Birmingham and Solihull Mental Health NHS Foundation Trust

Forensic inpatient/secure wards

Quality Report

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Date of inspection visit: 25 May 2016
Date of publication: 12/09/2016

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXT64	Reaside Clinic	Reaside Clinic	B1 2RB

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

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

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

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

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

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

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

Summary of findings

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Overall summary

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

- Although environmental and ligature point risk assessments were completed they did not identify all risks. A ligature point is anything which could be used for the purpose of hanging or strangulation.
- There were blind spots within the seclusion room and the clear windows compromised patients' privacy and dignity. Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance, which is likely to cause harm to others.
- Anti-barricade door systems were not fit for purpose. They posed risks to staff and patients. An anti-barricade door prevents a person from barricading themselves in a room.
- Staff had access to two resuscitation emergency bags to use across seven wards. Entering and exiting wards with air locks could contribute to a delay in staff accessing the emergency equipment.

However, we also found the following areas of good practice.

- All patients had up-to-date, comprehensive risk assessments and management plans.
- The trust completed a timely investigation and action plan following the death of an inpatient. The trust ensured staff and patients were supported through the process.
- The trust shared lessons learnt across all services.
- The trust had plans to replace all anti-barricade mechanisms at Reaside to one single type by October 2016. Due to the customised build of the mechanisms, completion had been delayed to December 2016.

Summary of findings

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

Are services safe?

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

- Although environmental and ligature risk assessments were completed they did not identify all risks. Ligature risks are places where a patient intent on harming themselves by strangulation could.
- There were blind spots within the seclusion room and the clear windows compromised patients' privacy and dignity. Seclusion refers to the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance, which is likely to cause harm to others.
- Anti-barricade door systems were not fit for purpose. They posed risks to staff and patients. An anti-barricade door prevents a person from barricading themselves in a room.
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- The trust completed a timely investigation and action plan following the death of an inpatient. The trust ensured staff and patients were supported through the process.
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The trust had plans to replace all anti-barricade doors at Reaside to one single type.

Summary of findings

Information about the service

Birmingham and Solihull Mental Health Foundation Trust (BSMHFT) provides a range of secure mental health services at different locations.

Reaside Clinic is one of the locations and the focus of this inspection report.

Reaside provides assessment, treatment and rehabilitation to patients with severe mental health problems who have committed a criminal offence or who have shown seriously aggressive or threatening behaviour.

It has seven male wards: Avon, Blythe, Kennett, Dove, Trent, Swift and Severn. It does not have female wards.

Severn ward is a psychiatric intensive care unit (PICU). This means that it manages patients who are acutely unwell and have higher risks. Avon and Blythe are acute admission and assessment units. Dove, Kennett, Trent and Swift primarily provide rehabilitation services.

People cannot freely access or leave the building and wards as doors are kept locked. Patients using the service are usually detained under the Mental Health Act.

CQC last inspected Reaside Clinic in May 2014. This inspection was part of the BSMHFT comprehensive inspection. The core service was rated as good.

In the 12 months before this inspection, there were five unannounced Mental Health Act monitoring visits. These visits highlighted complaints from patients about the wards' physical environment, the tannoy system and insufficient ward-based activities.

Our inspection team

The team that inspected Reaside consisted of CQC inspection manager, two CQC inspectors, one mental health act reviewer, five specialist advisers and one expert by experience. Experts by experience are people who have had experience as patients or users of services. The specialist advisers included a forensic consultant psychiatrist, nurses and an occupational therapist.

Why we carried out this inspection

This focused inspection was carried out after the CQC reviewed the trusts root cause analysis (RCA) and action plan following an inpatient death. An RCA is a method of problem solving used for identifying the root causes of faults or problems. Reaside had also been issued with a regulation 28 report. A regulation 28 report is issued by coroners when they consider that action can be taken to prevent future deaths.

This focused inspection report reflects detailed findings within the Safe domain only.

An unannounced Mental Health Act review was also undertaken on Severn ward.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about Reaside Clinic, Birmingham and Solihull NHS Trust. We requested information such as the root cause analysis and action plan following an inpatient

Summary of findings

death, policies and procedures for observation, prevention and management of violence and the regulation 28 report and action plan. We announced the inspection a week before to allow the trust time to prepare security procedures and ensure staff availability.

