showed there were regular shifts which were not covered and meant the unit would often be short staffed. When we visited the unit on 21 January 2014 in the morning, we found there were five staff still to be identified for the afternoon shift. During the afternoon shift the ward was unable to fill two staff shifts and were short staffed. We spoke with the unit manager and the deputy manager about staff levels. They told us it was “very difficult” to find staff to cover the ward sometimes and they were often short staffed. This meant the management team were often having to arrange staff cover and not able to lead the unit. Staff members told us they felt “pressured” as agency workers would not have a clear understanding of people’s needs.

Agency staff told us they did not have time to read the care plans and would rely on substantive staff to handover information. We found there was no robust handover for staff. For example, when we spoke with one member of staff about a person they were observing, they did not know the person’s name or details about their treatment.

Environment

We saw that the showers were broken and had not been available to people for approximately a year. We were told by the deputy manager that the showers would create flooding into corridors and this was unsafe for people as they could slip over.

(for example, treatment is effective)

We looked at people’s care records on the older adult units and found the recording of information was inconsistent. Initial assessments had been completed for people but not signed by members of staff who completed the assessment. People had not signed their care plans and we were unable to identify how people were involved with their treatment decisions.

In the majority of care plans there were no dates for people’s care to be reviewed and reviews had not been undertaken. We found people were not listed as attending their ward round and people had not signed the ward round to confirm their attendance. There was nothing to demonstrate that they were involved in decisions about their care and treatment.

We looked at one person’s records on Swanswell Ward and found that no ECG had been undertaken when they were on a depot injection. This meant the person’s health needs were not being reviewed and the person was potentially at further risk for their health needs. When we spoke with a member of nursing staff they told us this had not been considered. We saw one person who was walking around in bare feet on Swanswell Ward. We asked the unit manager if a risk assessment had been carried out identifying the risks and actions to protect this person’s safety. The unit manager told us they had not. This was confirmed when we looked at their care records.

We looked at seven records on Swanswell Ward and found that for five people a ward round had not been undertaken by the consultant for three weeks. We noted a ward round had been completed for people who were new admissions to the unit. We spoke with staff about the delay in the ward rounds and this had been because the consultant had been on annual leave and no consultant cover had been arranged. This meant the person had not been reviewed for three weeks which could potentially affect the person’s treatment or care. We were unable to identify if this had impacted on people’s treatment or discharge plans.

We observed a ward round for Quinton Ward where junior doctors told us, “carers are usually invited to the ward round.” We saw there was a medical consultant, staff nurse

Are services for older people effective?

Services for older people

and junior doctor who attended the ward round. We were unable to see how the person or their carer was routinely involved with the ward round as care plans to demonstrate involvement, were not signed.

One person we spoke with told us, “Never see the doctor.” Another person told us, “I do not have a named nurse.” Staff told us they would be assigned a person to observe; however due to the high number of agency staff used there would be no continuity of which staff members would observe a person.

We found that staff on the unit were not sharing good practice or ways to care for people in a consistent and effective way.

An occupational therapist who worked on Quinton Ward told us how they used a hidden packet of sweets to curb a person’s anxiety. They told us, “I hope everyone knows about the sweets” and “I’m sure everyone knows.” We spoke with another member of staff about the hidden sweets and they were unaware this could be used to curb this person’s anxiety. We found there was no care plan and no meeting had taken place to share ideas or guidance on this person.

During our inspection we saw that some records of observations were not recorded at the time and were completed retrospectively. We also found that some observation records were not available. There was no system in place to identify gaps within the observations records. This meant that people’s behaviour or treatment could not be robustly monitored or reviewed which could potentially impact upon people as their behaviour, or triggers for challenging behaviour, would not be identified. A member of staff told us, “the regular staff are under pressure as you need to remind agency staff about personal care needs and diets”. “There are a lot of violent incidents mainly in the afternoon roughly once a day. We have to restrain people in some violent incidents. If they haven’t attended to personal care for a number of days, we try with different staff and in some cases if they are on a section we might force them.”

