Ambleside Ward, Dorothy Pattison 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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

Ratings

Overall rating for this location

Are services safe?	
Are services responsive?	

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Acute wards for adults of working age and psychiatric intensive care units		Ambleside ward is a 21-bed ward that provides acute mental health care for adults of working age within the Dorothy Pattison Hospital. It is a female-only ward which cares for: • patients detained under the Mental Health Act (1983) • informal patients. Dorothy Pattison Hospital is run by Dudley and Walsall Mental Health Partnership NHS Trust and was last inspected in February 2016 and was rated by CQC as requiring improvement.

Summary of findings

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

Summary of this inspection

Our inspection team

Team Leader: Julie Bains, CQC Inspector (Mental Health) Central West region

The team that inspected the service comprised three CQC inspectors.

Why we carried out this inspection

We carried out this unannounced responsive inspection after CQC received a number of concerns from patients during a Mental Health Act Reviewer's visit. Patients told us they were concerned about safe staffing levels, and safeguarding of patients and children. CQC inspectors did not review every aspect of the safe and responsive care, as this was reported in the comprehensive inspection on 1-5 February 2016, when we rated the provider as requires improvement.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited Ambleside ward, looked at the quality of the ward environment, and observed staff interaction with patients
- spoke with the deputy manager
- spoke with eight patients who were using the service
- spoke with six other staff members; including consultants, nurses, the activity coordinator and healthcare assistants
- looked at two treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service including infection control audits, minutes of meetings, staff rotas, training and sickness absence records, incident reporting and complaints records.

Information about Ambleside Ward, Dorothy Pattison Hospital

Ambleside ward is a 21-bed ward that provides acute mental health care for adults of working age within the Dorothy Pattison Hospital.

It is a female-only ward which cares for:

- patients detained under the Mental Health Act (1983)
- informal patients.

Dorothy Pattison Hospital is run by Dudley and Walsall Mental Health Partnership NHS Trust and was last inspected in February 2016 and was rated by CQC as requiring improvement.

What people who use the service say

Five patients said they felt safe on the ward, as staff were available to deal with situations as they happened and they could talk to staff when needed. However, patients said the staff sat in the office rather than in the communal areas.

Detained patients said the ward never cancelled planned section 17 escorted leave but unplanned section 17 leave was delayed until a member of staff was available to escort them to the local shops.

Summary of this inspection

Patients said they do not have locks in their bedrooms doors and not being able to lock them has resulted in personal possessions going missing.

Patients said the planned activities on the ward did not always take place if the activities coordinator was not on duty.

Summary of this inspection

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found the following areas of practice that needed to be addressed:

- Patients and staff told us the use of bank and agency staff was high and one to one meetings with their named nurse did not always take place.
- Patients told us that staff spent too much time in the office and not in the communal areas.
- Staff we spoke to were unclear on the trust's child visitor's policy and where patients and child visitors could meet on the ward.

However, we found the following areas of good practice:

- The ward undertook infection control audits on a monthly basis.
- The trust met safe staffing levels on the ward and the deputy manager was able to increase staffing levels when required to keep patients safe.
- Detained patients never had planned section 17 leave cancelled.
- Staff discussed learning from incidents and changed processes resulting from the lessons learned
- Staff received training and had to meet the competencies required before they undertook observation of patients to keep patients safe.

Are services responsive?

We found the following areas of practice that needed to be addressed:

- The patient's bedrooms did not have locks on the doors, so were unable to lock their rooms to keep their possessions safe and secure
- Planned ward based activities at weekends were not always delivered by staff.
- The ward did not display information on how to make a complaint.
- The ward staff did not follow the trust's complaints policy

However, we found the following areas of good practice:

Summary of this inspection

- The ward had a range of facilities to support patients' needs and an activities coordinator to deliver ward based activities.
- Patients said they could personalise their bedrooms with personal possession from home.
- The patients had access to a large, secure garden area.
- Patients and staff said patients could to keep their mobile phones whilst on the ward.

