Dudley and Walsall Mental Health Partnership NHS Trust

Bushey Fields Hospital

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Clent
Core service provided: Acute admission ward

Male/female/mixed: male

Capacity: 22

Kinver
Core service provided: Acute admission ward

Male/female/mixed: female

Capacity: 20

Wrekin
Core service provided: Acute admission ward

Male/female/mixed: mixed

Capacity: 16 + 2 bed extra care area

Core service provided: Psychiatric Intensive Care Units and health based places of safety

Male/female/mixed: mixed

Capacity:

Holyrood
Core service provided: Older People

Male/female/mixed: mixed

Capacity: 17

Malvern
Core service provided: Older

Male/female/mixed: mixed

Capacity: 22

Bushey Fields Hospital is in Dudley and offers specialist assessment, care and treatment to adults and who are experiencing mental health difficulties. Bushey Fields Hospital has three acute wards – one male ward (Clent), one female ward (Kinver), and an admission ward (Wrekin). It also has two older people's wards (Holyrood and Malvern).

We found a number of inconsistencies across the different services.

We found that on some wards, staff were not trained to meet the specific needs of the people who use services and this increased the risks to both people using the service and staff.

In the majority of wards there was continuity of care and most staff understood the needs of the people they were caring for. Staff worked with other providers to ensure that transfers and discharges were effective.

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

There was a system for staff to report incidents.

Incident reporting was not completed in a consistent manner and we could not see evidence that the results of local audits were analysed and shared quickly enough within the older people's wards.

On some adult acute wards, we saw examples of learning from audits and incidents being embedded and changes to practice being made as a result.

Some wards were better managed than others and we had concerns about the care environment and treatment on Holyrood ward.

We saw that people were treated with dignity and respect and saw staff and people who use services interacting positively with each other in most wards.

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

Staff were unaware of the future plans for the older people's service.

We saw evidence that people were nursed in isolation in the extra care areas, were prevented from leaving the extra care area and refused contact with other people.

The staff had not recognised that the practices used in the extra care areas may meet the threshold of seclusion, as defined by the Mental Health Act Code of Practice.

Summary of findings

The medicine management team had recently introduced a 'drop-in' session to discuss any medicine issues with patients.

There was good collaborative working regarding physical health needs with the general hospital, which is on the same site.

We saw that the health-based place of safety did not meet the recognised environmental standards.

We saw that the older peoples wards were mixed gender and placed people at risk of receiving care that compromised their dignity.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Mental Health Act responsibilities

We reviewed the detention papers for a number of detained patients across a sample of wards. The detention papers were easily accessible in each file and included the full set of detention papers.Ward staff had a range of measures to address disturbed and aggressive behaviour and manage risk.We saw that there was a separate two-bed extra care area to provide more intensive support for male patients who were acutely mentally unwell across Bushey Fields Hospital. Female patients from Dorothy Pattison Hospital were also occasionally transferred to the extra care area at Bushey Fields.

We saw that people were cared for in the extra care area for relatively short periods of time. Many of the people cared for in the extra care area were transferred to psychiatric intensive care units (PICU) when it became obvious that people required more specialist psychiatric input.We saw evidence that patients were nursed in isolation in the extra care areas, were prevented from leaving the extra care area and refused contact with other patients.Section 17 Leave decisions were generally well recorded with good parameters.

Acute admission wards

Staff were aware of the electronic incident report system and told us that all incidents were recorded in this way.The hospital operated a locked door policy on each of the wards. Leaflets were available on the wards which offered information to people and visitors on this policy.Staff confirmed they received regular safeguarding training and were aware of the procedures for reporting and referring allegations of abuse.Staff told us that the staffing levels were increased when needed. People were on different levels of observation, based on their needs. Staff told us that each person's level of risk was reviewed each day.Risks and risk management were monitored through regular reviews, which were completed at ward level. Risk assessments were comprehensive and contained detailed strategies to reduce risks.People's medicines were continuously reviewed and checked by the medicine management team during their stay. This included checking that when people were detained under the Mental Health Act (1983) that the correct legal documentation for medicines for mental disorder were completed and available.The observation of people who had been treated with medicines for rapid tranquillisation were not always recorded or available in their care records.Staff told us that the staffing levels were increased when needed. Ward staff told us that the agency staff used did not always receive appropriate induction and training in some of the trust's policies, such as observations and management of aggression.

Health-based places of safety

There was evidence of good working relationships between the many parties involved in the hospital-based place of safety.We spoke with managers and looked at the information we received from the trust and saw that there were no recent serious or untoward incidents in the hospital-based place of safety.

Services for older people

We saw that staff completed a risk assessment on admission for every person. This assessment included the risks posed to person's physical health and the risks people posed to themselves and others. Care records showed that risks were discussed and reviewed by the multi-disciplinary team.We found that where risks had been identified, plans were not always in place to describe how they should be managed.Regular pharmacist visits to the ward and other systems checked that medicines were prescribed and administered safely.During our inspection, we saw that the trust and the staff on Malvern ward appropriately assessed and managed an infection outbreak that had occurred on the ward.Staff

understood the signs of abuse and were able to tell us how they would report any safeguarding concerns in accordance with local policy and procedures.Across both older people's wards, there was a high use of temporary staff.Incident reporting was not completed in a consistent manner.We saw that the wards were locked, as per the policy, to provide a safe environment. Some patients on Malvern ward understood their right to leave the ward; however, patients we spoke with on Holyrood were not aware of this right.We found a number of concerns regarding the environment of Holyrood ward, including multiple locked corridors.During our inspection we witnessed an incident that resulted in an informal patient being secluded in a locked bedroom corridor for 30 minutes. Staff were unaware that they had not ensured the correct safeguards were put in place and the safety of the patient was compromised.

We saw that the environment placed people at risk of receiving care that compromised their dignity; this was because the wards were mixed gender.

Are services effective?

Mental Health Act responsibilities

We found that staff were working in accordance with the Mental Health Act Code of Practice. Detention papers were properly scrutinised, attempts were made to ensure that patients were informed of their rights, and the rules around consent to treatment were followed, including locally devised standard forms to record consent to treatment, rights and urgent treatment decisionsWe spoke with representatives from the Independent Mental Health Advocacy (IMHA) provider and heard that levels of engagement and referrals with statutory advocacy services for detained patients across the trust were inconsistent. We heard that the trust did not have an agreed comprehensive engagement protocol with the IMHA provider.

Acute admission wards

Staff told us that clinical guidance, protocols and procedures were available through the trust's intranet. Some staff could not access the intranet so were unable to consult the information within the guidance documents.Staff told us that they had access to community records and paperwork, which helped them develop risk assessments for people's admissions to the hospitals.Care coordinators worked closely with the hospital staff and people who used the service to prepare for extended leave and discharge arrangements.Good liaison and transfer between Bushey Fields Hospital and the local general hospital when dealing with physical health care issues.Staff told us they were up to date with the mandatory training for 2013/14. Staff told us that they could meet with their line manager for individual supervision and, although this did not happen on a regular basis, they felt they could approach their line managers and request supervision when it was needed. Staff told us that each month the team had a reflective practice discussion which they felt was extremely useful.The trust and ward staff told us about the recent introduction of the 'Triangle of Care'. A review of the documentation identified that some had been completed while others had not.

Health-based places of safety

We found that staff were working in accordance with the Mental Health Act Code of Practice in relation to the place of safety. There were appropriate pro-forma and flagging systems to ensure that staff worked within the Code of Practice – for example to record key demographic details, issues such as transfers between places of safety and the outcome of the use of the hospital-based place of safety.Despite environmental work being carried out, the health-based place of safety at Bushey Fields did not meet national guidance or standards.

Services for older people

We saw that some of the care and treatment provided was based on national guidance.Staff had not received specialist training in order to meet the needs of the people using the services.Pre-discharge meetings took place with relevant professionals.Malvern ward had been accredited by the Royal College of Psychiatrists.

Summary of findings

Are services caring?

Mental Health Act responsibilities

Under the Mental Health Act detained patients must be informed about their rights while they were detained. Patients confirmed that they had been told about their rights and received them in writing.Detained patients have a right to access Independent Mental Health Advocacy Services (IMHA). We saw that the detained patients were routinely told about the availability of the IMHA service on the adult wards, where appropriate. However, there were a small number of detained patients who would not have instructed an advocate because they did not fully understand their role. There was evidence that not all relevant patients were assessed as benefitting from an IMHA service, and it was not clear that a referral to the IMHA had been made.We saw that people had personalised care plans, including detailed care plans relating to detention under the Mental Health Act.

Acute admission wards

People were fully involved with the planning and review of their care. Some people told us they were involved in making decisions and choices about the support they needed.On the wards we visited we observed staff and some people were relaxed and comfortable; others were not quite so. We saw that staff were understanding and considerate when people were distressed and anxious.Each bedroom door was fitted with an observation screen, so that people can be discreetly observed during the night without being disturbed. People we spoke with during the course of this inspection told us that staff treated them with dignity and respect.

Health-based places of safety

Patients were positive about their experiences and did not raise any complaints – for example about the way they were taken to the health-based place of safety.People were involved in decisions about their care where this was possible, for example through agreeing to informal admission at the end of the assessment.Under the Mental Health Act, people brought in to the hospital-based place of safety under police powers must be informed about their rights while they were there. On this inspection, we saw that the hospital had leaflets and a pro-forma to record that these rights had been given. We heard that staff made attempts to assist patients to understand their rights.

Services for older people

The people on Malvern ward told us they were involved in making decisions about their care and treatment. However, on Holyrood ward we observed that people were not always given choice regarding decisions about care and treatment.Care records showed that people received regular reviews by nursing and medical staff. We saw that some staff on Holyrood ward helped people to understand information, but this was not always the case.We saw that peoples physical health needs were assessed and monitored. Any deterioration in physical health was acted upon.We observed staff interacting with people both positively and negatively.Leisure-based activities were not consistently promoted within older people's services.People who use services and their relatives told us the staff treated them with respect. On one of the older people's wards, we observed during an unannounced evening visit, that all people had a commode in their bedrooms. Staff told us they were there to offer choice, but acknowledged that the need for a commode was never assessed.The environment placed people at risk of having their dignity compromised; this was because the wards were mixed gender.We saw that people's confidential information was not protected on either of the wards. Both wards had large 'patient boards' in the nurses' office. Both boards were visible to other people and visitors.

Are services responsive to people's needs?

Mental Health Act responsibilities

People admitted to hospital or assessed under the Mental Health Act had their detention regularly reviewed at ward rounds.Patients commented on the lack of meaningful activities, especially in the evenings and at weekends, and we observed this too.We saw examples of good liaison and transfer between hospital and psychiatric intensive care.

Summary of findings

Acute Admission wards

Some people experienced delays when being discharged from hospital. Very few leaflets, information and guidance were readily available in other languages apart from English. There was no reference on the leaflets we saw that they could be available in other formats or languages.Information was available on the wards we visited on how people can make a complaint. Most of the people we spoke with knew where the information could be found and how to make a complaint.

Health-based places of safety

People were rarely in the place of safety for longer than four hours and frequently a lot shorter.Information we saw showed that most people were able to access an inpatient bed in their local acute psychiatric service when a decision was reached to admit to hospital.

Services for older people

We saw that people on Malvern ward were given information about the hospital's weekly communion and prayer room.Staff told us that a telephone interpretation service could be used.People told us, and we saw, that they could not always go to bed when they wanted.People were transferred to other hospitals if their physical health deteriorated.We saw that on one of the wards, people who use services and relatives had the opportunity to feed back about care and treatment. Relatives on the other ward told us no opportunities were available to give feedback.There was a complaints system in place which people who use services and their representatives could use.

Are services well-led?