Staff also told us there were issues regarding staffing due to the reliance on agency staff. This was especially more difficult to manage in the afternoon and evening shifts and had led to incidents on a regular basis, with no learning from these incidents discussed. They also said the number

of people placed on observations had increased and it had been difficult to allocate staff to manage these. This meant there was no time for paperwork or care plans to be accurately maintained.

During our inspection we found there was a designated female lounge for people on Swanswell Ward. As there were both male and female people on the wards there is a requirement under the Mental Health Act Code of Practice to ensure that male and female sleeping and bathroom facilities are segregated and a female only lounge is available. When we visited Quinton Ward we were told by the deputy manager that there was a female lounge; however this was used by a man. We looked at the lounge and found “Interview Room” was labelled on the door and only one chair was available. This lounge was located within the female corridor. We spoke with the manager about a designated female lounge. They told us the female lounge was a different lounge within the unit. We checked this lounge and found a male person relaxing in the lounge. We spoke with staff who told us that anyone could use that lounge. This meant it was not clear to staff or people using the service which lounge was for use by women only.

Are services for older people caring?

Quinton Ward

During our inspection to this ward we saw a number of examples where care was not being delivered in a compassionate way and there were concerns about the ability to provide continuity of care. There was a lack of good person centred care plans and an inconsistent staff group meant that staff did not always fully understand the care individuals required. We found that some from some staff there was no verbal interaction or comfort offered at times of distress.

Some staff did not know about the person they were caring for and had not been given the opportunity to read the person’s care plan records.

Three members of staff told us they had to “restrain” a person to give personal care. We spoke with a nurse who explained that they managed people in the least restrictive way possible. We looked at the person’s care plan which had been implemented from September 2012. This directed staff to step out of the area if the person appeared to become distressed to allow them to calm down. The care plan further stated that during this time a ‘MAPA’ team

Services for older people

would be assembled who would approach the person to continue with his hygiene needs. If the person remained agitated or aggressive then the team were to use the least restrictive manner possible. There was nothing in the care plan to show that since it was started, despite being reviewed monthly, that staff had made the care plan more person centred. For example how the person responded to different members of staff or had sought best practice guidance. The nurse told us that the restraint for personal care had been discussed with a family member. We were unable to find confirmation of this within the care plan.

During our inspection we saw one person was not given the privacy and dignity they needed with some personal care following an incident. Staff told us they had not been informed and therefore were not fully aware of individual behaviours. We checked the person's care plan and there was no guidance to staff on how to manage this.

We saw one person sat in a lounge who was observed by a member of staff at all times. We saw that no one spoke with the person or tried to engage them with activities. On the day of our visit the member of staff sat in the doorway to the lounge which gave the impression of blocking the doorway.

We saw another person who repeatedly told staff they wanted to go to bed. We found that staff would guide the person to a lounge that was already full and told the person they would take them to their bedroom but did not do this. The manager told us that person's bedroom door was locked but would be unlocked on the person's request.

We found that the environment on the ward was not one that would make a person feel safe, comfortable and offer privacy. We saw there were two rooms on Quinton Ward which were not in use. The manager told us the sensory room and conservatory was not in use as they were being used to store broken furniture.

We found metal bars within people's bedroom doors that could be used as a ligature point. We noted several wires within people's bedrooms coming from their beds. We found there was no risk assessment available to decide the level of risk to each person.

Are services for older people responsive to people's needs? (for example, to feedback?)

We found for one person that the nursing staff had sent a letter to the person's GP giving them details of the person's admission and care plan. For this person the unit had co-operated well with other providers to co-ordinate the person's care.

We spoke with nursing staff on Swanswell and Quinton Wards who told us about their knowledge and skills of physical health. They told us how they interpreted the MEWS (medical early warning signs) scores and their knowledge was poor. They told us they always referred people on to the main hospital or called a doctor to assess people. We identified that staff were slow to respond to alert the medical team if a person became unwell.

We found that a male corridor for people on Swanswell Ward was next to a designated female corridor on Quinton Ward. We noted a door, which separated the wards, had a panel of glass to see through each of the wards. This meant there was a risk that person's privacy and dignity was not maintained.

