Good

Dudley and Walsall Mental Health Partnership NHS Trust

Wards for older people with mental health problems

Quality Report

Bloxwich Hospital
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Date of inspection visit: 1-2 December 2016
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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RYK01	Bushey Fields Hospital	Holyrood Ward	DY1 2LZ
RYK01	Bushey Fields Hospital	Malvern Ward	DY1 2LZ
RYK34	Bloxwich Hospital	Linden Ward	WS3 2JJ
RYK34	Bloxwich Hospital	Cedars Ward	WS3 2JJ

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

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

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

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

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

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

Summary of findings

Contents

Summary of findings

Overall summary

We rated wards for older people with mental health problems as good because:

- Following our last inspection in February 2016, we rated the wards for older people with mental health problems as good overall and in the safe domain. During our most recent focussed inspection of the safe domain, we have found no evidence to suggest that the rating should change from good.
- The service made robust use of risk assessments and observation to ensure that patients and staff were safe at all times. Staff clearly documented individual risks in patients care records and we saw that these were regularly reviewed.
- Staffing levels were sufficient to maintain the safety of patients and ensured that staff could appropriately manage any challenging behaviour.
- The ward environments were clean and well maintained. Staff were diligent in maintaining the cleanliness of the wards and we saw examples of cleaning schedules and environmental risk assessment.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- There were sufficient staff to meet the needs of patients. The observations' policy was carefully tailored to mitigate assessed risks. Good observational practice by staff engaged patients in meaningful activities with staff doing observations, helping to improve patient well- being and reduce stress and agitation, thereby reducing risk of and behaviours that might lead to untoward incidents.
- Wards had medical cover from doctors and consultants when required, with doctors either present on wards or available at short notice on call. The service managed medicines safely with good support and monitoring from pharmacy services, ensuring patients received medicines they needed safely.
- Staff reported incidents and safeguarding issues. There was a high level of incident reporting because staff were diligent in reporting all issues of potential concern.
- There were robust procedures in place for monitoring, analysing and resolving any outlier incidents, such as higher than expected use of rapid tranquillisation.
- Staff completed risk assessments relating to both the physical and mental health needs of patients upon admission. They updated these regularly. This ensured any risks associated with their well-being were monitored and managed.
- The service checked equipment to ensure it was safe. Wards were clean, well maintained and uncluttered.

However:

- We found a discontinued alarm was still in place in disabled toilet in Holyrood ward. The manager arranged to have this removed once we alerted them to it.
- A maintenance check on a bath chair was overdue. The manager arranged for the service to check this once we alerted them to it.
- Training done by staff was not always captured promptly on the trust's training data.

Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good

Summary of findings

Are services well-led?	**Good** 

Summary of findings

Information about the service

The service provides treatment and inpatient care in Dudley and Walsall for older people with mental health problems.

Each area has one ward that admits men and women with functional mental health problems and one ward that admits men and women with organic mental health problems – most have dementia.

Bushey Fields hospital in Dudley has Holyrood, a 17 bed organic ward and Malvern, a functional ward with 22 beds.

Bloxwich hospital in Walsall has Linden a 20-bedded organic ward and Cedars a functional ward with 20 beds. Since the last inspection, bed occupancy had been reduced to 14 on Linden Ward, with plans to reduce the beds on both Linden and Cedars to ten on each.

Each site has a manager and a clinical lead. They work together closely to provide cover for both wards.

Our inspection team

Our inspection team was led by

James Mullins, Head of Hospital Inspection (Mental Health), Care Quality Commission.

The sub-team that inspected this core service comprised three CQC inspectors.

Why we carried out this inspection

We inspected the wards for older people with mental health problems as part of the unannounced focussed inspection of the trust in November 2016.

We previously inspected these wards in February 2016. There were no compliance actions. However, since then, CQC had received concerns about changes to the running of the service, including concerns about the lack of consultation with clinicians in the changes, and a shortfall of medical resources and qualified staff, leading to a high use of agency staff on some wards. These concerns prompted an unannounced inspection to review the safety of this service.

How we carried out this inspection

To fully understand the experience of people who use services, we asked the following question of this service and provider:

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

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at three focus groups. This information suggested that the ratings of good for effective, caring, responsive and well led, that we made following our February 2016 inspection, were still valid. Therefore, during this inspection, we focused on issues that we had received information about, which were related to the safe domain.