Mental Health Act responsibilities

We saw that there were good systems in place for receiving and checking detention papers when patients were first admitted under the Mental Health Act.There was good evidence of administrative and medical scrutiny to ensure that people were detained lawfully and appropriately in accordance with the Mental Health Act.The trust had not recognised that the practices used in the extra care areas may meet the threshold of seclusion, as defined by the Mental Health Act Code of Practice. There were no proper reporting mechanisms or audits of the use of the extra care areas to ensure that they are only used as a last resort, that the guiding principles of least restrictive care was met, and that appropriate safeguards were in place.The policies and protocols relating to the extra care area were not robust

Acute admission wards

Acute Inpatient Mental Health Services (AIMS) accreditation had been awarded to all three acute admission wards. Accreditation was also awarded for the provision of Electro-convulsive Therapy (ECT).Staff on the wards were able to confidently tell us how the governance arrangements had a positive effect on the future planning and provision of care. They gave examples of where the learning from incidents had improved working practices.Noticeboards were provided in ward areas and contained information about accessing the independent advocacy services, accessing care plans, complaining, medication, effective hand washing and people's rights while in hospital.People told us that a weekly meeting was arranged where they were able to discuss ward issues.Staff told us that business meetings took place each month which were open to all levels and grades of staff. They told us that the senior staff of the trust visited the wards regularly and sometimes worked alongside ward staff.Staff told us they feel supported by their immediate managers.

Health-based places of safety

There is a multi-agency place of safety and conveyance committee. It receives information and monitors themes, trends and incidents arising from places of safety and conveyance issues.The refurbishment of the health-based place of safety

did not fully follow guidance.The trust had a policy called 'The Multiagency Operational Policy for section 136 of the Mental Health Act 1983', dated March 2010, which included the use and operation of the health-based place of safety. The trust had informed a previous Mental Health Act monitoring visit that the policy would be updated; however, we found on this inspection that the policy had not been reviewed in line with current royal college guidance.

Services for older people

The staff told us they were unclear about the future of the services.Staff were encouraged to attend meetings to discuss service improvements.All staff were aware of the systems in place to report quality concerns, but a few staff did not feel they could discuss this with senior managers.Staff told us immediate managers responded well to concerns raised.We could not see evidence that the results of local audits were analysed and shared in a timely manner.All staff told us they felt supported by their line managers and the teams they worked within.They also said they had opportunities to attend reflective practice sessions and annual appraisals. Nursing assistants told us they did not have clinical supervision.

Summary of findings

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

Mental Health Act responsibilities

When we visited the hospital, we saw that there were a number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward.We found that where it was necessary to use the Mental Health Act, people were lawfully detained and that the staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights on admission. Mainly on the older people's wards, where patients lacked capacity to understand their rights, staff were not always proactive enough to help patients understand their rights, for example by referring people to specialist advocates. There was only a small number of people who had been receiving treatment for mental disorder for long enough for special rules in the Mental Health Act to be followed. However, where this was the case, the appropriate certificates had been completed to ensure that treatment was properly and legally authorised, with one exception. We saw the use of the extra care area could mean that patients were secluded (according to the Mental Health Act Code of Practice definition). There were safeguards in place while patients were in this area but these did not meet the safeguards of the Code. The policy framework for the use of the extra care area needed improvement. We found that the staff and managers were providing services to people under the Mental Health Act in safe, caring, effective and responsive ways. However, we saw that improvements were needed to ensure that the Mental Health Act responsibilities were managed in better ways by improved audits and policies, and by ensuring that appropriate action was completed following our Mental Health Act monitoring visits and the trust's own audits.

Acute admission wards

Bushey Fields Hospital provided inpatient acute services to people in the Dudley and Walsall areas. People told us that they felt safe and if they had concerns about their safety they would be able to speak with staff on the wards. Risk assessments were completed and reviewed at regular intervals. The action was determined by the level of risk that was identified. Staff were clear about their responsibilities for reporting incidents and concerns, but did not always receive feedback from their line managers quickly enough. Staffing levels varied, with staff reporting some shortages on the wards. Bank and agency staff were used to cover these shortfalls but did not always have the skills and knowledge to fully meet the needs of people.People were involved with the planning and review of their care. Some people commented they were fully involved with making decisions and choices about their care. Others felt they were not involved. Capacity assessments were completed when people were unable to make informed decisions and choices. Best interest decisions were made by the main care giver and fully documented. People were positive about the staff, saying they were helpful, friendly and supportive. Staff were knowledgeable about the care and support needs of people on the wards. Some staff were very positive about the recent changes within the teams and how they work; others were less positive. Numerous meetings take place with all levels of staff to share information about the development of the service, the changes made and any other issues that relate to the service.

Psychiatric intensive care units and health-based places of safety

The trust does not have a psychiatric intensive care unit (PICU) at any of its locations. Patients were taken to neighbouring trusts when they required PICU care. There is a hospital-based places of safety (HBPOS) managed by the trust at Bushey Fields. Hospital-based places of safety are also sometimes called section 136 suites. Section 136 of the Mental Health Act is the police power to remove someone experiencing mental distress from a public place to a place of safety. National guidance encourages the use of hospital-based places of safety rather than police stations so that people experiencing mental health distress or crises receive appropriate treatment. We carried out a 'Mental Health Act

Summary of findings

admission and assessment focused visit' to the Dudley and Walsall area in June 2012. As part of this, we considered the use of the hospital-based place of safety at Bushey Fields hospital. We saw positive practice, but also raised issues about compliance with the Mental Health Act Code of Practice and national guidance (see the 'well-led section for more information).

Services for older people

People were assessed on admission to establish if they were a risk to themselves or others, but plans were not always in place to describe how individual risk should be managed. The staff told us that adequate training was not always provided to enable them to follow best practice in the management of people's behaviours that challenged. This meant that some people were at risk of receiving unsafe or unsuitable care. People could not be assured that they were cared for in an environment that protected their right to freedom. Some people had restrictions placed upon them that were not assessed or managed effectively to promote their safety. We saw that some of the care and treatment provided was based on current national guidance and best practice. People told us they were treated with respect, but we saw that people's dignity was not always maintained due to the mixed gender environment. We observed some staff providing care and treatment with compassion, but also in a negative manner. Systems were in place to enable people to be transferred and discharged from the ward. We saw that staff worked well with people who use services, their representatives and other professionals to do this. The wards were equipped to cater for people with physical disabilities and doctors were based on site to provide out-of-hours care and treatment if this was required. We saw that feedback from people who use services and their relatives was not consistently sought as a method of measuring the quality of care.

Systems were in place to monitor the quality of the systems and processes on the wards. For example, the quality of patients' care records was assessed and monitored. Prompt action was not always taken to improve quality as a result of the monitoring. Staff told us they felt supported, but we saw that some of the staff's development and competency needs were not regularly assessed and monitored. The trust told us they had recently implemented a new management structure within older people's services in response to quality concerns. This meant that the trust had taken appropriate action to address the concerns that had been raised.

Summary of findings

What people who use the location say

We left comment cards at Bushey Fields Hospital and some people completed these before and during the inspection. The results were analysed at provider level.

We left comment cards at three hospital sites and community locations before and during the inspection.

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

Areas for improvement

Action the provider MUST take to improve

- Ensure that the environment on Holyrood ward at Bushey Fields Hospital reflects national guidance to safely meet the care needs of people suffering with dementia.
- Ensure that the quality of care and treatment within older people's services reflects best practice and national guidance, and that practice is monitored and evaluated on a regular basis.
- The use of seclusion must be correctly recorded and practice monitored against the Code of Practice. The trust must ensure that areas used for seclusion are safe and risks removed and the appropriate safeguards put into place.
- Ensure that the mixed gender units comply fully with the national guidance.

Action the provider SHOULD take to improve

- Develop a clear vision for older people's services and share with staff, patients, relatives and stakeholders.
- Ensure that specialist training is provided to all staff working in specialist areas of the trust.
- Risk management plans should be developed and implemented from individuals' risk assessments, and people should be involved in developing these plans and advance decisions where appropriate.
- Develop and implement audits to assess practice against the Mental Health Act Code of Practice as well as the legal documentation in use. Ensure the Mental Health Act scrutiny committee are informed of the outcomes of these audits and develop action plans where needed.
- Identify ways in which informal patients can leave the ward and understand their rights to leave.
- Improve levels of engagement with the IMHA service
- Ensure that the health-based places of safety reflect the national guidance regarding environment to ensure people using services are protected against the risks of potentially unsafe or unsuitable premises.

Good practice

Our inspection team highlighted the following areas of good practice:

We saw examples of good practice where there was good liaison and transfer between hospital and psychiatric intensive care where people required this.

The medicine management team had recently introduced a 'drop-in' session to discuss any medicine issues with patients.

Good collaborative working with the general hospital, which was on the same site, to ensure people's physical health needs were met.

Summary of findings

During our inspection we saw that the trust and the staff on Malvern ward appropriately managed an infection outbreak that had occurred on the ward.

We saw that there were good systems for receiving and checking detention papers when patients were first admitted under the Mental Health Act.

Learning from incidents had improved working practices.

Bushey Fields Hospital

Detailed Findings

Services we looked at:
Mental Health Act responsibilities; Acute admission wards; health-based places of safety; Services for older people;

Our inspection team

Our inspection team was led by:

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

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

Background to Bushey Fields Hospital

Bushey Fields hospital is located in Dudley and offers specialist assessment, care and treatment to adults and older adults who are experiencing mental health difficulties. Bushey Fields hospital has three acute wards. One male ward (Clent), one female adult ward (Kinver), an admission ward (Wrekin) and two older adult wards (Holyrood and Malvern).

Clent ward has 22 beds and Kinver ward has 20 beds. Wrekin ward has 16 beds and a two bed extra care area. Wrekin is mixed gender.

The older adult's wards are both mixed gender although they do have separate male and female sleeping areas, toilets and bathroom facilities. Malvern ward has 22 beds whilst Holyrood ward has capacity for 17 beds.

Why we carried out this inspection

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

How we carried out this inspection

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

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

Detailed Findings

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

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

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

During the visit we held focus groups with a range of staff in the location, such as nurses, doctors, therapists, allied health professionals. We talked with people who use services and staff from all areas of each location. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences receiving services from the provider. We carried out an unannounced visit on the evening of 28 February 2014.

Mental Health Act responsibilities

Information about the service

Bushey Fields Hospital provides assessment and treatment for people with mental health needs. This location is registered with us to assess and treat people under the Mental Health Act 1983 (MHA), so all the wards can accept detained patients if needed and all wards serve the community of Dudley.

Many of the wards at Bushey Fields Hospital have been visited by our Mental Health Act Commissioner to monitor the use of the MHA within the last eighteen months. On these visits we saw positive practice but also raised issues with compliance with the Mental Health Act Code of Practice which we report on in the well led section.

Summary of findings

When we visited the hospital, we saw that there were a number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward.

We found that where it was necessary to use the Mental Health Act, people were lawfully detained and that the staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights on admission. Mainly on the older people's wards, where patients lacked capacity to understand their rights, staff were not always proactive enough to help patients understand their rights, for example by referring people to specialist advocates. There was only a small number of people who had been receiving treatment for mental disorder for long enough for special rules in the Mental Health Act to be followed. However, where this was the case, the appropriate certificates had been completed to ensure that treatment was properly and legally authorised, with one exception. We saw the use of the extra care area could mean that patients were secluded (according to the Mental Health Act Code of Practice definition). There were safeguards in place while patients were in this area but these did not meet the safeguards of the Code. The policy framework for the use of the extra care area needed improvement.

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

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We spoke with detained patients to ask them if they felt safe on the wards. One detained patient stated: "I feel safe. Its sometimes gets noisy but staff deal with incidents well and talk to patients".