Detailed findings from this inspection

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

Safe	
Responsive	

Summary of findings

We found the following areas of practice that need to be addressed:

- The locks to the bedrooms had been removed so patients were unable to secure their rooms
- Patients reported staff spent too much time in the office and not enough time with them in the communal ward areas. Detained patients had to wait up to two hours before staff became available to take them on unplanned section 17 escorted leave.
- Staff we spoke to were unclear on where child visits should take place and they did not follow the trust's policy for pre-arranged visits for child visitors. Staff did not fully adopt all new practices resulting from the learning from an incident. Not all concerns and complaints raised by patients were recorded.

However, we found the following of good practice:

- The hospital had single-sex accommodation, which complied with Department of Health guidance on same-sex accommodation.
- Safe staffing levels were met for May-July 2016. The deputy manager was able to increase staffing levels to provide safe levels of care. The deputy manager assessed the competencies of the staff before being allowed to undertake one to one observations with patients. Staff understood the principles of safeguarding and raised safeguarding alerts. Staff reported incidents and received feedback during handovers, debriefings and monthly meetings.
- The activity coordinator planned activities for patients and patients had access to the activities room at all times.
- Detained patients planned section 17 escorted leave was never cancelled

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Safe and clean environment

- Ambleside ward is a female only ward and complies with Department of Health guidance on same-sex accommodation.
- Staff followed infection control principles and we saw records of audits undertaken between May and July 2016 reporting 100% compliance for hand hygiene.
- The ward was visibly clean, airy, well maintained and suitably furnished.
- The garden was well maintained, secure, and accessible to patients and visitors at all times.
- All staff on the ward had alarms. An emergency nurse call system was in place to summon support from other wards when this was required.

Safe staffing

- Staffing levels were two qualified nurses and three healthcare assistants during the day and one qualified nurse and three healthcare assistants at night. The night shifts, when up to full establishment, ran on two qualified and two healthcare assistants. We saw evidence of this happening in the shift rotas we reviewed. If needed, the ward had access to a night coordinator, a qualified nurse, who provided additional nursing cover, when required.
- There were staff vacancies on the ward for one qualified nurse and one healthcare assistant. The deputy ward manager said the trust was recruiting to fill the vacancies.
- Over the previous three months, 01 May to 31July 2016, the ward had employed bank and agency staff to cover 621shifts. The deputy manager told us, to provide continuity of care; the qualified nurses who worked on the ward covered the majority of planned sickness and

annual leave. In addition, one qualified agency nurse had worked on the ward every week for the previous seven months. The patients said regular nurses and healthcare assistants staffed the ward although they often saw different healthcare assistants on the ward, especially undertaking one to one patient observations.

- The sickness rate for the 12 months up to June 2016 was 7.9% against a NHS national average of 4.5%.
- Trust data showed the ward achieved safe staffing levels for the months May to July 2016. The staffing rotas covering 25 April to 07 August 2016 showed sufficient staff on the ward and an appropriate skill mix achieved. However, patients and staff told us the level of bank and agency staff affected the quality of patient care. They said the lack of substantive staff negatively influenced nurses' availability to undertake weekly one-to-one sessions with the patients.
- The deputy ward managers were able to adjust levels of staffing to meet their needs. For example, where a patient required close observation they were able to ask additional staff to undertake the task. During the inspection, we saw an increase in staff numbers to provide increased patient observations.
- Five patients told us the staff spent too much time in the office and not enough in the communal areas. Patients said when staff were in communal areas did not engage with the patients. The ward staff meeting minutes dated 24 June 2016 recorded that staff had been told to interact more with patients.