During the inspection visit, the inspection team:

- Visited all four of the wards at two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- Spoke with eight patients who were using the service

Summary of findings

- Spoke with a ward manager, two clinical leads, and a deputy ward manager.
- Spoke with six carers of patients currently using the service
- Spoke with three qualified nurses, six health care support workers, an agency worker, an occupational therapist, a housekeeper, two consultants, a locum doctor, a pharmacist, and two student nurses
- Checked three clinic areas and in the process reviewed medication charts
- Reviewed 14 treatment records
- Observed a ward handover
- Looked at a range of policies, procedures and other documents relating to the running of the service.

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What people who use the provider's services say

Patients and carers we spoke with during our unannounced visit were very positive about the staff and the care and treatment they provided. Patients were complimentary about the friendliness, availability and helpfulness of staff. Most patients we spoke with were very complimentary about the food.

Carers told us that whenever they visited, often without prior notice, they found high standards of staffing in both numbers and quality, and high standards of cleanliness, with patients well cared for.

Good practice

Staff undertaking risk-based observations ensured these were beneficial, rather than intrusive, for patients. They did this by engaging patients in positive interactions and activities, based on a good understanding of their needs and wishes.

Areas for improvement

Action the provider SHOULD take to improve

- The provider should ensure they maintain and check all equipment used by patients in accordance with agreed schedules.
- The provider should ensure that managers keep an accurate record of training done by staff so that they can identify any training needs.

Dudley and Walsall Mental Health Partnership NHS Trust

Wards for older people with mental health problems

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Holyrood Ward	Bushey Fields Hospital
Malvern Ward	Bushey Fields Hospital
Linden Ward	Bloxwich Hospital
Cedars Ward	Bloxwich Hospital

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- Not all areas of the wards were visible from a single view point owing to there being some blind spots. However, we saw that staff were constantly in attendance, so reducing risk. Staff undertaking observations engaged in positive activities with patients, again reducing risk. At night, staff were stationed in the areas of the ward where patients' bedroom were located.
- The service managed ligature risks with comprehensive environmental risk assessments and individual risk assessments. The service effectively balanced ligature risk and the need for a dementia friendly environment on the two organic wards, Linden and Holyrood. Staff were aware of where ligature cutters were located.
- Both men and women were admitted to the wards. However, the wards complied with guidance on eliminating mixed-sex accommodation. Bedrooms for men and women were located in separate corridors and wards had female only lounges.
- Clinic rooms were fully equipped and resuscitation equipment was accessible. Staff checked equipment daily and signed to confirm this. The service audited equipment checks on a monthly basis. Our unannounced visit showed all emergency drugs were in date and checked regularly.
- All ward areas were clean, uncluttered and free of unpleasant odours. Each ward had its own housekeeper who kept furnishings maintained to a high standard. Records and our observations were supported by positive comments by visiting relatives we spoke with, who told us they always found wards clean and well maintained whenever they visited.
- Cleaning schedules were in place and items such as bath chairs had stickers to show when they were next to be cleaned. All these were in date. Maintenance stickers were in place on electrical equipment such as bath chairs. We found a bath chair on Holyrood where the maintenance check was a week overdue. The service promptly contacted the trust estates management to ensure this check took place.
- Environmental risk assessments were in place. Regular legionella checks and reports took place within the service following reports of higher than average levels of legionella in trust premises.
- Staff adhered to infection control principles and the wards displayed hand-washing signs.
- Staff checked fire alarms and doors weekly. All wards had access to appropriate alarms and staff knew how to use them. Staff had personal alarms to alert other staff in the event of assistance being required. We saw these used effectively, with staff responding promptly. However, we noted that a discontinued alarm in the disabled toilets on Holyrood was still in place. The manager agreed it should be removed, and recorded this as an action to do.