During the inspection visit, the inspection team:

- visited all seven wards and looked at the quality of the ward environments and observed how staff were caring for patients
- spoke with 10 patients who were using the service
- spoke with the managers or acting managers for Severn, Avon, Blythe and Dove wards
- spoke with the matron for Reaside Clinic and reviewed action plans following the recent death
- spoke with 13 other staff members; including doctors, nurses, occupational therapists and psychologists
- attended and observed three handover meetings
- looked at 15 treatment records of patients
- looked at a range of policies, procedures and other documents relating to the running of the service

Areas for improvement

Action the provider MUST take to improve

Action the provider MUST take to improve:

- The trust must ensure that staff are able to observe all areas of the seclusion room.
- The trust must ensure that patients' privacy and dignity is maintained while in seclusion.
- The trust must ensure environmental and ligature risk assessments are reviewed and updated.
- The trust must ensure that staff can safely use the anti-barricade doors currently in place and that all risks they pose are reduced.

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve:

- The trust should review the amount of resuscitation equipment across Reaside.

Birmingham and Solihull Mental Health NHS Foundation Trust

Forensic inpatient/secure wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Severn, Blythe, Dove, Trent, Kennett, Swift and Avon Wards	Reaside Clinic

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

- All ward layouts were similar, consisting of two separate corridors that ran at right angles from a central lounge area. Staff told us they always had a member of staff present in the lounge, so that corridors could be observed.
- The ward layouts did not allow staff to observe all parts of the wards. Convex wall mirrors were used to manage blind spots. However, we found Severn ward had a damaged mirror that did not fully allow staff to view the blind spot. Staff were aware that it was damaged and had reported it one month previously. They told us they were waiting for it to be replaced. Staff did not know how long it would take.
- Ward, estate and risk team staff completed environmental and ligature risk assessments. Joint assessments were a new initiative to improve and provide an objective assessment of the environment.
- We reviewed the environmental and ligature risk assessments and found that staff had not identified all risks. The trust replaced all the anti-barricade mechanisms on Severn ward a few months before our inspection. The new doors had a gap of approximately two inches at the top where a ligature could be attached. The staff had not identified this.
- Wards had anti-ligature furniture, for example, anti-ligature bathroom fittings and wardrobes. This reduced the risk of patients using fittings to harm themselves.
- Staff knew where to access ligature cutters in an emergency.
- Reaside Clinic had a number of different types of anti-barricade bedroom doors. We found them all to be unfit for purpose. This was because they either presented ligature risks or were difficult to use. The anti-barricade doors on the unit, except for the newly installed doors on Severn ward, needed a crow bar or screw driver to remove the anti-barricade device. On Kennet ward, we asked staff to demonstrate the removal of a door. One member of staff was unable to do so as they did not have the physical strength to undo it. When the door was open, it was possible to remove two large pieces of wood from the frame that could then be used as either a weapon or a weight-bearing ligature point if placed between the door top and wardrobe shelf in the bedrooms. We checked the environmental and ligature risk assessments for this ward. Staff had not identified this as a risk.
- The unit did not have clear written guidance on any wards concerning either the use of tools to operate the anti-barricade systems or the safe monitoring of the tools when in use within the ward areas.
- The trust inducted all staff to use the anti-barricade mechanisms in place. The trust had implemented a programme of sessions for staff to practice use of the mechanisms.
- On Dove ward, there were five different types of anti-barricade door system in use. This had the potential for confusion in terms of what mechanism staff would be need to open the door. Staff had colour coded each type of door to reduce confusion. A laminated poster kept in the ward office described the tool to be used for releasing each of the colour coded mechanisms. We felt, in a crisis, this many mechanisms could cause delay.
- We reviewed trust plans that outlined all anti-barricade doors at Reaside would be standardised by December 2016. They had chosen a door that was fit for purpose. This would ensure staff were able to open then in a timely and safe way.
- Wards were male only, therefore complied with the Department of Health guidance on same sex accommodation.
- Each ward had its own clinic room. They were visibly clean and tidy. Staff checked that clinical equipment was maintained and cleaned as necessary.
- Staff across Reaside had access to two emergency resuscitation bags. These were based on Dove and Severn wards. Staff told us they could take the bags to different parts of the clinic within the time set by the

resuscitation council. However, we felt that the door air lock on Severn ward might create a delay for staff entering or exiting, preventing staff getting to the emergency in time.

