Alpha Hospitals (NW) Limited

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Quality Report

Buller Street
Off Bolton Road
Bury
Lancashire
BL8 2BS
Tel: 0161 762 7200
Website:www.alphahospitals.co.uk

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This report describes our judgement of the quality of care at this hospital. 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.

Summary of findings

Letter from the Chief Inspector of Hospitals

Do not include in report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

Patients were not protected against the risks of unsafe or unsuitable premises because their safety and dignity was compromised by the facilities, cleanliness and layout of the seclusion rooms. Seclusion rooms were found to be dirty and one did not have shower facilities or natural light. Sanitary facilities were located in the same room as the sleeping/living area.

Patients were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Patients were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

There was enough qualified, skilled and experienced staff to meet patients' needs.

Are services effective?

Patients received good quality care most of the time. However, care and treatment was not consistently delivered in a way that was intended to ensure their safety and welfare following the use of rapid tranquilisation treatment. The provider had not protected patients against the risk of unsafe care and treatment because physical health checks on young people were not consistently done following the use of rapid tranquilisation.

Patients were cared for, or supported by staff where concerns had been identified as part of the criminal checks on staff. These concerns had not been risk assessed by the organisation as part of the employment process. There were concerns identified in the criminal records check on staff as part of the recruitment process. The provider had not risk assessed the concern to demonstrate that one staff member was suitable to provide care and support to patients.

There was generally good multidisciplinary working.

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. Staff reported being supported by the acting hospital manager and ward managers..

Are services caring?

Patients said they felt safe and staff treated them with dignity and respect.

Summary of findings

Are services responsive?

The hospital staff carried out assessments of patients who were usually already in another hospital to consider the appropriateness of admission to this hospital. The hospital worked with NHS staff to coordinate the transfer of patients into this hospital, including transferring patients who were already detained under the Mental Health Act.

Patients and young people knew how to raise concerns or complaints. Patients knew how to contact advocacy services and we saw posters advertising details of the independent advocacy service available.

There were no flexible transitional arrangements in place between services for young people and adults of working age when a patient reached 18 years of age..

Are services well-led?

The provider had an effective system in place to identify, assess and manage risks but this was not used effectively to monitor the risks to the health, safety and welfare of patients. There was a suitable governance system in place but this was not effectively used as the provider was failing to meet its own key performance targets around governance and providing a system of safe, effective care.

Summary of findings

Service	Rating	Why have we given this rating?

Alpha Hospitals (NW) Limited

Detailed findings

Services we looked at
Forensic inpatient/secure wards; Child and adolescent mental health wards;

Detailed findings

Contents

Background to Alpha Hospitals (NW) Limited

Alpha Hospital (NW) Limited is a mental health hospital in Bury, Lancashire. It is owned and managed by Alpha Hospitals Limited. Alpha Hospital Bury provides in-patient care, treatment and support for people whose rights are restricted under the Mental Health Act. The hospital provides a range of rehabilitation, low and medium secure facilities, specialist services for people who are deaf and services for adolescents and young people.

Our inspection team

Our inspection team was led by:

Nicholas Smith Head of Hospital Inspection.

The team that inspected this location were a CQC inspection manager, three CQC inspectors, a Mental Health Act reviewer, a consultant psychiatrist, an occupational therapist, and specialist child and adolescent social worker.

How we carried out this inspection

To get to the heart of people who use services' experience 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?

Before visiting this location, we reviewed information which we held about the service.

We carried out an unannounced visit to this location on 9 February 2015, 10 February 2015 and 11 February 2015.

During the inspection visit, the inspection team:

- looked at the quality of the hospital environment and observed how staff were caring for patients
- spoke with patients who were using the service
- spoke with front line staff including nursing staff and support staff, including a social worker, occupational therapist, the mental health act administrator, the medical director and consultant psychiatrists based at the location
- interviewed senior managers with responsibility for these services, including the acting head of hospital.

Detailed findings

• spoke with the lay hospital manager who carry out the duties of the hospital manager under the Mental Health Act

We also:

• looked at treatment records of patients.

• carried out a specific check of the medication management in the hospital and looked at all relevant prescription charts and

• looked at a range of policies, procedures, audits and other documents relating to the running of the service.

The team would like to thank all those who met and spoke to the inspection team during the inspection. People were open and balanced with the sharing of their experiences and their perceptions of the quality of care and treatment at this location.

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

Action the provider MUST take to improve

- The provider must ensure that physical health checks on young people are undertaken following the use of rapid tranquilisation.
- The provider must ensure that individuals using the seclusion rooms have their privacy and dignity maintained when they are using the toilet facilities that are contained within the seclusion room.
- The provider must ensure that risk assessments are undertaken for staff where concerns have been identified in the recruitment process.
- The provider must ensure that the governance system is used effectively to provide a system of safe, effective care.

Are services safe?