Safe staffing

- The safe staffing audit carried out by the trust set the establishment levels for qualified nurses at two per shift at all times. Wards had two nurses rostered to duty on each day shift, supported by health care assistants.
- Managers were able to adjust staffing levels based on the needs of patients. This was evident on wards where additional staff were used to meet fluctuating observation levels required to ensure particular patients remained safe.
- Wards had no current vacancies for health care assistants. Holyrood and Malvern had no current vacancies for nurses. Linden ward had 4.8 vacancies for nurses and Cedars ward had 2.4 vacancies for nurses. These vacancies had been recruited to and new staff were awaiting start dates.
- Staff sickness for the four wards averaged 5.6% for the twelve months to October 2016.
- The service used agency and bank staff when necessary. Data produced by the trust showed agency and bank staff used on 175 occasions in the six months from May to October 2016, mostly to cover vacancies and additional observations. Of these 135 were used on the two dementia wards, Linden and Holyrood. The majority of agency staff used were familiar with the wards and regularly worked with the patient group.
- There were sufficient staff to ensure that 1-1 time, escorted leave, and physical interventions could happen safely. Staff would escort patients to hospital

appointments, and would accompany them initially on any hospital stays, in accord with assessed risk and need. We saw staff using observations positively by engaging with patients in good interactions and activities. We undertook Short Observation Framework for Inspection (SOFI), sessions on Linden and Cedars wards. These study the interactions of patients who may not be able to articulate concerns easily. Results of these showed overwhelmingly positive interactions taking place, with staff reacting promptly to requests, and supporting and enhancing patient safety and well-being.

- Doctors were present on wards every day between 9-5, with weekly ward rounds, and were on call at all other times. The base for out of hours cover was at Dorothy Pattison hospital or at home. The target for a response time out of hours was 30 minutes. The wards at Bushey Fields were located on the site of Russells Hall general hospital meaning that access to medical care was close by. All staff we spoke with told us medical cover was always prompt and good quality.
- Staff had received mandatory training in a range of topics including moving and handling, safeguarding, equality, diversity and human rights. Individual electronic records flagged up where staff were due for refresher training. Centrally held records indicated levels of training on mandatory areas between 60% and 99%. One ward manager told us that these figures did not reflect the level of training compliance within the staff team and gave us examples of recently completed training that was not yet reflected on the centrally available training figures. We spoke with a member of the governance team who told us that action was being taken to make sure training was recorded more promptly on figures kept centrally by the trust. Staff interactions with patients and discussions with us showed staff had a good grasp and ability to practice areas covered by mandatory training.

Assessing and managing risk to patients and staff

- Staff undertook a number of risk assessments on admission. These included nationally recognised risk assessment tools covering all areas of physical and mental health and risk, such as falls, hydration and nutrition and tissue viability. We looked at a sample of 14 care records across the four wards and saw that staff regularly updated risk assessments. There were records of full physical health examinations on admission and records of ongoing attention to physical and mental health needs.
- Staff were clear where there were individual risks and observations were in place to manage these. Most risks were on Linden and Holyrood wards and were related to potential falls. We saw how staff managed falls risks by observations and support to those deemed at risk. Nurses discussed details such as how they would take into account possible effects of colds, infections and medication in falls risks.
- Staff did not use blanket restrictions, however did search patients' property on admission. Staff looked for items such as mobile phone chargers and glass bottles. Staff did this to ensure the safety of patients during their stay. The teams used a sensitive approach in collaboration with the patient.
- Although doors were secure, with a particular emphasis on keeping patients safe on Linden and Holyrood ward, notices by exit doors made it clear that informal patients could leave at will. Staff supported patients in accord with assessed risks to be independent, leave the ward, and make use of the local facilities such as coffee shops and nearby supermarkets.
- Observation policies and procedures were in place to minimise against the risk from potential ligature points and falls. Staff placed themselves in areas of risk such as the bedroom corridors at night. Patients identified as high risk were monitored using level three observations.
- De-escalation techniques such as distraction, talking to and guiding people to quiet areas were widely used so that restraint was a last resort. Staff showed a good knowledge of the individual needs of patients and this helped them distract and engage patients who became agitated. Staff used bedrooms for de-escalation only if this was care planned and risk assessed. We saw staff gently supporting and calming a patient who became agitated and allowing them to gradually become calmer by engaging with them positively or allowing them time and space to settle. Trust figures for restraint for November 2015 to October 2016 showed a total of 153 restraints, with 81 reported on Linden ward. These reflected the fact that the service had a culture of high reporting, and the majority of restraints involved

Good

Are services safe?

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

minimal contact, where staff gently escorted patients away from potential conflict. We observed staff gently de-escalating potential incidents of conflict by good observation and intervention and engagement.