During our inspection on Quinton Ward, we saw that ten people were on level two observations where staff had to record information about a patient every 15 minutes. These were completed by one member of staff. We found that four people were on level 3 observations where a person has uninterrupted observations by a member of staff.

The lounge area had a television but no DVD player to play films or other entertainment. We noted the television was set in a corner and was therefore only accessible to a few people in the room. We saw there was a display cabinet in the corner but found there was nothing on display and on the shelves was a tumbler with a name on it and rubbish. In the toilet there was a used pull up incontinence pad that had been left behind the sink taps.

Services for older people

Are services for older people well-led?

We visited Quinton Ward and found several areas of concern had not been addressed by the ward manager or senior manager team. For example, the issue of the ward being short staffed had been identified during November 2013 but no substantive staff had yet been employed.

We looked at the staffing levels for the unit and noted that three members of staff were on long term sick leave. We found one member of staff was on work related sick leave following an incident on the 18 October 2013. During this incident two substantive members of staff and one agency worker were injured. We noted their MAPA (Management of Actual or Potential Aggression) training was not up to date.

We found the incidents of violence reported by Quinton Ward were significantly more than the incidents reported on Swanswell Ward. We examined three incidents where staff had been injured. We noted that the three incidents all had both bank or agency workers injured during the incidents and these workers had not been MAPA trained. There was a lack of information available or description on the incidents and no analysis. Any learning following incidents was not shared through an opportunity for staff to 'de-brief' on how to avoid similar incidents and protect the safety of staff and patients.

We looked at the sickness reports for Quinton Ward which showed a trend of increased sickness absence. There was significantly more absence due to injuries obtained on Quinton Ward. We spoke with the unit manager and staff on Quinton Ward about the support provided. They told us there was a lack of specialised training available to them such as training in challenging behaviour and caring for people with dementia, which was specific to people's needs.

We spoke with one member of staff who told us they were involved in an incident where they had been bitten by a person. They told us they did not feel supported and had only been contacted to identify when they would return to work.

Another member of staff told us they were pregnant and that an 'expectant mothers risk assessment' had been completed; however a copy was not available. We were unable to identify what support was given to the member

of staff who was still working in an area with a significant number of violent incidents and where the staff member routinely worked long days. A personal alarm was not always available to this member of staff.

We spoke with staff about the ward and they told us there were insufficient personal alarms for bank or agency staff. The deputy manager told us they had to risk assess on a shift by shift basis to decide on how the alarms were allocated. The ward manager confirmed this and the issue of personal alarms had been raised but no action had been taken so far. We were told by staff that that the allocation of personal alarms was not an issue on Swanswell Ward.

One member of staff told us they felt more support was needed in transition from band five to a band six level, particularly in the bleep holder role. The bleep holder is responsible for staffing or issues within the wards where additional support is required.

Another member of staff on Quinton Ward told us they knew the whistleblowing policy and on one occasion had used it. They told us they did not feel supported when they reported their concerns and nothing was done. They felt people did not speak to them for reporting but felt there was a "Good reporting culture." They told us, "It's the best team we've had as there is more regular bank staff."

We noted there was an agenda and notes from a staff meeting held on 6 September 2013; however the staff that attended, or any actions agreed, were not recorded. We spoke with staff who said there were no staff meetings. The manager confirmed there had been no further staff meetings planned at the time of our inspection and was unable to show us any further minutes.

We were told by the unit manager on Swanswell Ward that a care plan audit had been undertaken during January 2014; however a copy of the audit was not available. We saw copies of notes that were sent to two members of staff which identified issues needing to be addressed. When we looked at the records to see if the issues had been rectified, we saw no action had been taken.

We spoke with five members of staff on Quinton and Swanswell Ward who told us they did not have regular supervision meetings with line managers or appraisals of their work. They told us their mandatory training was up to date; however they did not have specialist training to meet

Services for older people

people's needs. For example, training in caring for people with a dementia, how to effectively deal with challenging behaviour, deprivation of liberty safeguarding or the Mental Health Act.