Learning from incidents and improving standards of safety

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

Safe and proportionate systems

Information showed that the hospital was working within or just above recommended bed occupancy levels. We saw that the wards had low levels of detained patients. For example on the day of our inspection, on Holyrood ward, only one of the patients was detained under the Mental Health Act. This meant that most patients were informal on each ward as they had made the capacitated decision to stay informally, or especially on the older people's wards they were not actively attempting to leave. The wards were regularly locked to keep people safe. We were given assurance that people were regularly reviewed in terms of observations and detention status to ensure that the staff kept people safe and ensured that people were cared for in least restrictive ways.

Risk management and Management in the Extra Care Area

We saw that when people were admitted under the Mental Health Act, they had a medical examination which considered any risks to people's physical health and a mental state examination which considered if people's mental health presented a risk to themselves or others.

Staff would also use information from community staff where people were using community services. In most circumstances, people were cared for in the community and in hospital by the same Consultant Psychiatrist so they got to know people well and this also helped manage risks.

Ward staff had a range of measures to address disturbed and aggressive behaviour and manage risk. These measures included engaging patients in activities, making best use of the ward environment (for example by using the quiet areas of the ward), verbal de-escalation and where necessary PRN medication was used.

We saw that there was a separate two bedded extra care area to provide more intensive support for male patients who were acutely mentally unwell across Bushey Fields Hospital. Female patients from Dorothy Pattison Hospital were also occasionally transferred to the extra care area at Bushey Fields Hospital. On the day of our visit we saw that one patient was using the extra care area but this was due to bed availability issues rather than requiring it on clinical grounds. We spoke with this patient and they confirmed that they were not subject to the restrictions that may be expected if they needed extra care. We looked at the records relating to people who had recently been cared for in the extra care area. We saw that the rationale for placing someone within this area, due to the acute phase of their illness, was well recorded and provided a clear explanation of why it was necessary to provide intensive nursing care input.

We saw that people were cared for in the extra care area for relatively short periods of time. The care and interventions patients received whilst placed in the area were detailed in comprehensive records showing that people were kept safe in the area and were nursed by two staff. We saw that there were regular reviews of the need to continue with the care in the extra care area, for example there were daily medical reviews. We saw that many of the people cared for in the extra care area were transferred to psychiatric intensive care units (PICU) and these decisions were taken when it became obvious that people required more specialist psychiatric input. The trust does not have a PICU at any of its locations. This meant that when patients needed to be admitted or transferred to a PICU; patients were taken out of area to neighbouring trusts.

The trust told us that they did not practice seclusion so we looked at the practices in the extra care area to check this. Seclusion is defined in the MHA Code of Practice as the

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"supervised confinement of a patient in a room which may be locked. Its sole aim is to contain severely disturbed behaviour, which is likely to cause harm to others". The definition of seclusion is not dependent on whether the door to the room is locked or even closed. Seclusion commences whenever a patient is made aware, or has cause to believe, that they are not able to leave a room or area. Seclusion can only be considered to have been discontinued when the patient is made aware that they are able to leave the room or area. The safeguards for regular nursing and medical reviews as prescribed by the Code of Practice should be implemented whenever seclusion occurs, regardless of the nature of the area of confinement.

From our reviews of the records relating to the use of the extra care area on Wrekin ward, we saw evidence that patients were nursed in isolation in the extra care areas, were prevented from leaving the extra care area and refused contact with other patients. The trust current protocol did not fully meet the safeguards for the reviews of seclusion prescribed by the MHA Code of Practice but with some minor amendments would meet these requirements, for example more frequent initial medical reviews and independent nursing reviews.

The trust should also ensure that there is a clock in the extra care area so patients can orientate themselves to the time.

We saw that patients were risk assessed and this was reviewed regularly. The risk assessments we saw identified risks that people faced or posed but the risk assessments could have provided more detail in terms of managing those risks. Leave decisions were generally well recorded with good parameters. However on one ward there were a number of Section 17 leave forms in the patient records we looked at that were no longer valid and had not been marked as no longer valid. This meant that people may be at risk if staff consult an out of date leave form.

Information from the trust showed that Kinver ward had higher levels of patients going Absent Without Leave (AWOL). More recently, we heard that incidents of patients going AWOL at Bushey Fields Hospital had reduced. This showed that where people needed to be detained in hospital, staff were working to keep people safe.

Are Mental Health Act responsibilities effective?

(for example, treatment is effective)

Adherence to the Mental Health Act Code of Practice

We found that staff were working in accordance with the MHA Code of Practice. Detention papers were properly scrutinised, attempts were made to ensure that patients were informed of their rights and the rules around consent to treatment were followed. This included locally devised standard forms to record consent to treatment, rights and urgent treatment decisions. There were appropriate flagging systems to ensure that staff worked within the MHA Code of Practice, for example to remind clinicians when the three month rule for consent to treatment would be reached and appropriate notices to ensure staff were aware of when the detention would lapse. We saw that where there were shortfalls these were picked up by the trust's own audits but some of these issues remained persistent and had not been fully addressed or completed.

We spoke with representatives from the Independent Mental Health Advocacy (IMHA) provider and heard that levels of engagement and referrals with statutory advocacy services for detained patients across the trust were inconsistent. We heard that the trust did not have an agreed comprehensive engagement protocol with the IMHA provider setting out expectations on each side, for example such as the sample engagement protocol outlined in the most recent guidance document IMHA: Guidance for Commissioners produced by NIMHE. We also saw out of date IMHA information on the wards at Bushey Fields Hospital which related to the previous IMHA provider.

There were a small number of people, who had been receiving treatment for mental disorder, for special rules in the Mental Health Act to be followed. In certain circumstances the patient's consent to the treatment plan, or a second opinion from a doctor appointed by the CQC, must be formally obtained before treatment, other than urgent treatment, can continue. Where this was the case, the appropriate safeguards were in place to ensure that the legal certificates had been completed so that treatment was properly and legally authorised.

Mental Health Act responsibilities

Patients were positive about the care they received from staff. Staff we spoke with had a good understanding of their role and duties in relation to the Mental Health Act. The trust had identified the need to improve the quality and uptake of MHA training for all staff.

Are Mental Health Act responsibilities caring?

Choices in decisions and participation

Under the Mental Health Act detained patients must be informed about their rights whilst they were detained. We saw that the hospital had a pro-forma to record that these rights had been given. We saw that nursing staff made regular attempts to assist patients to understand their rights and we saw records showing assessment of people's understanding of their rights. Patients we spoke with confirmed that they had received their rights orally and in writing.

We saw that nursing staff made regular attempts to assist patients to understand their rights. We saw that on occasion's patients still did not understand their rights despite these attempts. It was not clear from the records what different or other ways that staff had used to aid patient understanding. For those patients with severe and ongoing cognitive impairment there was no proper system to record that the patient will never fully understand their rights. There was one detained patient on Holyrood ward. Records showed they were given their rights whilst first detained at Bloxwich hospital and they had not understood them. There were no recorded attempts to provide information to this patient on transfer to Bushey Fields despite many days passing. We spoke with the ward manager who could not explain why attempts to explain rights to this patient had not been given or recorded and agreed to address this. When we returned on an out of hours visit, we saw that a further attempt had been made to ensure the patient had been given their rights.

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

People or their representatives were involved in decisions about their care where this was possible. The care plans we saw showed that patients were involved and were written in an individualised way. Care plans were well written and provided good written instruction on the care and support plan for each patient for any member of staff to pick up and understand. The trust may wish to ensure that fuller patient involvement is evidenced in the care plans on occasions, for example by ensuring that the patients' own self assessed priorities in recovery from their acute mental health crisis is recorded. This would ensure that the trust is properly evidencing the guiding principle of the Mental Health Act Code of Practice around participation.

Dignified care

When we visited the acute wards we spoke with a small number of people detained under the Mental Health Act. We asked them if they were treated with dignity and respect. One patient who had been cared for in the Extra Care Area told us: "I felt quite glad that I had been there this time"". The patient complained that they could not go for a smoke in the ECA; stating staff were too busy to let patients out. The patient stated that the internal doors within the ECA were "always open" but stated that there were significant restrictions on leaving the ECA and a lack of fresh air – stating it "would be better if there was a window".

Patients were positive about their experiences despite being subject to compulsion and did not raise any complaints, for example about the way they were conveyed. Detained patients confirmed they were treated with dignity and respect and were complementary about the staff providing care to them. We saw that people had individualised care plans including detailed care plans relating to detention under the Mental Health Act. Detained patients confirmed that staff worked with them in respectful ways – this was summed up by one patient who stated: "staff are pretty good".

Mental Health Act responsibilities

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

Responding to people's needs and reviewing care

We saw that people admitted into hospital or assessed under the Mental Health Act, had their detention regularly reviewed at ward rounds. We saw that these reviews included representatives of the medical and nursing teams, family and patients were encouraged to attend and to a lesser degree there was involvement of community teams.

We observed the care provided to detained patients and saw there was a limited range of activities to encourage and support people to undertake activities. Patients commented on the lack of meaningful activities especially in the evenings and at weekends.

Transition of patients

We saw examples of good practice where there was good liaison and transfer between hospital and psychiatric intensive care where people required this.

In most circumstances, people were cared for in the community and in hospital by the same Consultant Psychiatrist so they got to know people well and this also helped manage risks. We saw liaison with community staff where people were working towards discharge. People were able to access an inpatient bed in the locality from which they came in most circumstances. The detained patients on the ward at the time of our inspection were appropriately placed and were not awaiting transfer.

We saw that where patients required inpatient support prior to discharge, patients would be transferred to Wrekin ward which was developing its' role to provide short term intensive pre-discharge nursing support to work towards recovery and eventually discharge.

Are Mental Health Act responsibilities well-led?

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

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

The trust had not recognised that the practices in relation to the extra care areas may meet the threshold of seclusion as defined by the MHA Code of Practice. The trust was not meeting the safeguards of seclusion, such as regularity of reviews as prescribed by the MHA Code of Practice, when episodes of confinement in the extra care areas met the criteria for seclusion. There were no proper reporting mechanisms or audits of the use of the extra care areas to ensure that these areas were used as a last resort, that the guiding principles of least restrictive care was met and that appropriate safeguards were in place. This meant that senior managers had no proper oversight of the extra care areas except in relation to financial considerations.

The policies and protocols relating to the extra care area were not robust enough, for example they had not been properly ratified, did not properly reference the MHA Code of Practice and did not properly guide or prescribe the standards of care that patients can expect in the extra care areas. The policy did not detail the current actual arrangements, such as the necessity for the current regularity of medical reviews, and the expected levels of. The trust had a separate observation policy which included separate forms for observations in the extra care area but staff were unclear whether these forms should be used in practice. The draft ECA policy did not refer to the observations policy and staff had difficulty accessing the policies in relation to the extra care areas when we asked for them. This meant that staff may not be able to access guidance in a timely manner to help guide care and recording of care within the extra care areas. The trust had a draft visiting policy for people in the extra care areas which was overly restrictive and did not afford respect for family life. For example the policy required patients to provide a list of visitors and their addresses, detailed exclusion of visitors without stating that such decisions

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were a serious interference with the rights of the patients and that such decisions should be regularly monitored by the hospital managers as required by the MHA Code of Practice.

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

We found that there were audits carried out to consider how well the Mental Health Act was being implemented at the hospital. Audits undertaken included detention papers, information on rights, consent to treatment, section 17 leave arrangements and care planning. The audit proforma was limited in scope and did not include many items we would expect when carrying out robust audits of MHA activity. For example it included whether the appropriate legal certificate was attached to the medicine chart but did not include whether the medication prescribed matched the medication detailed on the medicine chart. The audit looked at section 17 leave in terms of whether risk assessments were carried out and superseded forms had been crossed out but did not look at other aspects of Code of Practice requirements such as ensuring clear parameters were recorded, whether a CTO had been consider if seven days leave had been granted and whether the patient had been given a copy of the form. There was no mention in the audit proforma about the duty to inform and refer to independent mental health advocacy services.