Assessing and managing risk to patients and staff

- Staff told informal patients on the wards that they were free to leave at any time and the entrance to the ward displayed this information. Patients and staff told us planned section 17 escorted leave for detained patients was never cancelled due to staff shortages. However, some detained patients told us they had to wait for up to two hours for unplanned section 17 leave, for example to visit a local shop. Detained patients said this was due to staff been unavailable to escort them when they made the request.
- Detained patients said the doctor reviewed and discussed their planned section 17 escorted leave on a weekly basis.
- The deputy manager said all staff, including agency staff, had to pass an 'observation competency test' by completing a questionnaire and discussing it with the manager before it was agreed they were competent to monitor patients who required regular observations to keep them safe. We saw evidence that staff had completed the observation competency test.
- The trust policy stated child visitors were permitted on the ward by prior arrangement. However, patients and staff reported child visitors would arrive with other visitors without prior arrangement.
- The ward staff we spoke gave different responses when we asked where children should take place, some said in the canteen, on the ward in the activities room, in the garden or in the staff area. The deputy manager told us the visitors' room, which was in the communal area, had become the patient activities room because the previous arts room was in a staff only area, which had restricted access for patients to when staff were available to supervise patients. This change resulted in activities being available to patients at all times. However, the new activities room was still used to accommodate child visitors. The deputy ward manager said they were in the process of sourcing a more suitable room for visits.
- One patient reported their child visitor had become upset when another patient frequently accessed the activities room during a family visit. Staff completed an incident form and a safeguarding alert submitted.
- Staff demonstrated they understood the principles of safeguarding and knew how to raise a safeguarding alert. Procedures were in place on the ward to ensure that safeguarding concerns were dealt with appropriately and immediately. The trust provided Ambleside ward safeguarding records for May-July 2016. Trust data showed a total of 26 alerts and 10 referrals raised by ward staff.

Reporting incidents and learning from when things go wrong

- The Trust provided details of the 123 incident reports by ward staff for the period 01 May to 31 July 2016 of which 12 were patient on patient physical assaults. This showed staff followed the incident reporting procedure and, during staff interviews; they demonstrated a good knowledge of how to report incidents.

- Managers provided staff with feedback from incidents at handovers, debriefings, and monthly meetings. Team meeting minutes for June and July 2016 showed the learning from an incident and staff discussed outcomes.
- There was evidence of staff responding to incidents and making changes to procedure on the ward. For example, a patient stated one of their possessions had gone missing from the storeroom. As all staff, including agency staff, had access to the storeroom, it meant investigating the incident was difficult. The deputy manager said the learning from this incident was that only substantive staff had keys to the storeroom and they signed a form to say they had accessed the storeroom, providing an audit trail should a similar incident happen again. The minutes of the team meeting on 21 July 2016 record that only regular staff have access to the storeroom and only those staff can store or return belongings to patients. The minutes did not refer to the updated process, which included the form for staff to sign. Staff confirmed only substantive staff had held the key to the storeroom but were not aware they were required to sign a form when they had entered the storeroom. This showed not all learning from the incident had been adopted in to practice by ward staff.
- A number of incidents had occurred on the ward, which had resulted in patients not having locks on their bedroom doors. Patients said they were unable to lock their bedroom doors to protect their property, resulting in property going missing from their rooms. Staff told us if the items were of low value, such as toiletries or underwear, they did not complete an incident form or raise the issue as a safeguarding alert. The trust confirmed that theft of any patient property, regardless of value, should be recorded using the incident reporting and safeguarding procedures. The Trust told us that since the Care Quality Commission's Mental Health Act reviewer had raised the issue during their visit, a request to reinstate the locks had been submitted to the estates department.
- Staff said that in the event of any incidents taking place on the ward they spoke to patients to let them know if anything has gone wrong. Two patients said that staff did inform them when things went wrong and staff asked how the incident had affected them. However, three patients said staff had not informed them of the outcomes of incidents.

Are acute wards for adults of working age and psychiatric intensive care unit services responsive to people's needs? (for example, to feedback?)