They told us, "Challenging behaviours are worse when using bank or agency staff. A lot of different people who don't know the ward often lack of experience of working with person group or challenging behaviour", "Makes it very stressful when trying to run the shift." A nursing assistant told us they had "Not had formal clinical supervision and

not had an appraisal." They told us, "Ward does have activities, but they do get cancelled due to staffing. I have noticed that some bank or agency workers don't know the ward or are used to challenging behaviour."

During our inspection on Quinton Ward we heard a professional visitor discussing a person's funding issues with a relative within the ward corridor. We noted the visitor appeared unprofessional in their manner to the relative and this was not challenged by staff. This meant that confidential details about a person could be heard by other people on the ward.

Services for people with learning disabilities or autism

Information about the service

Gosford Ward is a nine bed mixed sex service for people with a learning disability who have additional mental health or behavioural problems. People are admitted to Gosford for assessment and treatment.

Summary of findings

Staff confidently raised concerns about the practice of other staff and action was taken as a result of this. This meant that people were safeguarded from harm and abuse.

Staff received the training they needed to meet people's individual needs, ensuring their wellbeing.

Some records were unclear and had not been updated regularly. This meant staff might not know how to support people to reduce their current risks and meet their needs.

There were six staff vacancies, which were being covered by bank and agency staff. Regular staff covered most shifts, but sometimes new staff did not know the person they were caring for or how to meet their needs.

People had detailed care plans that included their involvement, and that showed staff how to support them. We saw that people were supported to have regular health checks to ensure their wellbeing.

Staff worked with the team of professionals involved in each person's care so that their needs were met. Staff worked with other providers so that when a person was discharged they received the support they needed.

Some records did not show that people had their rights explained under the Mental Health Act. This could have an impact on their health and wellbeing.

Staff had an understanding of what they needed to do to make improvements to benefit people.

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism safe?

We saw that an incident, where a person had been placed at risk of harm, was investigated appropriately and action was taken to safeguard people from harm and abuse. Other staff had reported the incident and told us they would feel comfortable to do so again, as they were listened to and people had been safeguarded as a result.

Are behaviours, processes and systems reliable, safe and proportionate for people who use services

Staff told us how they had received the training they needed to meet people's complex medical needs, and staff were confident in how to support the person and their needs.

It was unclear in one person's records whether or not an extra dose of 'as required' medicine was given. The ward manager agreed to look at this to ensure it did not have a detrimental effect on the person's health. The person's daily notes stated that an extra dose had been given which contradicted their medicine record that stated only one dose was given. Therefore, it was unclear and potentially unsafe as the person may have received more than the dose prescribed for them.

Understand and manage risk to the person using services and others with whom they may live with

One person's records showed that assessments to review where someone maybe at risk had not been fully updated. This meant staff might not be aware of the person's current risks and how to support them to reduce these. The person had complex needs and staff were identifying new risks regularly as would be expected in an assessment and treatment service. Their records stated their risk assessments should have been reviewed earlier in the month had not been done despite dates and reminders in their records for it to be. It was not clear from two people's records what the risks of them moving around were, so staff might not know how to support each person. Staff we spoke with knew, but the potential for staff not to know was high as a number of bank and agency staff were used.

Staffing levels and quality of staffing enables safe practice

We were told that there were six vacancies for staff; one for a band 5 nurse and five for health care assistants. The

deputy manager told us there was a delay in recruiting some staff as the trust had not agreed whether Health Care Assistants recruited would be band 1 or 2 so this impacted on permanent staff being recruited. Staff told us, and we saw, that these vacancies were covered by regular bank and agency staff. On the second day of our inspection we saw a new bank staff member was on duty. The staff member was inducted appropriately and the shift leader ensured the new member of staff would not be working with people who had complex medical needs. Some staff told us that some people did not like new staff and had refused to go out with them. This meant they missed out on activities outside of the ward environment. We saw this impacted on people's wellbeing and staff told us this could impact on their recovery and discharge.