- Reaside had a seclusion room on Severn ward. It was visibly clean and well maintained. Patients could view a clock and television if wanted, both of which were secured inside a cupboard, within the seclusion room.
- Severn ward also had a High dependency area within the ward. Nurses could use this to care for patients who needed one to one or a quiet space. We could not look at this at the time of inspection as it was in use.
- The seclusion room had a ligature-free toilet and shower area separate to the bed area.
- The seclusion room had a blind spot in the shower and toilet area. We found that staff could not view all of this area, even if they looked into the convex mirror in the bed area. Staff told us that they were able to view this area by using the convex mirror or looking through the acrylic front of a cupboard that housed the television and clock. We found that you were not able to view the blind spot in this way and that by looking through the acrylic frontage staff had to enter the high dependency area.
- The two doors to the seclusion room had metal hatches, through which staff passed items. They also had observation windows. We found that observation through the windows would have been impossible for anyone shorter than around five feet six inches, as the windows were situated high in the door. Staff told us that a high-seated stool had been ordered for shorter staff to use.
- The windows in the seclusion room were clear and overlooked an outside area. This did not provide patients with privacy and dignity.
- The ward environments were mostly visibly clean and tidy, apart from the toilets and bathrooms. They were unclean and there was a strong smell of urine in these rooms on all wards we visited except Trent ward. Bedrooms were not en suite and patients shared toilet facilities. Most wards had three toilets between 14 patients.
- Housekeeping staff worked across the unit seven days a week. We observed staff cleaning the wards. Housekeeping staff followed cleaning schedules.
- We observed good hand hygiene and infection control in practice. Staff checked and recorded fridge temperatures in clinics and kitchens daily. Kitchen areas were visibly clean and had cleaning schedules for staff to follow.
- Receptionists issued all staff and visitors with personal alarms when entering the Reaside. A small crocodile clip attached these to the person. We found these came undone easily and become detached from the person. This would mean a person would not have access to an alarm if it had come unattached unknowingly.

Safe staffing

- Reaside had set nursing staff levels for each ward. This included a band 7 ward manager, band 5 and 6 qualified nurses, and band 3 unqualified nurses. Each ward had slightly different whole time equivalents (WTEs) based on identified needs. For example, Severn ward had a higher staff to patient ratio due to the increased care needs of the patients.
- All wards had one nursing WTE band 7 and three nursing WTE band 6s, except Severn ward, which had five WTE band 6s. Other nursing WTEs for each ward were:
- Avon – 10.53 band 5s and 15.99 health care assistants (HCAs)
- Blythe –10.53 band 5s and 13.12 HCAs
- Dove – 7.92 band 5s and 9.64 HCAs
- Kennett – 7.66 band 5s and 9.64 HCAs
- Severn –13.86 band 5s and 19.89 HCAs
- Swift – 7.92 band 5s and 9.64 HCAs
- Trent – 7.66 band 5s and 9.64 HCAs.
- Reaside had one band 6 nurse vacancy, 14 band 5 nurse vacancies and five band 3 HCA vacancies. Mangers told us that nine band 5s and three band 3s had been recruited and were awaiting start dates.
- Staff sickness for the 12 months before our inspection was 4.26%. The national average is 4.24%.

Are services safe?

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- Staff turnover for the 12 months before our inspection was 16%.
- We reviewed nursing shift rotas for the wards we visited. They indicated that there were enough staff on the day shifts to meet patient needs. Staff told us that day shifts were usually always covered and that it was rare that shifts were not.
- Staff on Dove ward were concerned that the trust had recently reduced night shift staffing levels for the ward. Two qualified nurses and one HCA were on duty at night. It had previously been two HCAs. Staff did not feel that this was safe practice.
- Ward managers told us they used permanent and bank staff to cover shifts. They said they would block book regular known bank staff if needed.
- Ward managers could increase staffing levels when needed.
- Staff said they occasionally rearranged or cancelled activities and section 17 leave when staffing levels were low. Patients confirmed this.
- If staffing was low on a particular ward, managers moved staff across wards to help with staffing levels, if clinical need allowed.
- Patients we spoke with told us that they had regular one-to-one time with their named nurse.
- Staff informed us that they received mandatory training. Ward managers monitored the uptake. We did not ask for specific figures on this inspection. However, we reviewed trust plans to provide extra training to forensic service staff, in line with the root cause analysis action plan. This included a review of resuscitation training, observation practice and caring for patients with a personality disorder.

