Black Country Healthcare NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the services

We received a number of notifications relating to the acute inpatient mental health services for adults. These related to the quality of care, staff attitudes and engagement with patients.

Due to the nature of the notifications we decided to visit two locations within the service. These were Hallam Street Hospital and Bushey Fields Hospital. Whilst there we visited 5 wards. The wards we visited were Abbey, Friar and Charlemont wards at Hallam Street Hospital and Wrekin and Clee wards at Bushey Fields Hospital

We did not rate this service at this inspection. The previous rating of requires improvement remains

Staff had completed and regularly updated risk assessments of all wards areas. however the trust had not removed or reduced any risks they identified. The trust used regular bank and agency staff to fill shortfalls in staffing. Staff had not completed risk assessments for each patient on admission / arrival, using a recognised tool. When staff had completed a risk assessment, they had not always reviewed this regularly, including after any incident. Risk assessments were not always completed in the electronic record. Patient notes were not comprehensive. All full time staff could access information easily but bank and agency staff were unable to access the electronic patient record. Staff had not always completed a comprehensive mental health assessment of each patient on admission or soon after. We found examples where mental health risk assessments had been used from previous admissions. Patients had not had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Staff had not always developed comprehensive care plans for each patient that met their mental and physical health needs. Care plans were not always personalised, holistic and recovery-orientated. Staff had not always explained to each patient their rights under the Mental Health Act in a way that they could understand. Informal patients had had restrictions applied to them preventing them from leaving the wards unsupervised. Staff did not always support patients to understand and manage their own care treatment or condition. Patients said there was a difference in the support that they received from the day staff and the night staff. Patients said that night staff were not as caring as day staff and did not offer the same level of support. Staff did not always understand and respect the individual needs of each patient. Staff did not always involve patients or give them access to their care planning and risk assessments. Some staff told us that they were less sure of the organisations visions and values since the trust merged twelve months ago. Governance processes did not always operate effectively at team level and performance and risk were not always managed well. The introduction of the electronic recording system had been problematic. Staff did not collect or analyze data about outcomes and performance in all areas.

We had significant concerns about the care and safety of people using the service and wrote to trust under section 31 Health and Care Act 2014. We asked the trust to provide an action plan detailing how they had addressed each of the concerns identified or how they planned to address immediately. The trust responded with a robust action plan detailing action they had and were taking to deal with all of the concerns we had identified.

How we carried out the inspection

Our findings

During the inspection we undertook five ward tours and clinic checks, we also looked at communal dining and therapy areas.

We spoke with nine patients and five carers to discuss their experiences.

We interviewed two service managers, a discharge coordinator, four ward managers, a modern matron, seven qualified nurses, seven health care assistants, two doctors, one occupational therapist, two student nurses, a house keeper and a ward administrator.

We attended one ward review. We also reviewed 9 sets of patients notes, incident forms from across all five wards, ligature risk assessments from both locations, audit paperwork and assorted policy documents.

Is the service safe?

Inspected but not rated

Safe and clean care environments

All wards were clean well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff had completed and regularly updated risk assessments of all wards areas. however the trust had not removed or reduced any risks they identified. We found ligature risks on all wards we visited identified in ligature risk assessments that had not been mitigated and the trust had not undertaken identified work to remove the risk and replace furniture, fixtures and fittings with anti-ligature alternatives.

Staff could observe patients in all parts of the wards.

The ward complied with guidance on mixed sex accommodation.

There were potential ligature anchor points in the service. Staff knew about any potential ligature anchor points but had not mitigated the risks to keep patients safe.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained and well furnished. .

Staff made sure cleaning records were up-to-date and the premises were clean.

Staff followed infection control policy, including handwashing.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly.

Our findings

Staff checked, maintained, and cleaned equipment.

Safe staffing

The service had high nursing vacancies and enough medical staff. Staff knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service did not have enough nursing and support staff to fill all shifts. The trust used regular bank and agency staff to fill shortfalls

The service had high vacancy rates. we were told that the trust was in the process of recruitment but that applications were low.

The service had high rates of bank and agency nurse and nursing assistant usage. the trust mitigated this by, wherever possible, using regular bank and agency workers who had good knowledge of the service and service users.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift.

Managers supported staff who needed time off for ill health.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. We looked at rotas on all the wards we visited and found that the correct number of staff per shift had been available.

The ward manager could adjust staffing levels according to the needs of the patients.