Are services for people with learning disabilities or autism effective? (for example, treatment is effective)

Evidence-based clinical guidance, standards and best practice

All records we saw included a detailed health plan so staff knew how to support people to meet their physical and mental health needs. People had regular health checks and were supported by staff where needed, to attend health appointments.

Records were not always clear in how to guide staff how to offer and provide care in a consistent way. In one person's record there had been an incident where they had been restrained in the prone position and staff told us this was the person's preferred position if they needed to be restrained. There was no record in their care plan that stated this. Permanent staff spoken with knew this was the preferred position. However, there were regular bank and agency staff who worked on the wards who had not received this information.

Demonstrate collaborative multi-disciplinary working across all services

We saw care plans were in an easy to read format. One person read through their care plan with us. This showed they understood it and it was written in a way they could understand. Care plans showed the team of professionals worked together to ensure they were effective in meeting people's needs.

Services for people with learning disabilities or autism

Quality of care measured and managed/Suitably qualified and competent staff

We saw one person had complex medical needs and staff told us they had received the specialist training to be able to support the person ensuring their safety and wellbeing.

Adhere with the Mental Health Act and have regard to the Code of Practice

Two people's records were unclear as to whether or not the person had the mental capacity to consent to their treatment. One person had not agreed to, or signed, their consent form but it stated they had the mental capacity to do so. We found there was nothing to say in their records why they had not signed and when we spoke to the ward manager they were not aware why they had not signed.

Are services for people with learning disabilities or autism caring?

Is there choice and are people enabled to participate

We saw that a meeting with an independent advocate took place on the first day of our inspection. Staff and people spoken with told us that this had not been regular as the advocate had not been contracted by the trust to provide regular advocacy support. An advocate would meet with people, listen to what they had to say and communicate their views to staff and to the trust to ensure the person's view was heard.

People participate in a review of needs/Staff communicate effectively

All people we spoke to told us that staff treated them well. Two relatives told us their relative was well cared for and staff were caring. Throughout our inspection we observed that staff treated people with respect, and interacted with them in the way they preferred, so that people were communicated with to ensure their wellbeing.

People receive the support they need

Staff told us, and we observed that they spent time with people to ensure they understood their care and treatment. One staff member told us that they were flexible in their working hours to ensure people saw them and received treatment when they needed it.

Privacy and dignity respected

Staff spoken with were aware of the need to offer single sex accommodation to people but this was not always

possible. For example, there were six male and three female persons on the ward at the time of our inspection. However, staff told us how they tried to accommodate this as much as possible to ensure people's dignity and privacy.

Are services for people with learning disabilities or autism responsive to people's needs? (for example, to feedback?)

Individual needs met

We saw that staffing levels were adjusted so people were observed as needed to ensure their safety and wellbeing.

Staff told us how they had developed a communication aid to enable a person to communicate their needs and ensure their health and wellbeing.

People told us they did not like the food provided and it did not offer them choice. One person told us that they had eaten food that did not respect their cultural background as there was no other choice offered. They told us they had not passed on this comment.

Providers work together during periods of transition

We saw in records and staff told us that they worked well with other providers, which meant people had the support they needed to ensure when they were discharged from hospital their needs would be met. We saw that staff from a new provider visited a person on the ward to complete an assessment of the person's needs. Staff spent time with the provider and the person to ensure they had the information they needed. Staff told us that sometimes when a person moved to a new placement, after discharge, they would support the person there and work with staff to ensure a smooth transition.

Provider acts on and learns from concerns and complaints

Staff spoken with told us about an incident the previous year which resulted in a person being put at risk of harm. They told us that appropriate action had been taken as a result and they had been well supported. They said that the situation had been handled well to ensure people's safety and wellbeing.

Services for people with learning disabilities or autism

Are services for people with learning disabilities or autism well-led?

The governance framework is coherent, complete, clear, well understood and functioning

Staff told us, and we saw how, they had involved people in the vision of the ward so they were clear as to the purpose of the ward and what people experienced there. We saw that the independent advocate had asked people for their

views about the ward in the meeting on the first day of our inspection. The ward manager told us that they would look at these to assess where needed improvements could be made.