We saw that although we had pointed out issues and the trust MHA audits were continuing to identify similar issues, when we returned the issues had not been properly resolved or progressed. For example Holyrood ward was last visited by our Mental Health Act Commissioner in January 2012 to monitor the use of the MHA. The commissioner saw positive practice in relation to a number of areas including staff working within the Mental Health Act, patient engagement in activities and cleanliness but the CQC raised issues which included poor documentation around detained patient rights. On this inspection, we saw little improvement in this area.

The audit carried out by the trust at this location in January and February 2013, to look at progress against the issues we raised, showed that the items we raised on MHA monitoring visits had not been fully progressed. For example the trust's audits identified that on Kinver ward staff had not evidenced least restrictive care in patient's care plans, informal patients were not informed of their right to leave, there was a lack of risk checks prior to leave and that out-of-date leave forms had not been struck through. The recent audit of Holyrood ward showed that it was not clear that IMHA referrals have been made for the small number of detained patients and there was a lack of information about the IMHA service available on the ward. We saw some of these issues reoccurring on this inspection. The trust's audits were identifying and assessing issues with departures from the MHA Code of Practice but weren't fully managing the risks associated because issues were still occurring on an ongoing basis. The trust had identified the need to improve the quality and uptake of MHA training for all staff.

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

Acute admission wards

Information about the service

Bushey Fields Hospital has three acute wards, one male ward and one female ward and an admission ward.

Summary of findings

Bushey Fields Hospital provided inpatient acute services to people in the Dudley and Walsall areas.

People told us that they felt safe and if they had concerns about their safety they would be able to speak with staff on the wards. Risk assessments were completed and reviewed at regular intervals. The action was determined by the level of risk that was identified.

Staff were clear about their responsibilities for reporting incidents and concerns, but did not always receive feedback from their line managers quickly enough.

Staffing levels varied, with staff reporting some shortages on the wards. Bank and agency staff were used to cover these shortfalls but did not always have the skills and knowledge to fully meet the needs of people.

People were involved with the planning and review of their care. Some people commented they were fully involved with making decisions and choices about their care. Others felt they were not involved. Capacity assessments were completed when people were unable to make informed decisions and choices. Best interest decisions were made by the main care giver and fully documented.

People were positive about the staff, saying they were helpful, friendly and supportive. Staff were knowledgeable about the care and support needs of people on the wards.

Some staff were very positive about the recent changes within the teams and how they work; others were less positive.

Numerous meetings take place with all levels of staff to share information about the development of the service, the changes made and any other issues that relate to the service.

Acute admission wards

Are acute admission wards safe?

Learning from incidents

Staff were aware of the electronic incident report system and told us that all incidents were recorded in this way. The clinical governance systems in place ensured all incidents were reviewed and actions and learning points recorded. Staff told us that the feedback from the review of incidents was a regular agenda item at ward meetings. We saw that copies of the minutes of ward meetings were available for staff to look at.

Safe environment

The hospital operated a locked door policy on each of the wards. Leaflets were available on the wards offering information to people and visitors on this policy. People who were at the hospital on an informal basis were informed of their legal rights for leaving the ward or hospital. Notices were placed on the doors to the wards advising people to see a staff member if they wished to leave the ward.

Safeguarding

Staff confirmed they received regular safeguarding training and were aware of the procedures for reporting and referring allegations of abuse. The training matrix and planner recorded that staff had either received training in safeguarding adults or it was planned.

People who used this service told us they felt safe but if they did have any concerns about their safety they would speak with their named nurse or any of the staff members. One person said: "I know how to make a complaint and know the staff would help me".

Risk management

Staff told us that staffing levels were increased when needed. For example when there was an identified need for close one to one observations to ensure the safety of people.

Risks and risk management were monitored through regular reviews which were completed at ward level. The multi-disciplinary team analysed the risks presented by each individual and any action needed to reduce the level of risk was taken. Environmental risk assessments and audits were completed and analysed by the heads of departments.

Medication

Medication management training was mandatory for all staff. Staff we spoke with confirmed they had received this training or a date had been booked. We saw a leaflet was on the wards to offer information and guidance for people and staff regarding the administration and safekeeping of medication. Each person was given a welcome pack relevant to the hospital, this included information about their medication and how they would receive it while staying at the hospital. One person told us their medication had been explained to them, what it was for and what the possible side effects were.

The trust had a medicines management team which consisted of a Chief Pharmacist, Deputy Chief Pharmacist, two locality pharmacists and two technicians who supported the safe use and management of medicines across the trust. Our pharmacist inspector met with the Chief Pharmacist, visited three of the wards, met with staff prescribing and administering medication, looked at medication administration charts, looked at the storage of medicines within the clinic rooms and considered the arrangements for the management of medicines.

We found that the medicine management team were actively involved in all aspects of a person's individual medicine requirements. Nursing staff also told us that if they had any medicine queries they had access to pharmacist advice at all times, including an out of hour's pharmacy service. We observed the medicine management team checking people's prescribed medicines which also involved discussing a query about one medicine with the patient's doctor. This resulted in a change to the person's treatment. A nurse also told us that the 'team are very helpful and will respond immediately if we are worried about anybody's medicines'. We found that the medicine management team provided a good clinical service to the hospital.

People's medicines were continuously reviewed and checked by the medicine management team during their stay. This included checking that when people were detained under the Mental Health Act (1983) that the correct legal documentation for medicines for mental disorder were completed and available. Any concerns or advice about medicines were highlighted to the person's doctor. This ensured that people's medicines were

checked, monitored and reviewed by a clinical pharmacist from admission through to discharge from the service. This meant that there were safety systems in place to make sure that the right medicine was given to the right person.

On occasions, people may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence. This is known as rapid tranquillisation. Arrangements were in place to provide guidance to medical and nursing staff for the treatment of severe mental and behavioural disturbance. We found that there was good recording of the reasons why rapid tranquillisation was given on individual patient files and we saw that it was only used on a small number of occasions. Following rapid tranquillisation, national guidelines state that nursing staff are required to record regular observations of the patient such as visual observations, blood pressure, temperature, oxygen saturation and respiratory rate. However we found that despite the availability of the policy and the training provided to staff, the required observation of people following administration of medicines for rapid tranquillisation were not always recorded or available in their care records. This meant that it was not always possible to determine if people were physically checked for their own safety following administration of medicines for rapid tranquillisation.

The medicine management team had recently introduced a 'drop-in' session to discuss any medicine issues with patients. This had been well received. One nurse told us: "It was really informative and very interesting for people. It gave people an understanding of what they were taking and helped them to be informed about their treatment. It really helped the nurses as well". This meant that patients' understanding of their treatment was improved and patients were encouraged to participate in treatment decisions.

Whistleblowing

Staff we spoke with told us they were aware of the whistleblowing policy and would feel comfortable and confident to report and escalates matters if needed. The whistleblowing policy was available on the hospital's intranet site for staff to refer to.

Managing risk to the person

Risk assessments were comprehensive and contained detailed strategies to reduce risks. These included moving and handling assessments with specific details relating to the level of support people needed; skin care with guidance about the level of support people needed to maintain healthy skin and nutrition assessments which recorded specific details about dietary needs. The action recorded in the assessments to reduce the risk to the person was not always followed up in a timely way. For example, referrals to the dietician and other healthcare services.

People were on different levels of observation based on the needs of each individual. Staff told us that the level of risk a person presented was reviewed each day. A joint decision by the medical and nursing staff established the level of observations that were required. Each observation was recorded on a monitoring document so that staff had full details of the actions and behaviours of the person to ensure their safety and the safety of other people on the ward.

The information pack given to all people offered information on the ward routines and that the hospital operated an observation policy where hourly observations were recorded. This meant that people were aware of the actions of staff and staff were aware of the whereabouts of each person at any given time during the day.

Safe staffing levels

Staff were allocated to work on each of the wards. Staff reported that recruitment for trained nurses were ongoing and that on occasion's bank and agency staff were used to cover the shortfalls in staffing levels.

Other ward staff told us that agency staff used were not always appropriately inducted and trained in some of the trust's policies such as observations and management of aggression. This meant that at times staff would not be able to fully meet the needs of people who used the service.

One person who used the service told us that at times there were not enough staff on duty to cope with incidents. They concluded that the staff had the skills to manage any situations which arose.

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

Use of clinical guidance

Staff told us that clinical guidance, protocols and procedures were available through the trust's intranet. Some staff could not access the intranet so were unable to

consult the information within the guidance documents. This meant that some information would not be readily available in a timely way for staff to refer to. This may have a significant impact when agency staff were used in terms of their ability to follow the ward protocols.

Collaborative working

Multi-disciplinary meetings were held each week with the consultant, ward staff, the person and/or their representative. Other professionals such as the occupational therapist or psychologist do not routinely attend these meetings.

Staff told us that they had access to the community records and paperwork which assisted them with developing the risk assessments for people's admissions to the hospitals.

Care coordinators worked closely with the hospital staff and people who used the service with preparations for extended leave and discharge arrangements. We spoke with representatives of the local general hospital who stated that the staff at Bushey Fields hospital worked with them to ensure people's physical health needs were met. They stated that referrals and the transfers of care were appropriate and coordinated. This meant there was good collaborative working with the general hospital which was on the same site.

One person told us they had been admitted to this hospital via the local accident and emergency department of the acute hospital. They felt that the move was well coordinated and smooth and the availability of the doctor was 'good'.

Leaflets were available on the wards with information on how to access the independent advocacy services. Some people we spoke with told us they were aware of this service, other people were unsure. In the care records we looked at we saw that some people had been offered help to access the advocacy services but had refused.

Monitoring of care

Risk assessments were comprehensive and contained detailed strategies to reduce risks. These included moving and handling assessments with specific details relating to the level of support people needed; skin care with guidance about the level of support people needed to maintain healthy skin and nutrition assessments which recorded specific details about dietary needs. The action needed to reduce the risk to people was recorded but not always in a timely way. For example we saw that the nutritional assessment for one person had been assessed as high risk. The recorded action was to contact the dietician for additional support and guidance. Staff stated that a referral had not been sent when we asked them about it.

The trust and ward staff told us about the recent introduction of the 'Triangle of Care'. The Triangle of Care is a guide for staff working in mental health services to promote the inclusion of professionals, people who used services, their carers and families in care-planning, decision making and the treatment of people. We saw that some had been completed with the person and their families. Others had not been completed.

The care and support plans were completed where there was an area of need. For example we saw care and support plans for maximising a person's independence, physical health, mental health and vulnerability. The person had been included in the formulation and review of the plan and had signed to indicate their inclusion in the process. A record had been made where a person refused to sign or take part in the process. Staff told us that each week a multi-disciplinary meeting was held to discuss and review the care and support needs of each person. The plans were reviewed and amended more frequently if a change of need was identified.

Physical health checks and care were well documented on admission to the hospital and throughout the person's stay. Staff used nationally recognised guidance, standards and assessment tools to monitor and assess physical health. This meant that staff ensured physical health assessments were made to get baseline data and ongoing physical health checks to direct ongoing physical healthcare.

On the day of our visit, one of the older people's wards had an outbreak of norovirus and was closed for new admissions and visitors. We saw there was good management of the current norovirus outbreak in line with infection control guidelines, including active involvement of the infection control team. Oversight meetings were held to monitor the physical health, individual symptoms and recovery for each person together with the management of the infection control procedures. This meant that people had their healthcare needs monitored to reduce the risk and to meet their individual needs.

Acute admission wards

Are staff suitably qualified and competent?