Patients had regular one to one sessions with their named nurse.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Staff had completed and kept up-to-date with their mandatory training.

The mandatory training programme was comprehensive and met the needs of patients and staff.

Our findings

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed ongoing risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

We examined incident forms which demonstrated that least restrictive options had been considered and used wherever possible.

Assessment of patient risk

The trust used a recognised risk assessment tool, however staff had not completed risk assessments for each patient on admission / arrival, using a recognised tool. When staff had completed a risk assessment, they had not always reviewed this regularly, including after any incident.

Management of patient risk

Staff did not always know about any risks to each patient. Bank and agency staff could not easily access the electronic recording system and risk assessments were not always completed in the electronic record. Because of this there was a possibility that they could not always act to prevent or reduce risks.

Staff could observe patients in all areas or could follow procedures to minimise risks where they could not easily observe patients.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

Staff understood the Mental Capacity Act definition of restraint and worked within it.

Staff followed NICE guidance when using rapid tranquilisation.

When a patient was placed in seclusion, staff kept clear records and followed best practice guidelines.

Staff followed best practice, including guidance in the Mental Health Act Code of Practice, if a patient was put in long-term segregation.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Our findings

Staff received training on how to recognise and report abuse, appropriate for their role.

Staff kept up-to-date with their safeguarding training.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Managers took part in serious case reviews and made changes based on the outcomes.

Staff access to essential information

Patient notes were not comprehensive. We found that all notes that we checked had sections missing or information stored in the incorrect section. All full time staff could access information easily but bank and agency staff were unable to access the electronic patient record. In order to make entries in patients records, bank and agency staff had to ask a full time member of staff to log on for them.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medication on their physical health according to NICE guidance.

Our findings

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff reported serious incidents clearly and in line with trust policy.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

We issued a section 31 letter of intent to the trust asking them to urgently provide an action plan, setting out how they had addressed the concerns, or how they intend to address the concerns as soon as possible. The trust responded immediately with an action plan detailing how they were dealing with the concerns.

Is the service effective?

Inspected but not rated

Assessment of needs and planning of care

Staff did not always assess the physical and mental health of all patients on admission. Care plans were not regularly reviewed and updated as needed. Care plans did not reflect patients' assessed needs, and were not personalised, holistic and recovery-oriented.

Staff had not always completed a comprehensive mental health assessment of each patient on admission or soon after. We found examples where mental health risk assessments had been used from previous admissions. We also found examples where risk assessments had not been undertaken for extended periods after admission.

Patients had not had their physical health assessed soon after admission and regularly reviewed during their time on the ward. We found examples where information relating to pre-existing health conditions had not been included as part of ongoing risk assessments and care plans.

Our findings

Staff had not always developed comprehensive care plans for each patient that met their mental and physical health needs. We saw examples where conditions had not been care planned and information relating to these conditions was scarce or missing.

Staff had not regularly reviewed and updated care plans in all cases when patients' needs changed.

Care plans were not always personalised, holistic and recovery-orientated. we found examples of care plans that were generic and had not been written in consultation with the patient.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They did not ensure that patients had good access to physical healthcare or supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They had not participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service.

Staff delivered care in line with best practice and national guidance. (from relevant bodies eg NICE)

Staff had not always identified patients' physical health needs and recorded them in their care plans. We saw examples where pre-existing conditions had not been included in care plans.

Staff made sure patients had access to physical health care, including specialists as required.

Staff met patients' dietary needs, and assessed those needing specialist care for nutrition and hydration.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes.

Staff used technology to support patients, though bank and agency staff did not have access to the electronic recording system unless they were logged on by a substantive member of staff.

Staff had not taken part in clinical audits, benchmarking and quality improvement initiatives.

Managers used results from audits to make improvements.

Skilled staff to deliver care

The ward team(s) included or had access to the full range of specialists required to meet the needs of patients on the ward(s). Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had (access to) a full range of specialists to meet the needs of the patients on the ward.

Our findings

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work.

Managers supported staff through regular, constructive appraisals of their work.

Managers supported permanent non-medical staff to develop through yearly, constructive appraisals of their work.

Managers supported permanent medical staff to develop through yearly, constructive appraisals of their work.

Managers supported non-medical staff through regular, constructive clinical supervision of their work.

Managers supported medical staff through regular, constructive clinical supervision of their work.