Leadership within the organisation is effective, maintained and developed

Staff told us that they had received an excellent rating from the Accreditation for Inpatient Mental Health Services for Adults with Learning Disabilities (AIMS- LD). Staff recognised however, that although they had achieved this rating, they needed to maintain the service provided to benefit the people who used it.

Community-based crisis services

Information about the service

The Crisis service was based at Swanswell point in Coventry. The service responds to urgent psychiatric referrals and provides home treatment care. The service is the first point of referral into mental health services and everyone has to be assessed by this team before accessing admission to the Caludon centre.

Summary of findings

This service was responsive to the needs of the people using it. People were seen up to four times each day for both medication management and psychological support while at home. The team planned in detail the type of intervention needed during each visit and fed back to the team at the next handover.

Community-based crisis services

Are community-based crisis services safe?

We found the crisis team provided home treatment and a responsive service to a large number of people in the Coventry area. People referred to the service always received a full assessment with one of five different outcomes; such as referral to a community mental health team (CMHT), referral back to the GP, admission to acute wards or managed through home treatment.

Risk assessments were properly completed but not signed by staff or the people using the service. Care plans were not used in the service although we were told the need for them has been recognised. The team have daily hand over detailing interventions with patients and highlighting any risk to patients.

Are community-based crisis services effective? (for example, treatment is effective)

We saw the crisis team provided an evidenced based service. People were supported for up to six weeks through a mixture of medication management and psychological interventions. The service used a survey to gain insight into the service provided and the results were regularly reviewed and used to help improve the service.

Are community-based crisis services caring?

The service provided regularly reviews its interventions and ensures it treats patients with dignity and respect. At each handover people were discussed and the type of support that was needed for the next visit agreed.

Are community-based crisis services responsive to people's needs? (for example, to feedback?)

The service provided regularly reviews its interventions and ensures it treats patients with dignity and respect. The service is entirely responsive to the needs of its patients and families. In agreement with the patient visits are arranged and carried out up to four times during the day and an on-call service is available for patients to contact in times of crisis.

At each handover people were discussed and the type of support that was needed for the next visit agreed.

Are community-based crisis services well-led?

We found that the crisis team manager took an active role in the day to day operations of the team and they were visible and accessible to their staff. They were knowledgeable about their patients and the challenges they face on a day to day basis.

Some staff we spoke to said they regularly saw the manager and received excellent support.

We saw that the consultant psychiatrist had an active presence in the team with regular review meetings held with the crisis team in attendance.

Other specialist services

Information about the service

Outpatient clinics were run across Coventry and Warwickshire. The aim is that they are close to the community they serve. Referrals are made via the Single Point of Entry service.

We visited the outpatient department for adults, older people and people with a learning disability on 22 January 2014. A schedule showed 12 doctors offering 80 people appointments, not including appointments for people with a learning disability.

We observed outpatients appointments and gave people and staff the opportunity to talk to us before or after appointments. We spoke with four people using the service, two carers and six staff.

Summary of findings

We found that the Caludon Centre was providing a specific service reviewing the needs of people living in the community. The outpatient department in the hospital provided safe and effective care. They had sufficient numbers of competent staff in place to meet people's needs.

Staff demonstrated a caring approach and people spoke positively about the care they received. We saw staff delivering compassionate care. Care was planned and based on people's individual needs. The service was responsive to feedback.

Other specialist services

Are other specialist services safe?

Learning from incidents

Staff detailed procedures to report any low level and serious incidents and for these to be reported to relevant staff /agencies, investigated and reviewed to prevent a reoccurrence. An example was given when staff referred to a decrease in people's falls after considering transport. We had some feedback from administration staff that there was not always discussion with managers after an incident. A doctor reported that there was little "joint learning" from other areas regarding incidents.

Safeguarding People

Systems were in place to ensure a safe environment for people and staff. Staff had access to alarms and staff support in the event of any emergency. Staff explained how they would manage if a person became distressed or upset.