Our findings

Safe and clean ward environment

We found issues about maintenance being completed proactively. For example on Wizard House the only bathroom containing a bath was on the first floor but we were informed that this bathroom had not been operational since the ward had opened the previous year, because the call button was too far away from the bath. This meant the females on the wards could not choose to have an immersed bath.

The quality of the seclusion rooms in the young people's services was poor. They were cold and dirty and had toilet and washing facilities in the same room. One seclusion room also had the shower located in the same room next to the bed. The seclusion room on Wizard House did not have access to a shower and did not have any natural light. The floor was also dirty. The seclusion rooms on the adult wards had toilet facilities within the general seclusion room without any proper designation to afford privacy and dignity.

We noted good control of physical security measures from the main reception area of the hospital. Reception staff controlled all access into the hospital via an outside intercom. All visitors were required to have photo identification and were escorted around the site. All staff signed in at reception on arrival to the hospital and collected a pager, a security key fob and a set of keys to access other areas. All internal access doors to communal areas, office areas and wards were locked and we saw each ward area operated an air lock facility through two sets of doors, operated separately and one at a time.

Medicines were stored securely on the wards we visited. Daily checks were made of room and refrigerator temperatures to ensure that the medicines remained suitable for use. Appropriate emergency medicines and equipment were available on all wards and we saw that they were checked regularly to ensure they were in date and suitable for use. We saw that all medicines needed were available.

Medicines were administered safely. We saw the process for giving patients and young people their regular medicines and we heard about the information they were given about their medicines.

A pharmacist visited the hospital weekly. We saw evidence of the checks and interventions the pharmacist made during their visits. The information from these visits was fed back to the nurses and doctors each week and we saw that any necessary action had been taken promptly. The pharmacist also attended monthly multidisciplinary meetings where any errors and concerns were discussed, and learning was shared. The hospital employed a practice nurse who led on medicines management and supported the nurses on all the wards. Alerts and medicine recalls were logged and acted upon by the hospital.

We looked at all the prescriptions and medication administration records across the wards. These were completed clearly and accurately by the doctors and nurses. Medicines to be taken 'when required' were written with instructions and indications for use. Alternatives were prescribed to allow nurses to choose the most suitable for the occasion. All the records we looked at showed that medicines were frequently reviewed.

A number of detained patients within the CAMHs service had both medication authorised by a Second Opinion Appointed Doctor on the legal form T3 and urgent treatment authorised under section 62 of the MHA. It was not clear if the section 62 form superseded the form T3 or not. In some cases, medication was being administered that was not covered by either form. We raised this within our MHA monitoring report and asked that the provider address these issues.

The appropriate legal certificates (T2 and T3 forms) were kept with the medicine charts to ensure that people who were detained under the Mental Health Act only received appropriate treatment for their mental disorder which had been properly authorised.

Patients and young people who had physical health concerns in addition to their mental health issues were monitored appropriately. We saw they had care plans to support and guide staff when looking after them. Some patients were prescribed medicines that required regular blood monitoring, these were done and the dose of medicine adjusted as necessary. Where patients or young people refused checks or interventions, this was recorded and discussed regularly with them and the staff looking after them.

Safe staffing

Are services safe?

We looked at safe staffing to see how the organisation ensured there were sufficient numbers of suitably qualified staff were available to support the patient's needs. The acting hospital director explained how there was a core allocation of staff to each ward for day and night shifts. Each ward had an allocation of qualified and support worker staff based on the patient numbers and type of ward. This was managed on a daily basis with staffing levels being increased dependent on the observational and care needs of the patients. We looked at the planned and actual rota system in place and could see how the staffing levels reflected the core allocation of staff and managed any additional staff requirements for each shift.

The core matrix stated that each night shift had a core staff / ward requirement of one qualified nurse. We saw on the rotas for example for Mulberry for the night shift of 21/11/2014 there were the following staff on duty: one qualified nurse (agency staff), five support workers (bank staff) and two permanent support workers.For Upper East for the month of January 2015 all shifts were covered by one permanent qualified nurse on each night shift. So a minimum of one qualified nurse was maintained.

To cover additional staffing requirements the wards offered the additional hours to existing staff, bank staff or a selection of regular agency staff was used. This ensured the patients on the wards had continuity of care provided by staff who they knew.

The actual staff rotas showed a large proportion of bank and agency staff used to cover night shifts. We discussed this with the acting hospital director who shared a recruitment tracker document with us to indicate their recruitment plan. The plan outlined the positions of team leader, nurse and mental health support workers; under each position category we could see the deficit, number of job offers made, anticipated start dates, recruitment pipeline with interviews scheduled and inductee and employment checks. This recruitment drive was anticipated to reduce the use of agency and bank staff..

As part of the inspection process we reviewed the service level agreements in place with the regular agency staff suppliers. Detailed assurances were outlined in the service level agreements which included the minimum level of training requirements, security checks and identification validation checks. None of the service level agreements detailed the method of restraint training the staff member had completed and in two of the three agreements it did not mention safeguarding training; This was discussed with the acting hospital director as the hospital had safeguarding and a particular restraint training as part of their core training for permanent staff. The acting hospital director confirmed they would review the agreements and assurances with the agencies.