- There had been thirty recorded incidents of rapid tranquillisation administered on the wards in the year from November 2015 to October 2016. Twenty of these were reported on Linden ward. Staff recorded each of these incidents and the governance team and the clinical lead reviewed them all. The pharmacy team reviewed all uses of these medicines. The incidents were clustered around specific patients at specific periods earlier in the year. The service took appropriate action to reduce the incidents. Since that time, incidents were less than one a month. The medications used were in line with best practice.
- The wards did not use seclusion rooms or long-term segregation. They encouraged patients to move about freely using the space available, which reduced challenging behaviours. Staff used de-escalation and guided patients away from hostile situations.
- Staff demonstrated a good level of understanding of safeguarding. All nursing staff and health care assistants had received level 3 training in safeguarding. All staff that we spoke to knew how to report a concern and showed an understanding of the process. Staff gave examples of safeguarding incidents they had reported and showed a good awareness of safeguarding issues, and how the service managed these.
- There was good medicines management practice (transport, storage, dispensing, and medicines reconciliation). Staff checked fridge and room temperatures daily. Medicines were in date and prescription charts were clear and well documented. Pharmacy technicians attended the wards daily and identified issues with medication quickly. Nurses dispensing medicines wore red tabards to alert people not to disturb them during medication rounds. Medicines were dispensed individually from the medicines room to reduce risk.
- Staff were aware of and addressed any outlier issues such as falls or pressure ulcers. Body mapping and the falls risk assessments were completed on admission and reviewed throughout a patient's stay. Wards had pressure mattresses on all beds and electrically adjusting beds were available. Staff could request additional equipment as required. Staff were able to discuss risk issues of particular patients knowledgeably, and risk management of falls and pressure areas were person centred.
- There were safe procedures for children that visited the wards. There were areas that visitors with children could use. Designated areas were available on the wards for children to visit and additional risk assessments completed if there were patients with a forensic history on the wards. Families were encouraged to use the conservatory and café areas at the Bloxwich site.

Track record on safety

- There were no serious incidents reported by the service in the twelve months prior to the inspection.
- There were 73 reports of staff receiving injuries in the six months from June to November 2016. These were all classed as low or no harm events, and reflected the culture of high reporting in the service.

Reporting incidents and learning from when things go wrong

- All staff knew what to report and how to report. On three of the wards, all staff were able to report directly into the trust reporting system. On Holyrood ward, health care assistants reported any incident to the nurse, who would then input the incident and details. The manager recognised this created additional work for the nurse, and meant that some incidents may not get reported if health care assistants believed the nurse to be busy. Plans were in place to train health care assistants on this ward to report incidents directly.
- The service had a high level of reporting. In the six months from June to November 2016, there were 478 incidents on all four wards. The ward with the highest number was Linden, with 185, of which 113 were classed as incidents of disruptive or aggressive behaviour. We discussed examples with staff of where staff had reported as incidents where they had intervened to de-escalate potential aggression and violence between patients. Although nothing untoward had occurred because of the intervention, staff were aware that it was reportable as part of risk management. A nurse gave an example of where they had amended a case note soon after it had been recorded as they felt it could have given a misleading view of a situation. They had then recorded this as an incident to ensure that the action was transparent.

Good

Are services safe?

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

- A recent self-harm incident had occurred when staff had not been aware that a relative had given an item to a patient, not realising it could be misused. Staff had responded promptly to this incident, minimising the harm done.
- Staff were open and transparent and explained to patients if and when things went wrong. These usually involved items being lost, or patients being involved in incidents of aggression. Carers we spoke with told how they were kept informed about incidents.
- Staff were able to give examples of feedback and learning from incidents as part of helping to improve the service.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care
<Enter findings here>

Best practice in treatment and care
<Enter findings here>

Skilled staff to deliver care
<Enter findings here>

Multi-disciplinary and inter-agency team work
<Enter findings here>

Adherence to the Mental Health Act and the Mental Health Act Code of Practice
<Enter findings here>

Good practice in applying the Mental Capacity Act
<Enter findings here>

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

Our findings

Kindness, dignity, respect and support

<Enter findings here>

The involvement of people in the care that they receive

<Enter findings here>

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge
<Enter findings here>

The facilities promote recovery, comfort, dignity and confidentiality
<Enter findings here>

Meeting the needs of all people who use the service
<Enter findings here>

Listening to and learning from concerns and complaints
<Enter findings here>

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values
<Enter findings here>

Good governance
<Enter findings here>

Leadership, morale and staff engagement
<Enter findings here>

Commitment to quality improvement and innovation
<Enter findings here>