Managers made sure staff attended regular team meetings or gave information from those they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role.

Managers recognised poor performance, could identify the reasons and dealt with these.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward team(s) had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings.

Ward teams had effective working relationships with other teams in the organisation.

Ward teams had effective working relationships with external teams and organisations.

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

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers did not ensure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice.

Our findings

Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy but we could not establish if patients who lacked capacity were automatically referred to the service.

Staff had not always explained to each patient their rights under the Mental Health Act in a way that they could understand, in the case of refusal or patients being unable to complete the process, this had not been repeated as necessary or recorded clearly in the patient's notes.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician and/or with the Ministry of Justice.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients did not always know that they could leave the ward freely. Though the service displayed posters to tell them this, we found examples where informal patients had had restrictions applied to them preventing them from leaving the wards unsupervised.

Managers and staff had not made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings. We requested information relating to care programme audits but the trust was unable to supply these.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Our findings

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

We issued a section 31 letter of intent to the trust asking them to urgently provide an action plan, setting out how they had addressed the above concerns, or how they intend to address the concerns as soon as possible. The trust responded immediately with a robust action plan detailing how they were dealing with the concerns.

Is the service caring?

Inspected but not rated

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They did not understand the individual needs of patients and did not always support patients to understand and manage their care, treatment or condition.

We saw that staff were discreet, respectful, and responsive when caring for patients.

Staff gave patients help, emotional support and advice when they needed it.

Staff did not always support patients to understand and manage their own care treatment or condition. We found examples where patients had not had their rights under the Mental Health Act explained to them and had not been provided with copies of their care plans.

Staff directed patients to other services and supported them to access those services if they needed help.

Patients said staff, for the most part, treated them well and behaved kindly, however we were told that there was a difference in the support that they received from the day staff and the night staff. Patients said that night staff were not as caring as day staff and did not offer the same level of support.

Staff did not always understand and respect the individual needs of each patient. We found examples where staff were not aware of some specific needs and were not able to relay these to inspectors.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed policy to keep patient information confidential.

Our findings

Involvement in care

Staff did not always involve patients in care planning and risk assessment. Staff actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission.

Staff did not always involved patients or give them access to their care planning and risk assessments. Patients told us that they had not been offered copies of their care plans and, in some cases, did not know what was in them.

Staff did not always make sure patients understood their care and treatment.

Staff involved patients in decisions about the service, when appropriate.

Patients could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported, informed and involved families or carers by including them in ward reviews and ensuring they were able to share their views on treatment and progress.

Staff helped families to give feedback on the service through the ward reviews meetings.

Staff gave carers information on how to find the carer's assessment.

We shared our concerns with the trust in a letter of intent and they responded with a robust action plan telling us how they were addressing those concerns.

Is the service well-led?

Inspected but not rated

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff.

Vision and strategy

Some staff knew and understood the provider's vision and values and how they applied to the work of their team. Some staff told us that they were less sure of the organisations visions and values since the trust merged twelve months ago. Some staff stated that senior leaders were less accessible and visible than prior to the merger.

Our findings

Culture
Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Governance
Our findings from the other key questions demonstrated that governance processes did not always operate effectively at team level and that performance and risk were not always managed well. The introduction of the electronic recording system had been problematic.

Management of risk, issues and performance
Teams had access to the information they needed to provide safe and effective care and used that information to good effect. However, temporary, agency and bank staff did not have access to the electronic systems which meant that they could not always access the information they needed quickly

Information management
Staff did not collect or analyze data about outcomes and performance in all areas. we found that audits of care planning and risk assessments had not been undertaken. The trust engaged actively in local and national quality improvement activities.

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Our findings

Areas for improvement

- The trust must ensure that risks to the health and safety of service users are assessed and do all that is possible to mitigate those risks.
- The trust must ensure the premises used for service users are safe, free of potential risks or have mitigation in place to reduce those risks.
- The trust must ensure that all staff involved in patient care and treatment have access to the electronic patient record system.
- The trust must ensure that patient care plans are personalised, holistic and recovery orientated.
- The trust must ensure that its staff explain to patients their rights under the mental health act in a way that they could understand.

Our inspection team

The inspection was led by One inspector, an inspector, an Inspection manager and a Mental Health Act inspector undertook monitoring onsite.

Two inspectors undertook interviews and document reviews remotely.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 12 CQC (Registration) Regulations 2009 Statement of purpose