Staff we spoke with told us they were up to date with the mandatory training for 2013/14. This included topics such as equality and diversity, fire safety awareness, health and safety, information governance, infection control and safeguarding vulnerable adults and children. Additional specialist training was available and planned for staff, for example, management of actual and potential aggression, the Mental Capacity Act 2005 and the deprivation of liberty safeguards. We were provided with a staff training matrix dated February 2014. This indicated the topics available, the number of staff that had completed the training and the number of staff due to undergo training. Staff told us the availability and range of subject areas were sufficient for them to do the job they were expected to do.

Staff told us that they had opportunity to meet with their line manager for individual supervision and although this did not happen on a regular basis they felt they could approach their line managers and request supervision when it was needed. Staff told us that each month the team had a reflective practice discussion which they felt was extremely useful.

Adherence to MHA code of practice

We saw the wards at the hospital operated a locked door policy. People we spoke with told us they could ask to leave at any time if they were not detained under the Mental Health Act (MHA). We saw leaflets were readily available to inform people of their rights to leave the ward when they wished to.

Are acute admission wards caring?

Choice in decisions and participation in reviews

People were fully involved with the planning and review of their care. Some people we spoke with told us they were involved in making decisions and choices about the support they needed. Other people told us they did not feel they were fully involved. The care plans and record of the reviews were signed by the person to indicate their inclusion in the process. Some people did not wish to take part; this was recorded in the plan to show that there had been verbal discussion and they were offered the option to participate.

One person who used the service told us: “I am aware of my care plan, the nurse has gone through it with me a couple of times”. Another person commented: “I have a copy of my care plan but can’t remember having a discussion about it”. Other comments received were: “I don’t know anything about it [the care plan]”.

Effective communication with staff

People we spoke with were generally positive about the staff, commenting that they were helpful, friendly and supportive. On the wards we visited we observed staff and some people were relaxed and comfortable, others were not quite so. People were engaged in a variety of activities either in a group setting or spending time alone. We saw that staff were understanding and considerate when people were distressed and anxious. Staff we spoke with were knowledgeable about the care and support needs of the people on the wards.

Regular meetings for people on the wards were held and facilitated by the activity coordinators. This meant that people had the opportunity to discuss issues about ward management.

Staff had regular ward meetings and we saw minutes of the meetings available in the ward offices. This meant staff who were unable to attend would be able to access the information and be aware of the findings of these meetings.

Communication sheets, daily reports and the diary were used to communicate the activities of the wards to the staff on the following shifts. Staff told us that time was allocated at each shift change to allow for an effective handover of information. A bank support worker told us that they received a full handover before starting their shift.

Do people get the support they need?

People we spoke with told us that the staff were helpful, supportive and had the right skills to support them with their needs. They told us they felt safe in the environment and that staff listened to them. We saw good interactions between staff and people who used the service on the wards we visited. Staff were visible and ready to offer support when needed.

Privacy and dignity

Each bedroom door was fitted with an observation screen, so that people can be discreetly observed during the night without being disturbed. People’s levels of observation

were assessed regularly and determined according to the level of risk. The observation screens can be opened or closed from inside the bedroom so that people can have some degree of privacy.

People we spoke with during the course of this inspection told us that staff treated them with dignity and respect.

Restraint

Care, contingency and crisis plans were completed and included the triggers and early warning signs that may indicate behavioural changes. They included the factors to consider in a crisis situation and the strategies to be used. Staff told us that on each occasion of distress the least restrictive action was used. This could be talking through the problem and/or distraction methods. Staff told us they were trained in managing actual and potential aggression. They were aware of the techniques required which meant people were restrained in the least restrictive way and for the shortest time possible. An incident report was completed following each occurrence.

Are acute admission wards responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

The hospital was situated in Dudley and served the people in the local areas. During this inspection we were told that a person had to be transferred to an intensive care unit out of the area when their care needs could not be met at the hospital. Staff told us there was no provision for intensive care services within this trust and people had to be transferred to services out of the area when this level of support was needed.

Some people experienced significant delays in discharge from the hospital. The provision of care for individuals with complex care needs meant that a delay had occurred in finding and securing suitable alternative accommodation.

Work of the trust reflects equality, diversity and human rights

Information on the service at the hospital was not provided in alternative languages to help people whose first language was not English. Very few leaflets, information and guidance were readily available in other languages apart from English. There was no reference on the leaflets we saw that they could be available in other formats or languages.

Weekly religious services were held at the hospital. Prayer centres, quiet rooms and multi faith rooms were available at other locations within the local area. Staff spoken with told us that the chaplain visited each week. Some people also confirmed this. One person we spoke with told us that their religion was of the utmost importance to them. They told us: "Staff observe and respect my religion and faith, a prayer room is provided for me".

Personal information recorded in the care plans gave details of the person's marital status but made no reference about their personal relationships and partnerships. There was no evidence of lesbian, gay, bisexual or transgender information being available. This meant that people were not supported to disclose their personal relationship preferences if they wanted to.

Providers working together during periods of change

Some staff we spoke with were very positive about the recent changes within the teams and how they worked. They told us they were kept well informed and aware of what was changing and when. Other staff did not have the same experience and felt they were unsupported with the changes.

Learning from complaints

The trust had a complaints policy and procedure which included the basic principles for managing complaints, the investigation processes and the time scales for handling complaints. Staff told us that they did not always receive feedback from senior management when complaints had been made.

Information was available on the wards we visited on how people can make a complaint. Most of the people spoken with knew where the information could be found and how to make a complaint.

Are acute admission wards well-led?

The Royal College of Psychiatrists Accreditation for Acute Inpatient Mental Health Services, for the provision of

assessment and treatment for working age adults, was awarded to Bushey Fields hospital, Clent, Kinver and Wrekin wards. Accreditation was also awarded for the provision of Electro-convulsive therapy (ECT).

Governance arrangements

Staff on the wards were able to tell us with confidence how the governance arrangements impacted positively on future planning and the provision of care. They gave examples of where the learning from incidents had improved working practices.

Staff stated that they felt engaged and involved in the recent transition of services. One nurse told us: "Changes are always difficult but we had opportunity to discuss options and choices of where we wanted to work".

Engagement with people who used the service

People we spoke with at the hospital said they felt able to speak with staff openly and comfortably. One person told us: "The staff are very approachable and I feel able to speak with them about any concerns I have or how I am feeling. This helps me a lot". Another person commented: "Staff would get a doctor if I needed one, even at weekends".

People at the hospital told us that talking therapies and psycho-education classes were held weekly. We saw a discussion group took place with an occupational therapist and a small group of people. Two people left the group and continued their discussion regarding the symptoms of depression.

Notice boards were provided in ward areas and contained information about accessing the independent advocacy services, how to access care plans, complain, medication, effective hand washing and people's rights while in hospital.

People told us that a weekly meeting was arranged where they could discuss ward issues. We saw that minutes of the meeting were completed and available on the wards.

Engagement with staff- ward to board

Staff told us that business meetings took place each month which were open to all levels and grades of staff. Issues around the principles and governance of the trust were discussed. Minutes of these meetings were completed.

Staff generally knew the chief executive officer and members of the trust board. They told us that the senior staff of the trust visited the wards regularly and sometimes worked alongside ward staff. A member of staff told us they had received a satisfactory response from the chief executive officer when they had contacted him through the 'Ask Gary' email system. 'Ask Gary' is a dedicated mailbox set up to encourage staff to email the Chief Executive.

Student nurses told us they felt well supported by the staff on the wards and had opportunities to develop their skills and knowledge.

Effective leadership

Staff working on the wards told us they work together and felt well supported by their managers. One staff member told us: "We pull together and work as a team, the hospital is very busy and sometimes we are stretched but the teams are very good at helping each other". They went on to say that the heads of departments are approachable and they received regular team briefs about the development of the service.

Psychiatric intensive care units and health-based places of safety

Information about the service

Bushey Fields hospital provides assessment and treatment for people with mental health needs. It has five wards – two adult acute in-patient beds and a ward focused on pre-discharge as well as two older people's wards

The trust does not have a psychiatric intensive care unit (PICU) at any of its locations. Patients were taken out of area to neighbouring trusts when they required PICU care.

There is a hospital based places of safety (HBPOS) managed by the trust at Bushey Fields. Hospital based places of safety are also sometimes called section 136 suites. Section 136 of the Mental Health Act is the police power to remove someone experiencing mental distress from a public place to a place of safety. National guidance encourages the use of hospital based places of safety rather than police stations so that people experiencing mental health distress or crises receive appropriate treatment.

We carried out a Mental Health Act admission and assessment focused visit to the Dudley and Walsall area in June 2012. As part of this we considered the use of the hospital based place of safety at Bushey Fields hospital We saw positive practice but also raised issues with compliance with the Mental Health Act Code of Practice and national guidance which we report on in the well led section.

Summary of findings

The trust does not have a psychiatric intensive care unit (PICU) at any of its locations. Patients were taken to neighbouring trusts when they required PICU care.

There is a hospital-based places of safety (HBPOS) managed by the trust at Bushey Fields. We found that where it was necessary to use the HBPOS, people were kept safe and assessed quickly. Staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights when they were placed in the hospital based place of safety.

We found that the staff and managers were providing services to people who required to be cared for in the hospital based place of safety in safe, caring, effective and responsive ways. However we felt that improvements were needed to ensure that the HBPOS were managed in better ways by improved audits and policies and by ensuring that appropriate action was completed following our Mental Health Act monitoring visits and to meet national guidance.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

Interagency working to provide safe care

There was evidence of good working relationships between the many parties involved in the hospital-based place of safety, including Crisis Resolution Home Treatment teams, the Approved Mental Health Professionals (AMHPs), the Doctors, the Police service, the Ambulance service and alternative places of safety (in particular Accident and Emergency departments). The arrangements to ensure people could be conveyed to a hospital-based place of safety were in place, including working arrangements for the police phoning in advance to ensure that the HBPOS was available and to assist staff to co-ordinate a speedy assessment. We heard that in most cases, the police stayed with people in the hospital-based place of safety until the assessment by professionals could be completed. We spoke with managers and looked at the information we received from the trust and saw that there were no recent serious or untoward incidents in the HBPOS. On exceptionally rare occasions we heard that the police had to use tasers to take control of situations. We heard that the police also took responsibility and returned the person where a decision was reached not to admit to hospital. This meant that there were arrangements to keep people safe whilst people were in the hospital-based place of safety until such time a decision could be reached on whether hospital admission was necessary.

The trust does not have a psychiatric intensive care unit (PICU) at any of its locations. This meant that when patients needed to be admitted or transferred to a psychiatric intensive care unit patients were taken out of area to neighbouring trusts. We spoke with staff about how quickly and safely people were taken to PICU care when they required it. We heard that whilst on most occasions a bed could be found in the local area there were at times delays and people were also sent to wide geographical areas. One patient told us that they had to be moved to a PiCU in another trust from the Extra Care Area stating that "I know it was the right thing to do at the time – going to a PICU was better for me at the time".

Are psychiatric intensive care units effective?

(for example, treatment is effective)

Adherence to the Mental Health Act Code of Practice and national good practice guidelines

We looked at the hospital-based places of safety (HBPOS) managed by the trust. We spoke with people who regularly assessed people in the HBPOS and the managers who oversee the area. We looked at the environment of the HBPOS, considered the policies for the use of these areas and reviewed records relating to the use of the areas. We benchmarked these against current guidance on good practice published by the Royal College of Psychiatrists.

We found that staff were working in accordance with the MHA Code of Practice in relation to the place of safety. There were appropriate proformas and flagging systems to ensure staff worked within the MHA Code of Practice. For example to record key demographic details, issues such as transfers between places of safety and the outcome of the use of the hospital-based place of safety.