Staff we spoke with had access to safeguarding adults training. An identified safeguarding lead was contactable for advice and information. Staff advised they were aware of the need to report abuse. We saw there were policies and procedures for staff to report any safeguarding concerns.

During our visit we found that one person was identified as being in a possible abusive situation. Staff had discussed with the person their potential financial vulnerability and whether they needed support to manage their affairs.

Risk Management

We observed that doctors undertook assessments with people which considered risks with reference to their age and capacity to understand. They encouraged people to identify areas of concern such as side effects, allergies to medication, risk of self-harm and neglect. Their current and past mental health and physical health was considered. During one interview with an older person the person's compliance with medication was not fully explored. This is important as inconsistent use of medicines may adversely affect people's health.

Staff gave examples of carrying out risk assessments before and after appointments to determine how urgent an

appointment was needed or if action was needed when people failed to attend appointments. Doctors would request additional support from colleagues for home visits if there were risk concerns.

Safe Staffing

Systems were in place to determine the number of staff required for outpatient's appointments. Staff reported a manageable workload. Most doctors reported feeling supported. One doctor in the older person's service reported that due to a colleague being on long term sick leave they were occasionally contacted to attend the ward to deal with an emergency and appointments would need rescheduling/cancellation. Another general adult doctor reported that several Consultant Psychiatrists were leaving the trust for reasons unknown and some doctors felt "isolated". People did not give us any feedback relating to difficulty accessing doctors. We saw the trust had systems in place to monitor and ensure adequate staffing.

Are other specialist services effective? (for example, treatment is effective)

Multi-disciplinary working

We found that doctors coordinated care and treatment needs for people's physical and mental health and ensured people, and staff, were kept informed. Systems were in place to liaise with external professionals and agencies, such as GPs and community care coordinators, keeping them updated on issues discussed. Specialist services such as physiotherapy, occupational therapy, dietetics, blood testing clinics as required could be contacted and accessed. Contact was made with the Driver Vehicle Licensing Authority (DVLA) where risks to people's driving safety were identified. Communication took place with Multi Agency Public Protection Arrangements (MAPPA) where people who had a forensic history posed a risk of harm.

A doctor advised they had some difficulty with interpreting services and had to rely on family to interpret. However we saw that the trust had systems in place to request interpreters in person and by telephone.

Measuring quality

We received a number of documents for the trust with high level data. However this did not include information on outpatient's service, such as the time taken to schedule outpatient's appointments after cancellation, and waiting

Other specialist services

times. The trust had a system for carrying out a range of audits such as monitoring health and safety in the service. Also they checked on staff access to training, supervision and appraisals to ensure they were competent for their role.

Systems were in place for people using the service, staff and others to give feedback on the quality of care, such as reviews and suggestion boxes. These were reviewed and actions taken for issues identified. Additionally the trust's website gave access to independent sites for people to give feedback such as patient opinion and NHS choices. When issues were raised by people across the service, feedback was shown via notice boards in a 'You said.... we did...' style.

Supporting Workers

There were systems in place to ensure staff had training and support as relevant to their role such as risk assessment and care planning. Most staff we talked to reported feeling supported in their work, especially in their teams, and all staff said their manager/supervisor was accessible for advice and guidance as required. Some areas, such as administration, advised team meetings did not take place but there was daily communication within the team about key issues, through informal supervision.

Are other specialist services caring?

Person-Centred care

We observed staff treated people with care, dignity and respect. Doctors held person centred discussions with people and communicated in a way they could understand. They gave people time to express themselves. People had opportunities to make choices about care and treatment and discuss issues that were important to them. We saw doctors checked with people their understanding of their mental health and also assessed their physical health considering issues such as their sleeping pattern and daily activities. People could discuss the effects of medication and request adjustments. Explanations were given about any tests proposed or received. A person told us, "I am content with my care." Carers were given opportunities to ask questions relating to people's care and treatment.

Are other specialist services responsive to people's needs? (for example, to feedback?)

