Birmingham and Solihull Mental Health NHS Foundation Trust

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

Quality Report

Caffra Suite
Oleaster
6 Mindelsohn Crescent
Edgbaston
Birmingham
B15 2SY
Tel: 0121 301 2200
Website: www.bsmhft.nhs.uk

Date of inspection visit: 6 September 2018
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXT1		Caffra Suite	B15

This report describes our judgement of the quality of care provided within this core service by Birmingham and Solihull Mental Health NHS Foundation Trust . Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Birmingham and Solihull Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Birmingham and Solihull Mental Health NHS Foundation Trust .

Summary of findings

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards

We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We found the following issues that the trust needs to improve:

Staff were concerned that twice in August 2018, two patients had been admitted above the agreed patient numbers. This had led to two patients sleeping in the seclusion room after they no longer needed seclusion. There were no other beds available. This could compromise a patients' dignity and privacy.

Staff expressed concerns about staffing levels and low staff morale. They said that it sometimes impacted upon patient leave being rearranged and their ability to take breaks. We found that the day time staff fill rate was consistently below 100% in the two months prior to inspection. Managers told us they tried to fill the gaps in the staffing rota when they could, but these staff were not always available.

We did not find that the procedures for personal alarms was robust. Staff told us permanent staff took their alarms home with them and any spares on the ward were distributed to bank and agency staff. If staff forgot to bring their alarms to work, there would be less available to bank/ agency staff and visitors. Staff were not aware that there were spare alarms kept on reception at the Oleaster Unit.

However,

On this focussed inspection we found that the staff were open and transparent. They were caring towards the patients and wanted to support them as best they could.

Staff completed incident forms to raise concerns about patients numbers and staffing levels. We saw that managers had kept in touch with the ward during periods where patient numbers were above agreed amount.

We saw that staff kept up to date care records. Patients had up to date risk assessment and management plans in place assessments.

The ward had a barber's chair and one of the ward staff had sourced the chair, specialist shaving, and hair dressing equipment themselves. The ward was planning to convert the unused bathroom on the ward into a mini-barbers shop.

Summary of findings

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

Are services safe?

- We saw from data that staffing levels during the day were often below the agreed staffing levels. This was due to vacancy rates and staff absences. Managers filled shifts where they could with bank and agency staff, however, they were not always available. Staff told us they were short staffed at times and this affected their ability to take breaks, their morale and occasionally affected their ability to take patients on leave.
- Three months prior to the inspection the ward had 419 unfilled shifts.
- Staff did not have access to personal alarms for our use on inspection.

However

- The ward environments were free of blind spots and staff could observe all areas.
- Staff were aware of any potential ligature risks and had undertaken actions to lessen these risks.

Are services responsive to people's needs?

We found

- The provider had admitted patients above the commissioned numbers twice in August 2018. This was due to a national bed shortage.
- On two occasions in August 2018, two patients who no longer needed seclusion had to remain in seclusion, with access to the rest of the ward, due to a lack of psychiatric intensive care beds.

Summary of findings

Information about the service

Caffra psychiatric intensive care unit is at the Oleaster centre. It is one of three psychiatric intensive care units for adults of working age provided by Birmingham and Solihull Mental Health NHS Foundation Trust.

Caffra provides 10 male beds for patients needing psychiatric intensive care.

The Caffra Suite takes referrals from and undertakes assessments for other similar services, as well as accepting admissions from other Psychiatric Intensive Care Unit (PICU) wards and acute wards. The ward gave advice and guidance on the care and support for patients within acute wards.

The CQC last inspected Caffra suite as part of a scheduled comprehensive inspection March 2017. The overall rating for the Acute wards and Psychiatric intensive care units was requires improvement. The core service was rated as good in caring, responsive and well led and requires improvement in safe and effective domains.

Caffra suite had an unannounced Mental Health Act review 10 July 2018. On that day the ward was providing care with one nurse less than the set staffing level. Patients were positive about the ward. The provider had completed an action plan in response to issues highlighted by the Mental Health Act review.

Our inspection team

The team that inspected the service included one CQC inspector and one CQC assistant inspector.

Why we carried out this inspection

We inspected Caffra Suite because we received information giving us concerns about the safety and quality of these services.

The CQC received information that the trust was admitting patients above commissioned patient numbers and that staffing levels were unsafe.

We carried out a focussed inspection of the safe and responsive areas to investigate concerns raised.

We did not rate this ward as it was a focussed inspection looking at Safe and Responsive domains only.

How we carried out this inspection

On the day of the unannounced inspection the ward staffing levels were initially below establishment numbers and there was one patient in seclusion due to an assault on a staff member during the night shift.

On the day of inspection, the ward had 10 patients, all of whom were detained under the Mental Health Act.

During the inspection visit, the inspection team:

- visited the Caffra Suite at the hospital, looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with one patient who was using the service
- spoke with the clinical nurse manager for the Oleaster and deputy ward manager for Caffra Suite
- spoke with three other nursing staff members
- spoke with an independent advocate
- looked at two care and treatment records of patients
- looked at staffing rotas and trust staffing levels.

Summary of findings

What people who use the provider's services say

One patient told us that the staff worked hard but there was not enough permanent staff available on the ward. They felt that agency/ bank staff were not always as familiar with care plans and permanent staff. They felt that there was a lack of activities on offer and they could not always access occupational therapy.