When we visited in July 2012, we asked that action was taken because the environment of the hospital-based place of safety did not meet the current national guidance. In response the trust told us monies were set aside for refurbishment and improvement of the HBPOS at both hospital sites and the refurbishment would be undertaken following consultation with Expert Service Users. On this inspection, we saw that there had been environmental improvements to the HBPOS at both locations. However each HBPOS environment was still not meeting the good practice guidance of the Royal College. For example at one or both locations the furniture was not fixed to the floor, there were potential self-harm hazards (for example a mirror or electrical sockets), there was no clock for people to orientate themselves to time and there was no CCTV installation or panic alarm system. The HBPOS at Bushey Fields was limited in space which made it difficult for the professionals involved in the assessment to carry this out, there was no adequate furniture for people to rest and there was only one exit door from the interview room. We also saw that both HBPOS had discrete access from a back door to the HBPOS. However there was no designated or allocated parking for the police or ambulance vehicles

Psychiatric intensive care units and health-based places of safety

outside the HBPOS at Bushey Fields which may lead to difficulties in conveying people safely especially if they are presenting with disturbed behaviour and could also compromise people's privacy and dignity.

Are psychiatric intensive care units caring?

Choices in decisions and participation

Records we saw in a small number of cases confirmed people were assessed quickly and were not kept in the HBPOS for assessments to take place. People were involved in decisions about their care where possible. For example agreeing to informal admission at the end of the assessment. The information and audits showed the police based place of safety was very rarely used so where people needed to be taken from their home, or from a public place to a place of safety, people were taken to a hospital-based place of safety to receive appropriate treatment and medical support.

Under the Mental Health Act people brought in to the hospital-based place of safety, under police powers, must be informed about their rights whilst they were there. By the nature of the police power and the short time allowed to keep people in the place of safety, people's rights are limited. When we visited in July 2012, we asked that action was taken because it was not clear that people were routinely given their rights when they were brought in under police powers. In response the trust told us they would improve practice in this area and audit the giving of rights when people were under police powers. On this inspection, we saw that the hospital had a leaflets and pro-forma to record that these rights had been given. We heard that staff made attempts to assist patients to understand their rights. We have included information on the audits of rights whilst in the HBPOS in the well led section.

Are psychiatric intensive care units responsive to people's needs? (for example, to feedback?)

Responding to people's needs and reviewing care

There was evidence of good working relationships between the many parties involved in the hospital-based place of safety, including Crisis Resolution Home Treatment teams, the Approved Mental Health Professionals (AMHPs), the Doctors, the Police service, the Ambulance service and alternative places of safety (in particular Accident and Emergency departments). The arrangements to ensure people could be conveyed to a hospital-based place of safety were in place, including working arrangements for the police phoning in advance to ensure that the HBPOS was available and to assist staff to co-ordinate a speedy assessment. There was a continued lack of delay during the assessment process both between arrest and the Mental Health Act assessment, and following the assessment and admission/discharge.

We visited the out of hour's services at Dudley and Walsall on the Friday evening of our inspection. We saw that at Bushey Fields hospital there was a multi-disciplinary CRHT, including a manager, an AMHP, onsite medical input, an occupational therapist and a support time recovery worker. We saw that these responses in dealing with emergencies and assessing in the HBPOS were further improved at Bushey Fields hospital due to the increased out of hours medical cover on a pilot basis and the co-location of the AMHP service with the Crisis Resolution and Home Treatment team. At Dorothy Pattison hospital, response times were reported as being longer due to the levels of out of hour's medical cover not being as robust and the AMHP service being located in the emergency duty team rather than integrated within the CRHT. However in both locations, people were rarely in the place of safety for longer than four hours and frequently in the place of safety for considerably shorter periods of time.

Information we saw showed people were able to access an inpatient bed in the relevant acute psychiatric service in the locality from which they came in most circumstances, when a decision was reached to admit to hospital. Where people were not deemed to require hospital stays we saw them offered follow up by the CRHT with the level of support determined by the levels of assessed and manageable risk.

Are psychiatric intensive care units well-led?

Governance arrangements and Effective leadership

We saw that there were good systems in place for administration under the Mental Health Act including good

Psychiatric intensive care units and health-based places of safety

checklists. Compliance with the statutory requirements of the Mental Health Act was well supported by experienced and committed MHA administrative staff and managers. The regular Mental Health Law sub group also supported compliance and good practice.

We were informed that since our visit in June 2012, the multi-agency place of safety and conveyance committee has met more frequently. It receives information and monitors themes, trends and incidents arising from places of safety and conveyance issues.

The re-provision and refurbishment of the environment of the HBPOS of safety has not had full regard to current guidance on the environment of the HBPOS.

The Trust had a policy entitled 'The Multiagency Operational Policy for section 136 of the Mental Health Act 1983' dated March 2010 which included the use and operation of the HBPOS. When we visited in June 2012 we highlighted that action was needed as the policy had not been reviewed or updated for some time and failed to keep up with national guidance. In response the trust stated the policy would be reviewed to ensure it contained relevant guidance and renamed and would be supplemented with staff awareness and training based on the new policy. This review would be based on broad consultation with key partners and would reflect the areas highlighted by the CQC. On this inspection we found that the policy had still not been reviewed and continued to be deficient in a number of areas for example there was no mention of the use of section 135, there was no guidance on the management of clearly intoxicated people attending the HBPOS, information relating to the transfer of patients and the rights of people was not sufficiently clear, the policy made no mention of human rights, there was no mention of the policy on searching people whilst in the section 136 suite and the policy does not reference Royal College guidance.

We found there were audits carried out to consider how well the HBPOS was being used. Audits undertaken included key demographic details, issues such as transfers between places of safety and the outcome of the use of the hospital-based place of safety. There was a good analysis of quantitative data in the report. However the audit was limited in scope in relation to qualitative data. When we visited in June 2012, we asked that action was taken because it was not clear that people were routinely given their rights when they were brought in under police powers. In response the trust told us that they would improve practice in this area and audit the giving of rights when people were under police powers. We looked at the audits on the use of the Mental Health Act in relation to the use of the Mental Health Act and section 136 provided by the Trust and spoke with the managers. It was not clear that the audit of the giving of rights had occurred.

We met with representatives of the lay hospital managers. Hospital managers were not routinely informed or given copies of our Mental Health Act monitoring reports. For example our admission and assessment visit in June 2012 to help them ensure that the responsibilities under the Act were properly delegated and discharged by staff employed by the trust.

Services for older people

Information about the service

Malvern ward has 22 mixed gender beds. Care and treatment is provided to older people with a functional mental health condition, such as; depression or schizophrenia.

Holyrood ward has 17 mixed gender beds. Care and treatment is provided to people with an organic mental health condition, such as dementia.

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

Summary of findings

People were assessed on admission to establish if they were a risk to themselves or others, but plans were not always in place to describe how individual risk should be managed. The staff told us that adequate training was not always provided to enable them to follow best practice in the management of people's behaviours that challenged. This meant that some people were at risk of receiving unsafe or unsuitable care.

People could not be assured that they were cared for in an environment that protected their right to freedom. Some people had restrictions placed upon them that were not assessed or managed effectively to promote their safety.

We saw that some of the care and treatment provided was based on current national guidance and best practice.

People told us they were treated with respect, but we saw that people's dignity was not always maintained due to the mixed gender environment. We observed some staff providing care and treatment with compassion, but also in a negative manner.

Systems were in place to enable people to be transferred and discharged from the ward. We saw that staff worked well with patients, their representatives and other professionals to do this.

The wards were equipped to cater for people who use services with physical disabilities and doctors were based on site to provide out-of-hours care and treatment if this was required.

We saw that feedback from people who use services and their relatives was not consistently sought as a method of measuring the quality of care.

Systems were in place to monitor the quality of the systems and processes on the wards. For example, the quality of peoples care records was assessed and monitored. Prompt action was not always taken to improve quality as a result of the monitoring.

Staff told us they felt supported, but we saw that some of the staff's development and competency needs were not regularly assessed and monitored.

Services for older people

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

Are services for older people safe?

How are peoples risks assessed and managed?

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

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

We found that where risks had been identified plans were not always in place to describe how they should be managed. We saw that one person had a number of risks identified through their risk assessment including behaviour that challenged, diabetes and a risk of falling. We could not see any information in their care records to assist and guide staff on how they should manage these risks. We noted that staff had needed to manage the person's behaviours that challenged, on two occasions despite not having any clear guidance. We asked the persons named nurse why suitable risk management plans were not in place. They said, "They do need updating, but I've not had time to go through the paperwork" and, "It's an impossible task".

Another person's care records showed they were at risk of harming others and no management plan was in place to record how this risk should be managed. This meant people were at risk of receiving inconsistent or unsafe care because plans were not always in place to inform staff on how to manage individual risks.

Pharmacists regularly visited the ward to check that medicines were prescribed safely and systems were in

place to check that the risks associated with medicines were considered. An example of this was the use of an antipsychotic medicine checklist. Antipsychotic medicines are one type of medicine used to treat some mental health conditions. Use of the checklist would show that the risks associated with these medicines had been assessed.

However, we saw that one person's antipsychotic medicine was increased, but their care records did not show why the medicine had increased or if the risks had been considered. We also saw that one person's benzodiazepine medicine was stopped abruptly on admission. The individuals care records did not acknowledge the risks associated with this. Benzodiazepine medicines are used to treat some mental health conditions. Stopping this type of medicine abruptly can affect people's health and wellbeing and meant systems were not always effective, or in place to protect people from the risks associated with medicines.

During our inspection we saw that the trust and the staff on Malvern ward appropriately assessed and managed the risks associated with infection, in order to manage an infection outbreak that had occurred on the ward. This meant that systems were in place to protect people from the risks associated with infection.

Do the staff and staffing levels protect patients from harm?

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

The ward manager on Holyrood ward told us they were using high numbers of temporary staff as there were staff vacancies on the ward. We saw that temporary staff were also used on Malvern ward. This meant there was a system in place to cover the staff vacancies.

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

We looked at three incident reports that had been completed following three patient incidents on Holyrood ward where people had exhibited behaviours that challenged. We found that one of the reports contained the wrong incident date and incorrect patient details meaning details relating to the incident were not recorded correctly. Two reports did not contain appropriate information to describe how the incident was managed. For example both reports recorded 'staff intervened' to manage the risk, but the details describing how the staff intervened were not recorded. We spoke with the ward manager about one of these forms. They said, "I know it's not a brilliant incident report. I spoke with the staff about it and gained more information". We asked if this additional information had been recorded. We were told, "I haven't completed my manager's form yet". This meant that incidents were not recorded effectively through the trust's incident reporting system and an accurate analysis of the incidents could not be completed.

During our inspection, we witnessed an incident involving behaviour that challenged on Malvern ward. This incident occurred near to the end of the staff's shift. The trust may wish to note that an incident form was not completed immediately after the incident occurred as the staff member involved did not complete this before they finished their shift. This meant that details of the incident were not immediately available and there was a risk that details relating to the incident may be forgotten or not accurately recalled before the staff member next came on shift and completed the report.

Staff on Holyrood ward told us they learned about action taken as a result of serious incidents through staff meetings. We looked at the January 2014 and February 2014 staff meetings for Holyrood ward. We saw that incidents were not on the agenda and were not discussed at either of these meetings. Staff on Malvern ward told us they learned about action taken as a result of serious incidents by looking at the 'embedding lessons learnt' folder. Staff showed us the folder. We checked to see that serious incident action plans for 2013 were in the folder. We found two copies of action plans for the 2013 period, however prior to our inspection the trust had made us aware of more incidents than this. This meant we could not be assured that the system for sharing learning from incidents was effective and there was a risk that staff may not be made aware of changes made in response to incidents.