Assessing and managing risk to patients and staff

- We reviewed 15 patient care records. All had up-to-date, comprehensive risk assessments. We found them to be personalised and detailed. All had risk management plans included.
- Staff used recognised risk assessment tools. This included the Historical Clinical Risk Management 20 (HCR20) and Structured Assessment of Protective Factors (SAPROF). The HCR20 and SAPROF are assessments of violence risk and a guide for Clinical interventions. Severn ward staff were piloting the use of the Short Term Assessment of Risk and Treatability (START). This is an assessment of short-term risk for violence (to self or others) and treatability.
- At the time of inspection, the trust was reviewing its observation policy. This was part of its action plan to ensure protected time was in place for observations.
- All patients on Severn ward were on five-minute observations. Staff told us that this was historical and was for maintenance of security rather than individual patients' clinical needs.
- Each ward allocated the role of security nurse to a member of staff. A security nurse completed hourly environmental and security checks.
- We did not request numbers for episodes of seclusion, long-term segregation and restraint for this focused inspection. However, we discussed the use of seclusion and restraint within Reaside. We did not find anything of concern other than the blind spots we noted in seclusion.
- Staff recorded restraints on an electronic recording system and documented them in patient notes.
- The trust had an up to date seclusion and long-term segregation policy. It was compliant with the Mental Health Act Code of Practice (2015). Staff could access this on the intranet.
- All staff were trained in management of aggression and violence.
- Psychology staff at Reaside had trained 79 staff in Positive Behavioural Support (PBS). The trust was piloting the use of PBS on Severn ward.
- We reviewed three PBS care plans. These were detailed, personalised and showed patient involvement.
- Handovers between nursing shifts kept staff informed of changes in presentation and risks. Severn ward was piloting the use of a standard handover tool. We observed this in use. Staff discussed each individual patient. Information shared included, what had happened on the shift, historical risk and current risks, any incidents from the previous seven days, assessment

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of mental state and tasks for the next shift. Staff said they found it useful to review incidents from the previous seven days within handover, especially if they had been off duty for a while.

- The use of rapid tranquilisation followed the National Institute of Clinical Excellence guidelines. Staff had access to monitoring tools and guidelines.
- Medications were stored at correct temperatures. This is important to ensure the medications are effective. Processes were in place that ensured correct storage, dispensing and medicine reconciliation.

Track record on safety

- The trust reported one serious incident requiring investigation (SIRI) in September 2015. This was a death of an inpatient at Reaside.
- The coroner's inquest investigating this death issued the trust with a regulation 28 report. Coroners issue a regulation 28 report when they consider that action can be taken to prevent future deaths. The trust responded to the regulation 28 report on 1 June 2016, giving a detailed action plan. This included replacement of all anti-barricade doors, replacement observation panels, piloting of a new handover tool, a review of the observation policy, implementation of robust environmental and ligature risk assessments and a review of medical emergency arrangements.

Reporting incidents and learning from when things go wrong

- On inspection, we reviewed the serious incident root cause analysis action plan completed following the death in 2015. The trust had completed in a timely manner and amended following feedback from those concerned. It contained an action plan that the trust had shared with the coroner and the Care Quality Commission.
- The trust had identified issues, and we could see on inspection that it had completed, or was in the process of completing, actions to address these. For example, a standard handover template and process had been implemented on Severn ward. The provider planned to roll out this model of handover across the trust.
- Staff had also begun to undertake joint environmental and ligature risk assessments with staff from the estates and risk teams. However, we did note ligature risks that had not been identified by these new assessments. We informed staff of these during our inspection.
- Staff and patients told us that they had debriefs after serious incidents and the trust offered additional support if needed.
- Staff attended psychology-led reflective practice groups.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 Health and Social Care Act 2008 (Regulated Activities)** **Regulations 2014: Regulation 12 Safe care and treatment.** • **The trust had not identified all blind spots and ligature risks.** • **Anti-barricade doors were not fit for purpose.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Dignity and Respect.** • Patients' dignity and respect was not maintained while in seclusion.