Patients were positive about the service they received.

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve

- The provider must ensure that there are adequate staffing levels to meet the needs of patients and ensure staff have access to breaks during their shifts

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The provider should ensure that patients are not admitted above the ward bed numbers.
- The provider should ensure that patients privacy and dignity are maintained and are only nursed in seclusion when clinically needed.
- The provider should ensure that staff are aware of systems in place to ensure adequate provision of personal alarms for staff and visitors to the ward.

Birmingham and Solihull Mental Health NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
The Caffra Suite	The Barberry

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

Caffra suite had no blind spots and staff could observe all areas. Staff had identified ligature points as part of an environmental risk assessment and were aware of actions to take to lessen the risks of these points.

At the time of inspection, the ward followed national guidance on same sex accommodation. However, staff told us that they occasionally had female patients admitted to the seclusion room. Staff told us at those times, staff from the female wards would be based on the wards to monitor the patient whilst in seclusion.

The seclusion room allowed for clear observation, two-way communication and had a toilet and a clock.

Staff kept the ward visibly clean and well maintained.

Staff did not offer inspectors personal alarms prior to entering the ward. When we asked for an alarm, staff said there was none available. Staff had distributed all spare to agency/ bank staff and visitors to ward. Staff told us all permanent staff have their own alarm which they take home with them. This was not safe practice and would not ensure that there was adequate provision of alarms on a daily basis. We raised this with managers who informed us that spare alarms were available on the reception of the Oleaster unit. However, on inspection, ward based staff were not aware of this.

Safe staffing

The staffing establishment for the ward was three qualified staff and three unqualified staff per day and two qualified per shift. Three shifts staffed the ward in 24 hours.

At the time of inspection there was one 0.8 whole time equivalent band 6 occupational therapist vacancy, six band 5 registered qualified nurse vacancies and four band three health care support worker vacancies. The manager told us the ward had three band 5 nursing staff and one health care support worker due to start within the next month.

At the time of inspection four substantive staff, three of which were qualified nurses were on long term sick leave.

Staff we spoke to said that there were high levels of work related stress.

The ward manager could book bank and agency staff where possible. However, managers told us, that bank/ agency staff were not always available. We saw that there was agency and bank staff used to fill gaps in the rota. However, there were occasions when the ward was under agreed establishment levels. The three months prior to inspection, the ward had 419 unfilled shifts. Bank and agency staff filled 2789 shifts in the three months prior to inspection. Information shared by the trust confirmed that they did not always meet agreed staffing levels. Data showed the average day time shift fill rate for qualified registered staff was 96.7% and for the night shifts it was 106%. For unqualified staff the day time shift fill rate was 92.5% and for nights 105%.

On the day of the inspection, the early shift had one registered nurse and three health care assistants at the beginning of the shift due to last minute staff absence. The trust had recruited three registered nursing staff in the last three months to oversee staffing levels across all core service wards. They worked as capacity utilisation nurses and support ward managers to fill gaps in staffing levels.

Staff told us they were a supportive team but recognised that working with very unwell patients, when staffing was short and patients admitted above agreed numbers, was difficult. They said it affected upon their wellbeing as it was difficult to always take proper breaks and caused low morale amongst the team. They said they managed to provide patients with one to one times, but they had to rearrange section 17 leave at times, if there were not enough staff on duty.

The ward had a psychiatrist who gave psychiatric input for all patients and was the responsible clinician (RC) for detained patients. The responsible clinician had support from a registrar.

Assessing and managing risk to patients and staff

We reviewed two patient care and treatment records. Both had comprehensive risk assessment and management plans in place. Staff updated risk assessments as needed and in a timely manner.

Are services safe?

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

Staff kept correct records for patients detained in seclusion and held seclusion reviews.

We reviewed the care records of the two patients admitted directly into seclusion from community urgent care bases or a health based place of safety. Both records showed that the patients needed seclusion on admission. Records showed that staff undertook seclusion reviews. However, when it had been identified that the patient no longer needed seclusion, there were no beds on the ward for the patient to move into. Staff informed the patients of this and they were nursed with the seclusion door open and allowed access to the main areas of the ward. Records showed that staff sought to move patients from seclusion as soon as there was a bed available.

Reporting incidents and learning from when things go wrong

Staff we spoke with were aware of what and how to report incidents.

Staff had completed incident forms for each time patient numbers were above the commissioned amount of beds.

Are services responsive to people's needs?

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

Our findings

Access and discharge

On inspection, staff said that two patients had been admitted to the ward above the commissioned numbers of patients. Staff had assessed that the patients needed to be admitted a psychiatric intensive care unit bed and had needed seclusion. Due to national bed shortages and assessed level of need, both patients were admitted straight into seclusion. This meant patient numbers for the ward were above agreed levels.

Both patients had no access to beds on the ward following a termination of seclusion. Staff and records confirmed that the patients bed stayed in the seclusion area but doors were open, so the patients could access the ward area.

We saw from records and staff told us, staff had looked for psychiatric intensive care beds within the Merit vanguard region and nationally. The Merit vanguard is a group of neighbouring NHS Trusts that work together to reduce the number of out of area inpatient admissions. Senior managers agreed that the detained patients should be admitted into the seclusion suite, above ward numbers as they were no beds available elsewhere.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The Trust did not ensure that staffing levels were adequate to meet the needs of the patients and staff. This was a breach of regulation 18.