Services for older people

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

Both the wards could only be accessed and exited via the use of a swipe card. Only staff could use the swipe cards, therefore access to and exit from the wards had to be facilitated by the staff. The staff told us that both wards were locked to provide a safe environment. A locked door policy was in place that confirmed this. Signs were found on or around the exits that explained informal patients could request to leave the ward by speaking to a member of staff. The trust may wish to note that the signs were not written in an easy read format to help patient's understand their rights to leave the ward. Some patients on Malvern ward understood their right to leave the ward, however people we spoke with on Holyrood were not aware of their right to leave the ward. One person said, "It's upsetting being locked inside". Another person said, "I feel trapped. I like freedom, we must have freedom". This meant that people were cared for in a secure environment, but informal patients may not have always understood their right to leave the ward.

We saw that people on Malvern ward could freely access their bedrooms throughout the day. However, Holyrood ward had multiple locked corridors containing bedrooms. We asked the ward manager why the bedroom corridor doors were locked. They told us they were locked to reduce the numbers of unwitnessed incidents on the ward. They gave us a document titled, 'Holyrood ward: Efficacy of locked corridor doors'. This document confirmed that the doors had been locked to reduce unwitnessed incidents. There was no evidence that other options had been considered to reduce the numbers of unwitnessed incidents on the ward, such as a review of staffing levels. This meant that people could not be assured that locking the bedroom corridors was the least restrictive option to ensure their safety.

People could only access their bedroom if a member of staff facilitated this. No signs were visible on the corridor doors to show people that bedrooms were located on the other side of the door and no information was visible to inform people on how they could access their bedrooms. During our inspection two people approached us asking where their bedrooms were. We asked one person how they would go about trying to find their bedroom. They said, "With great difficulty. I would walk and walk and walk like I did yesterday". This meant that people who use services did not have access to information to enable them to orientate themselves to the ward environment.

There was limited signage in the bedroom corridors to show people how they could exit the corridors. Exit buttons were available at some of the exits. This meant that people could exit some of the doors independently if they understood the system. The signs we did see, that contained information about exiting the corridors, were not located on the doors and they were not clearly visible to the people who used services. We saw one person attempt to leave their bedroom corridor. They knocked on the exit door and shouted, "He's shut me in, can you let me out?". A member of staff responded to the person's request after a two minute period and they were assisted to leave the corridor. This meant that at times people were restricted to certain areas of the wards as they were not always aware of how they could freely exit the bedroom corridors.

We asked four members of staff and two student nurses if the people who use services could access their bedrooms during the day. All the staff and one student nurse told us that people could access their bedrooms with staff assistance. However one student nurse said, "Patients are not allowed in their bedrooms during the day. They will just go to sleep and cause problems through the night". This meant that patients may not have received a consistent approach from people who were responsible for delivering care and support.

We saw that patient call bells were not available in people's bedrooms on either of the wards. Malvern ward had a system in place where identified people could be given a call alarm that was worn on their wrists. The ward manager told us they only had three of these wrist call alarms. This meant that if more than three people required a call alarm, there would not be enough to meet the identified need. We asked staff on Holyrood how people could summon help if they were in their bedrooms. One staff member said, "I can't answer that". The ward manager said, "Patients couldn't raise the alarm or call for help, but you would hope that we would be checking on them regularly enough". We asked the ward manager how they would ensure these checks were planned and completed. They said, "We would check on them every five to ten minutes. It's not recorded; it's an ad hoc thing". This meant that on

Services for older people

Holyrood ward people who use services would not be able to effectively summon help if they needed to when they were in their bedrooms which were located in locked corridors.

During our inspection we witnessed an incident where one informal patient's behaviours that challenged were managed by restricting their movements around the ward. The person was contained within a bedroom corridor for approximately 30 minutes. During this time we witnessed the person attempting to leave the corridor which resulted on them banging and kicking the doors and shouting, "Let me out", and, "call the police". This appeared to be an episode of seclusion as the person was not free to return to the main ward. This meant that the person was prevented to leave the corridor despite requesting to leave.

The person sustained an injury during this incident. This was because the environment they were contained in to manage their behaviours that challenged was not safe or suitable for their needs. This meant the individual was not protected from harm during the incident.

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

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

Medical staff told us they followed guidance from the National Institute of Health and Care Excellence (NICE). This meant that people received medical assessment and treatment that was based on the best available evidence of good practice. The trust may wish to note that peoples care records did not always record the clinical reasoning and justification of medical decisions. For example, one person's antipsychotic medicine was increased even though their care records showed they were settled on the ward. This meant that we could not find a record of the medical team's justification for changing the person's treatment.

The NICE guidance for dementia recommends that behaviour analysis is completed to aid the assessment and treatment of people's behaviours that challenge. We saw no evidence in any of the care records we looked at that showed that behaviours were analysed. This meant that the causes and progression of peoples' behaviours that challenged were not being analysed in accordance with national guidance.

The NICE guidance for dementia also recommends that people receive specialist functional assessment and treatment from specialist staff. We saw that there were full time occupational therapists who worked on both wards. This meant that people could receive regular functional assessment and treatment in accordance with national guidance.

We saw there was a sensory room on Holyrood ward. The NICE guidelines for dementia recommend the use of multi-sensory stimulation. During our inspection we saw the occupational therapist utilising the room with a patient. The room remained locked for the remainder of our inspection. We asked staff if they accessed the room. The staff told us that it was mostly used by the occupational therapist. One staff member said, "We tend to leave that to the occupational therapist". This meant that the multi-sensory approach was not consistently used by the ward staff as part of peoples care and treatment.

We saw that therapeutic groups, based upon good practice evidence, were facilitated on Malvern ward. These groups were run by the occupational therapist and included relaxation and anxiety management.

Do the staff work in partnership with others?

Pre discharge meetings took place where other professionals pertinent to patient discharge were invited to attend. This could include the persons care coordinator, social worker, relatives and advocate. This meant that the staff worked with other professionals and people that were important to the patient in order to facilitate effective discharges from the wards.

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

How is the quality of care assessed and managed?

A staff member on Malvern ward told us that patient meetings were regularly held. They told us the meetings focused on gaining people's opinions about the quality of the food, activities and the availability of staff for one to one sessions. We asked to see the minutes of these

meetings, but the most recent minutes shown were dated August 2013. This meant that we could not be assured that people's opinions were regularly sought in the assessment and monitoring of quality on the wards.

We asked the ward manager of Holyrood ward if patient meetings were held. They told us they were not. They said, "We have tried this in the past but they were not successful. The last one was about a year ago". This meant that people's opinions about the quality of care and treatment were not regularly sought.

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

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

Staff told us they received regular mandatory training which included moving and handling, infection control and safeguarding adults. We were unable to confirm that all staff were up to date with their mandatory training by looking at staff records, but the staff we spoke with were able to give us information which demonstrated they understood moving and handling, infection control and safeguarding subjects. The staff also told us that they were required to undertake regular training in the Management of Actual or Potential Aggression (MAPA). During our inspection we asked six staff if their MAPA training was in date. Four out of the six staff told us they had either not completed MAPA training or their training was now out of date. One person told us that they didn't feel all the staff knew how to manage incidents involving behaviours that challenged. They described how staff responded to an incident they were involved in. They said, "The nurse saw it happen, but I think she was shocked and didn't know what to do". This meant that although staff had received some mandatory training, some staff were not suitably trained to safely manage and support people who exhibited behaviours that placed them or others at risk of harm.

Holyrood ward provided care and treatment to people with a diagnosis of dementia. Staff told us they had not received recent dementia training from the trust. We saw that one person's care plan stated, 'Validate X's (the patient) thoughts and feelings". Validation theory is an intervention used in dementia care. It involves treating people with empathy and understanding to help them to work through their emotions. For example, if a person asked to see a deceased relative staff should try to understand why the person seeks that support. We asked three staff members how they would respond to an older person who was asking for a deceased relative. All three staff members told us they would distract the person rather than try and work out why the person needed the support from their deceased relative. During our inspection we observed one person repeatedly asking to see their deceased husband, and another person frequently asked if they could go and see their deceased mother. We observed staff either ignoring the peoples request or distracting the people. This meant that the staff did not have the skills to implement the validation theory in accordance with peoples' care plans.

Some people on the ward did not always have the ability to make specific decisions about their care and treatment. When a person is unable to make a decision for themselves, then a best interest decision can be made if it is in accordance with the Mental Capacity Act 2005. This act stipulates that when making a best interest decision staff must consider whether there is another way of making the decision which would have less effect on the person's rights and freedom. This is known as the least restrictive principle. After we observed the previously described incident on Holyrood ward which involved restricting a person's movements within a locked corridor, we spoke with five qualified nursing staff to see if they understood the concept of least restrictive principle. Four of the staff told us they would manage the person's behaviour in the same manner as we witnessed as they believed they were acting in the person's best interests. Only one of the nurses told us they may have managed the incident in a different way. They said, "I could have followed the person around the ward at a safe distance and intervened as necessary". This meant that four of the five nursing staff lacked the knowledge and understanding required to follow the least restrictive principle and people who use services could not be assured that their rights would be promoted.

Both wards used agency staff to ensure there were sufficient staff numbers to deliver patient care and

treatment. Student nurses also worked on the wards. Agency staff and the students we spoke with confirmed they had received suitable ward inductions to enable them to work effectively on the wards.

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

We looked at one person's care records who was detained under the Mental Health Act 1983. Care records relating to their detention, care and treatment showed that the principles of the Act had been followed and adhered to. For example we saw that the patient had been read their rights under the Act.

Are services for older people caring?

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

The people on Malvern ward told us they were involved in making decisions about their care and treatment. One person said, "The doctor involves me in my care".

We spent time observing the care on Holyrood ward during the evening of our unannounced inspection. We saw that a staff member turned the TV off and turned the radio on without any consultation with the people. We saw that the people who use services were guided into the dining room at supper time where they were offered toast and a hot drink. People were not given the choice of eating their supper in the lounge area rather than the dining room. This meant that people were not involved in making these decisions.

Some people on the wards were unable to make decisions about some aspects of their care and treatment. Care records showed that best interest decisions were made in accordance with the Mental Capacity Act 2005. This meant that peoples' abilities to make specific decisions were assessed and appropriate professionals and representatives were consulted with to make decisions in the persons' best interests. One relative confirmed this by saying, "We have had to speak for X about their future. We have discussed this with all the professionals".

Are people's needs reviewed regularly?

Care records showed that people received regular reviews by nursing and medical staff. The staff told us that the following issues were discussed during reviews; medication, mental capacity, risks, physical health and discharge planning. This meant there was a system in place to review the needs of patients.

People on Malvern told us they could also discuss their care needs during one to one time with their named nurse. This meant that people who use services were offered different opportunities to discuss their needs.

How do staff ensure people understand their care and treatment?

People on Malvern ward told us that their named nurses helped them to understand their care and treatment during their one to named nurse time. One patient said, "The nurses sit and talk to me about my care plan".

We saw that some staff on Holyrood ward helped people to understand information in a manner that reflected their level of understanding. For example, we saw staff used gestures and actions to assist individuals to understand verbal information. This however, was not always the case. For example, we saw one staff member respond to a person who asked, "Where can I get a bus from? I need to see my mum" with, "Not at the moment, you're not going anywhere". The staff member did not make any effort to enable the person to understand why they could not leave the ward. This meant that people were not always assisted to understand their care and treatment.

Do people receive the support they require?

We saw that peoples' physical health needs were assessed and monitored. Any deterioration in physical health was acted upon. For example, we saw that dietary supplements had been prescribed for a person because staff had identified they were losing weight. Staff also told us how they met the dietary needs of people with diabetes. This showed that people were supported to maintain their physical health.

We spent time observing the care on both wards. We saw some positive interactions between staff and the people who use services. For example, we saw that a person was comforted after an incident involving another person assaulting them. We also saw that some staff initiated conversation with a person who was under constant observation. However, we also observed some negative interactions. We observed one person walking around Holyrood ward attempting to find their bedroom. We saw two staff members ignore this person when they asked how

they could find their bedroom. We also saw that one staff member did not actively interact with the person they were supporting who was on constant observation unless they asked them a direct question. This meant that people were not consistently treated with compassion.