- **Access and discharge**
  - In the first six months of 2016, the bed occupancy rate on Ambleside ward was 107%. The percentages were greater than 100% because sometimes the ward had more patients then beds. This was because some patients were on leave.
  - When patients returned from leave in the community the bed that they had previously occupied was not always available. This was because of the pressure across the trust to find beds for people needing immediate admission to hospital. When a patient's bed was not available on return from leave, the trust found the patient a bed within the trust. However, some staff said that this caused problems for patients because patients would be potentially in an unfamiliar ward environment and supervised by different staff. Two patients said they felt anxious when going on leave in case they lost their bed and had to go to another ward. While other patients said, they had been on overnight home leave many times and their bed was always available on their return.
- **The facilities promote recovery, comfort, dignity and confidentiality**
  - On the ward, there was a range of facilities to support patients' needs. These included a lounge, kitchen, clinic room, dining room, and an activities room.
  - There were limited rooms for patients to meet visitors and the patients said they would use the canteen or the garden for visits. However, they said if they required privacy, the staff on the ward would facilitate the request.

- Two patients reported that the ward did not have suitable visiting rooms for child visitors; this had led to one child visitor become upset due to another patient accessing the room during a visit.
- Patients were able to personalise their bedrooms with personal items and decorations during their stay on the ward. On admission, the staff completed a property log, listing all items brought in with patients. The trust has a policy in place for staff to follow for the management of personal items that could present a risk. For example, staff kept mobile phone chargers, hairdryers and hair straighteners in a separate locked storeroom with only staff access, as the electrical leads could be used as a potential ligature. A ligature point is a fixed item to which a person could tie something for the purpose of self-strangulation.
- There were lockable safes in each of the patients' rooms to allow them to store their possessions. Where patients needed to store large amounts of valuables they could do so in a safe located in the nursing station until transferred to the trust's cashier.
- The patients told us they were unable to lock their bedrooms. They said this affected their privacy and dignity and had resulted in other patients entering their rooms and removing personal items.
- The ward allowed patients to use personal mobile phones. On admission, staff asked patients to sign an agreement that they would respect the privacy of others and not take photographs or make recordings on the ward. Patients and staff said patients had access to a ward phone to make private phone calls.
- Patients on the ward had access to a well-maintained garden, which they frequently used. Staff supervised patient access to the garden, if required.
- Patients had access to activities including at weekends. However, patients told us the activities coordinator only worked 18 hours a week and when they were not on duty, planned activities such as bingo were cancelled, especially on a Saturday.

Meeting the needs of all people who use the service

- The ward used noticeboards and leaflet stands to display information for patients covering a range of subjects including the Mental Health Act and patients' rights, healthy eating, and local and national support networks.

Listening to and learning from concerns and complaints

- The trust provided the complaints record for 01 May to 31 July 2016, which showed Ambleside ward had one formal complaint and one informal concern. The concern had been resolved and the complaint was still under investigation.
- The deputy manager stated there should be a noticeboard on the ward displaying information on how to make a complaint, and leaflets available in both the leaflet stand and in the welcome pack given to patients on admission. We undertook a tour of the ward and could not see this information on display, which we brought to the attention of the deputy manager, who acted on our concerns immediately, requesting the administrator to print leaflets and update the welcome packs. The deputy manager told us they would update the noticeboard to display the information.
- Six of the patients that we spoke with said that they knew how to make a complaint and said that they felt confident in making complaints. However, patients said that staff did not listen to or act on complaints or concerns when they had made them and they did not receive any acknowledgement of the complaint or concern from the trust. The staff and deputy manager acknowledged they have received informal concerns regarding the removal of patients' property from their rooms but had not recorded them according to the trust's complaints policy.

The trust immediately started an investigation after the concerns raised by patients during the Mental Health Act Reviewer's visit and will act on the findings of the investigation.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider MUST take to improve

- The trust must replace the locks to patients' bedrooms and give patients the keys so they can secure their bedrooms.
- The trust must ensure staff understand and adhere to the child visitors' policy and know where patients can see child visitors on the ward.

Action the provider SHOULD take to improve

- The trust should ensure staff completes incident forms and safeguarding alerts for all patients' property that goes missing on the ward.
- The trust should ensure all staff adhere to the complaints policy.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The trust must ensure the staff follow policy and procedure to safeguard child visits**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **The trust must ensure patients can lock their bedroom doors.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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