Meeting individual needs

We observed doctors assessing people at different stages of engagement with mental health services such as at initial referral and then reviewing previous care and treatment. People had opportunities to give feedback on their changing needs at appointments. For example one person talked with their doctor regarding how the medication was not helping them and the doctor responded to their concerns. This evidenced staff responding to actions identified for the trust's 2013 National Community Mental Health Service User Results: 'Medication Related Questions' actions.

We saw people were consulted about the timing between appointments and doctors gave details of appointment times. People told us that the length of appointment was suitable for them and they felt able to take part in decision making. Some people commented that if appointments were cancelled they had to wait several months before the next. We were not able to access data to check this.

We saw that a range of information relating to self-help and advocacy was available to people in the waiting area. One person told us they had expected more information and discussion about services available to them. We noted that the person's situation was still being assessed and therefore it may not have been appropriate to advise on services at that time.

Transition to other services

Systems were in place to liaise with external professionals and agencies, such as GPs and community care coordinators, keeping them updated on issues discussed. After discussions about medication changes, updated prescription sheets were copied to the GP and pharmacist to keep them informed and updated on people's progress. One doctor told us there were sometimes difficulties on being updated on a person's situation when people were admitted to hospital for treatment and referred to how they liaised with the crisis team who then became the main contact for communication.

Other specialist services

Learning from concerns and complaints

We found there was information displayed for people to give feedback to the trust on the service such as complaints leaflets. An 'Annual Complaints Compliments and PALs' (Patient Advice and Liaison Service) Report summarised themes raised in relation to the complaints systems, learning from complaints and any areas for improvement. Reception staff gave examples of supporting people to give feedback such as ensuring they had complaints forms to give to people and contacting senior managers if a matter needed dealing with immediately. A further example of staff responding to people's needs was when a person raised they were worried about a relative's mental health, who also used services, and the doctor agreed to contact them. This showed that staff considered the impact of the person worrying and also considered the potential risk to the other person.

Are other specialist services well-led?

Some staff reported receiving emails from the trust's executive team giving information and updates of changes taking place in the trust. One staff member told us they

received the trust's vision by email but there was no opportunity for participation and engagement. Some doctors reported that they took part in audits in the service to ensure quality assurance.

Staff feedback systems

One staff member gave feedback that sometimes changes took a long time such as ensuring, e.g. baby changing facilities were available in the waiting area, which had been requested and awaited. A doctor told us that several doctors had given feedback to managers raising concern about people being admitted to hospital with limited paperwork and information about the person. But it still continued and they were unsure if actions were being taken.

Leadership

Staff reported clear lines of accountability and staff knowing who to report to. They told us they had regular contact with their immediate managers, however reported they did not have face to face contact with higher level board members. One staff member told us board members were seen "once in a blue moon." Another told us the trust was a "less well managed NHS organisation" compared to another place they had worked but did not expand on this.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HCSA 2008 (Regulated Activities)
Treatment of disease, disorder or injury	The registered provider was failing to protect patients against the risks associated with the unsafe use and management of medicines. Regulation 13

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 20 HCSA 2008 (Regulated Activities)
Treatment of disease, disorder or injury	People who use services were at risk of unsafe or inappropriate care and treatment from a lack of proper information about them and the safe keeping of their information. Regulation 20.(1) (a) (b) (i)(2)(a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HCSA 2008 (Regulated Activities)
Treatment of disease, disorder or injury	The registered person had not as reasonably practicable made suitable arrangements to ensure the dignity, privacy and independence of service users. Regulation 17(1) (a)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 23 HCSA 2008 (Regulated Activities)
Treatment of disease, disorder or injury	The registered person did not have suitable arrangements in place to ensure that staff were

This section is primarily information for the provider

Compliance actions

appropriately supported to enable them to deliver care and treatment to service users and to an appropriate standard, by receiving appropriate training, professional development, supervision and appraisal

Regulation 23. (1)(a)

This section is primarily information for the provider

Enforcement 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	<p>Regulation 9 HCSA 2008 (Regulated Activities)</p> <p>The registered person did not take proper steps to ensure that each service user was protected against the risk of receiving care or treatment that was inappropriate or unsafe.</p> <p>Regulation 9. (1)</p>