Some people on the wards had Deprivation of Liberty Safeguarding (DoLS) authorisations in place. These safeguards should ensure that a care home or hospital only deprives someone of their liberty in a safe and correct way, and that any restrictions are only made when it is in the best interests of the person and there is no other way to look after them.

We asked six staff if any people had a DoLS authorisation in place. None of the staff could give us an accurate answer detailing which people had an authorisation in place. This meant that the systems in place for handing over information about peoples' needs was not always effective and people were at risk of receiving unsafe or unsuitable care.

People on Malvern ward told us, and we saw, that leisure based and therapeutic activities were promoted on the ward. During our inspection we observed staff running a bingo session for people to participate in. Staff told us that activities were promoted on Holyrood ward, but during our inspection we observed no provision of leisure based activities other than the TV and radio being on. Peoples' relatives confirmed that they also observed no activity provision. One relative said, "More should be going on. It would stop people wandering around so much". This meant that leisure based activities were not consistently promoted within older people's services.

Are people treated with dignity and respect?

People who use services and their relatives told us the staff treated them with respect. One person said, "The staff are all nice". One person's relative said, "The staff respect X, they have been fantastic". This meant that people and their relatives felt they were treated with respect.

On Holyrood ward we saw that every person had a commode in their bedroom. We asked staff why this occurred when the people were able to walk to the toilets. Staff told us that the commodes were there to offer people choice. We asked if there was a system in place to remove commodes from individual rooms if they did not require one, but we were told that the need for commodes was never assessed. This meant that the person's previous level of function was not always acknowledged and respected and their previous routines and independence were not always promoted.

We saw that the environment placed people at risk of receiving care that compromised their dignity; this was because the wards were mixed gender. Holyrood ward had separate toilets for males and females, but these were not easily identifiable. During our inspection we observed males accessing the female toilet and vice versa. On two occasions we saw male patients using toilets with the doors open. These toilets were in direct view of communal areas which meant the two patient's dignity was not maintained.

We requested a formal risk assessment around this issue, but were told one was not available. The staff told us they always tried to encourage people to use the correct toileting facilities, but this was very difficult to monitor. This meant that an effective system was not in place to assure people that their dignity would be consistently maintained.

We saw that the patients' confidential information was not protected on either of the wards. Both wards had large patient boards that were located in the nurse's office. These boards contained confidential information, such as a patient's detention status under the Mental Health Act 1983. The patient board on Malvern ward was visible to the public from outside the office window and the patient board on Holyrood was visible to patients and their visitors from the corridor. On Holyrood ward information highlighting which patients were diabetic was recorded on a board in the dining room that was also on display to patients and their visitors. This meant that patients' confidential information was not protected.

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

(for example, to feedback?)

How do the staff meet the diverse needs of people?

We saw that people on Malvern ward were given information that told them about the hospitals weekly communion and prayer room. We were unable to establish

if people received support to attend communion as no person we spoke with wanted to access this service. This meant that opportunities were available for some people who wished to seek religious support.

Staff told us that a telephone interpretation service could be used if people's language needs required this. This meant a system was in place to enable people whose first language was not English to be involved in their care and treatment.

People told us, and we saw, that their preferences of when they would like to go to bed could not always be met. On Malvern ward we saw that four people were sitting in the lounge at 11.50 pm. They told us they were waiting for their medication. We asked all four people what time they preferred to go to bed. Two people did not answer, but two people told us they preferred to go to bed between 10.00 pm and 10.30 pm. They told us that they did not usually have to wait for their medicines, but they had experienced recent delays in receiving their night time medicines. Staff told us these delays were due to the use of agency staff who were not familiar with patients' medication needs. On Holyrood ward during our evening observation, we observed one person asking to go to bed on five occasions during a 30 minute period. We asked the staff member who was supporting this person why they could not go to bed. The staff member said, "They have to wait for their supper and medicines". This meant that individual preferences could not always be met.

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

We saw that emergency medical equipment was available, this included a defibrillator. Staff told us they were trained in resuscitation techniques and the information they gave us about how they would respond to a medical emergency confirmed this. Nursing staff told us that they had access to on site doctors during the evening and night. This meant that staff had a system in place to seek emergency medical support out of hours.

How does the trust facilitate transfers and discharges between services?

The staff told us that some people were admitted to the wards because a bed in their local area hospital was unavailable. The staff we spoke with told us that when this situation occurred, they regularly communicated with the person's local hospital and people were transferred as soon as a bed was made available. This meant that if people were admitted to the wards because beds were not available at their local hospital, a system was in place that ensured they were transferred to their local area as soon as possible.

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

How do the staff learn from feedback?

Staff on Malvern ward told us that peoples' feedback was regularly sought through patient meetings. People were unable to confirm this and no recent minutes were available to demonstrate that feedback was acted upon.

We saw that people who use services and relatives were given feedback forms on Malvern ward giving them the opportunity to provide feedback about the care and treatment. However we did not see any results from these feedback forms and we were not shown evidence of how the comments had been analysed or acted upon. Therefore, we were unable to ascertain if the feedback gained was used to improve quality.

Relatives we spoke with on Holyrood ward told us their feedback about the quality of care had not been sought. One relative told us, "I don't feel enough information has been supplied about my relative's dementia". This meant that there was no effective system in place to gain feedback from peoples' relatives.

There was a complaints system in place which people and their representatives could use. People and their relatives told us they would be happy to make a complaint if they needed to. One ward manager we spoke with told us how they would manage a complaint to ensure that it was investigated and managed appropriately.

Services for older people

Are services for older people well-led?

Is there a clear vision for services for older people?

We spoke with six medical and nursing staff members about the future of older people's services at Bushey Fields. All the staff told us they were unclear about the future of the services. One staff member said, "There is no regular forum to discuss this yet, but I expect the new managers will set this up". Another staff member said, "We are waiting for the commissioners to decide what service they want". This meant there was no clear vision outlining the purpose and future of older people's services at Bushey Fields.

Are the staff engaged in service improvement?

The nursing staff were encouraged to attend staff meetings where service improvement ideas could be discussed. We saw that some areas for improvement were discussed and shared during staff meetings. For example, changes to nursing documentation were shared so that the care records could be more effective. Allied health professionals and medical staff told us they also had regular meetings where service improvement was discussed. This meant that information was shared with staff at a local level in relation to service improvement.

We asked four members of nursing and allied health professional staff if they were aware of a service improvement plan for the services for older people. All four confirmed they had heard of this, but did not know how to access it. We asked the trust to share their older people's service improvement plan with us, but we have not received this. This meant we could not confirm if a formal plan was in place outlining if the trust had identified whether the services for older patients at Bushey Fields was in need of improvements and how these were to be made.

In total we spoke with 26 members of staff who worked on the Bushey Fields older people's wards. Staff interviews were held on a one to one basis or through focus groups. All the staff were aware of the systems in place to report concerns with quality and standards. However, two of the staff felt that they were not able to share concerns about quality with senior managers. Another staff member also told us they did not feel engaged in service improvement. They told us, "The trust is autocratic". This meant that a small group of staff felt they could not or were not able to participate in service improvement processes.

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

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

We saw no evidence that the results of the audits were analysed and shared in a timely manner. For example the minutes of the older adults' service standards meeting dated 19 February 2014 recorded that a falls audit had been completed. The minutes stated, 'the audit was done during summer 2013 and the recommendations are still to be discussed and circulated'. This meant there had been a significant delay in sharing the recommendations to improve quality and reduce the risk of falls.

We also saw that care records audits were being completed by the deputy manager on Holyrood ward. We saw that the last audit on 14 January 2014 had identified that improvements were required. We saw, and the deputy manager confirmed, that no action plan had been put in place yet to address the identified issues. The ward manager told us they left care record audits to the deputy to complete and follow through. This meant that the ward manager was not aware, and was not overseeing, the care record audit process to ensure that prompt action was being taken.

Staff told us, and we saw, that ward managers responded to staff concerns. For example, we saw an incident had been reported by a staff member about inappropriate staff behaviour on one of the wards. This incident had been investigated and prompt action had been taken to address the concerns that had been raised. This meant that ward managers responded promptly to concerns where staff actions had the potential to impact negatively upon patient care.

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

How are the staff supported?

Through one to one interviews and focus groups we spoke with 26 members of staff who worked on the older people's wards at Bushey Fields. All staff told us they felt supported by their line managers and the teams they worked within. One staff member said, "The manager is very approachable". Another staff member said, "I can go to my manager if I need to". This meant that staff felt supported within their local teams.

All the staff told us they had opportunities to attend reflective practice sessions and annual appraisals. Nursing assistants on Holyrood told us they did not receive regular formal supervision and we were unable to speak to any permanent nursing assistants on Malvern ward about supervision. Supervision is a process where staff competency and development needs can be regularly assessed and monitored. We asked the ward manager about supervision for nursing assistants. They said, "They are encouraged to go to the reflective practice sessions and they can take up clinical supervision from any staff member if they wanted to. It's up to them who they go to". Nursing assistants we spoke with told us they did not have clinical supervision. This meant that there was no formal system in place to enable the competency and development needs of nursing assistants to be regularly assessed and monitored.

We looked at how staff safety was managed on the wards. Permanent staff told us they had been issued with personal alarms, but there was inconsistency amongst temporary staff as less than half of them told us they had been issued with an alarm. These alarms could be used in the event of an emergency situation such as, if a patient exhibited threatening behaviours. We asked 13 staff across the two wards if they had an alarm on their person. Only two of the 13 staff were carrying their alarms. We asked the ward manager on Holyrood if there was a system in place to ensure that staff wore there alarms. They said, "They know they should have them, I can only tell them so many times". This meant there was no effective system in place to ensure that staff could seek assistance in the event of an emergency.

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 Treatment of disease, disorder or injury	Regulation 9(1)(b)(i), 9(1)(b)(ii) and 9(1)(b)(iii) The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe, by means of – b) the planning and delivery of care and, where appropriate, treatment in such a way as to – i) meet the service users individual needs, ii) ensure the welfare and safety of the service user iii) reflect, where appropriate, published research evidence and guidance issued by the appropriate professional and expert bodies as to good practice in relation to such care and treatment This regulation was not being met as patients were not always cared for in an environment that assured their safety and welfare. Individual patient preferences and needs were not always met because the staff did not have the knowledge and skills to meet these needs. We saw that seclusion was practiced without following the guidance from the Mental Health Act 1983 Code of Practice.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10(1)(b) The registered person must protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to –

Compliance actions

b) identify, assess and manage risks relating to the health, welfare and safety of service users and others who may be at risk from the carrying on of the regulated activity.

This regulation was not being met because an effective system was not in place to manage patient's identified risks.

An effective system was not in place to enable patients to summon assistance in the event of an emergency. This risk had not been adequately managed on Holyrood ward.

There was no effective system in place to ensure that staff could summon assistance in the event of an emergency where they or others were at risk of harm.

Patients could not be assured that risks were managed in accordance with the least restrictive principle.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury	Regulation 17(1) (a) 17.—(1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure— (a) the dignity, privacy and independence of service users; How the regulation was not being met: We found that people's privacy and dignity was not respected because the separate toilets for male and female patients were not easily identifiable. We saw male patients using female toilets and vice versa and staff did not intervene. We saw male patients using toilets and not closing the doors, these toilets were in the communal areas of the ward and could be directly viewed. We saw that each bedroom had a commode placed in there at night. Staff told us told that the need for commodes was never assessed. This meant that the person's previous level of function was not always acknowledged and respected and their previous routines and independence were not always promoted.