Prior to the inspection, concerns were raised through the whistle blowing and safeguarding processes about staff's understanding of the use of restraint in the young people's services. As a result the provider confirmed the agency staff who were supplied to the hospital did not have the same physical intervention training as the staff employed by the organisation. The provider assured the CQC and other partner agencies that agency staff would complete the organisation's physical intervention training. During the inspection we saw evidence that agency and regular staff had to complete physical intervention refresher training as part of the provider assurance plan by March 2015.

We saw there were suitable staff available in the adult and young peoples' services to provide one to one or higher ratios of staffing if required. Staff described the different levels of observation the provider used and their duties when supporting people who were on prescribed levels of observation. Staff told us it was unusual for activities to be cancelled due to staffing levels.

Another example we saw regarding the use of staff was on Primrose ward. The manager told us all the young people on this ward had the opportunity to engage in a comprehensive activity plan which included planned access to the garden and self-structured time. We reviewed the ward activity planner which confirmed there was a wide range of diversional, therapeutic and educational opportunities available to patients on this ward.

We learned that following a review of incidents, it was noted that many incidents on one of the CAMHS wards occurred in the evening. In response to this, the ward had developed social evenings, whereby young people could spend evenings off the ward mixing with others. In addition, the ward was also positively promoting group outings for young people in receipt of section 17 leave. A number of outings were planned each week to places chosen by them. Whilst this was a relatively new initiative, there was evidence it had resulted in a more settled ward and a decrease in the level of incidents.

Assessing and managing risk to patients

Are services safe?

We saw that comprehensive risk assessments were completed to inform care plans and evidence based risk formulations were made which informed risk management plans. Risk assessments were carried out by staff during patients' initial assessment and reviewed or updated during care review meetings or if patients' needs changed. This meant that there were appropriate risk management plans for patients.

We noted all documentation was updated regularly and involved patients and their representatives as requested. We noted before every multidisciplinary review patients were invited to consider what they wished to discuss. Patients had actively participated in planning for these care review meetings.

Staff we spoke with were all able to give a good explanation of what safeguarding meant and how to protect patients and young people from abuse. Staff we spoke with could identify different types of abuse and how patients and young people could be potentially vulnerable. Staff were able to describe the policy and procedure for escalating safeguarding concerns and were able to describe what they would do to keep patients and young people using the services safe.

Staff[had completed safeguarding training and we looked at the induction package and records which included safeguarding and management of violence and aggressive behaviour mandatory training.

The provider had a good track record of telling us about safeguarding incidents about working age adults and young people. We received regular notifications about incidents in the different services. The local authority designated officer for children (LADO) had also provided advice and guidance for staff on what incidents meet the threshold for the LADO to be involved in a children's safeguarding incident.

The provider had a comprehensive range of policies, procedures and practices in place in relation to safe guarding people in their care. Safeguarding alerts and concerns were reported and discussed frequently, in a regular meeting with senior managers and the local authority safeguarding team representatives. We saw from the safeguarding tracking log that other key stakeholders were invited to discussions as appropriate including commissioners of the service and the police.Staff were able to describe the whistleblowing process and all of the staff we spoke to felt confident in raising any concerns in relation to poor practice. Staff described how they could report any concerns anonymously if required.

Reporting incidents and learning when things go wrong

We looked at the records for the use of restraint, seclusion and long term segregation and reviewed the associated provider policies. We saw evidence that the acting hospital director, one of the three quality managers, monitored and evaluated monthly any incidents resulting in a management of violence intervention, restraint, seclusion, long term segregation and rapid tranquilisation.

Are services effective?

Our findings

Assessment of needs and planning of care

During our inspection we reviewed 12 child and adolescent mental health service (CAMHS) care records and 12 care records relating to adult patients. We spoke with 17 adult patients and 6 young people about their care, welfare and treatment. We observed multidisciplinary care review meetings, care handovers and shift de-brief sessions on some of the wards.

Care records we looked at had thorough pre-admission assessments, post admission needs assessments, a detailed personal profile, a family history and care plans. Care records we reviewed included sections on all aspects of physical health, psychological and social needs, as well as likes, dislikes and preferred lifestyle choices.

We found good evidence that physical health care was prioritised and we noted that the provider had appointed a dedicated nursing post to oversee positive initiatives with physical health management plans for all patients and young people who used the service. We saw evidence of full physical health checks for all patients and young people as well as regular tests carried out as appropriate such as weights, blood tests and electrocardiograms. We saw on Blueberry ward good examples of staff documenting when young people refused to consent to physical health observation.

Across the young person's male wards there was evidence of the routine use of rapid tranquilisation however the majority of records we reviewed the physical monitoring charts were incomplete in relation to the monitoring of rapid tranquilisation.

For example we saw incomplete records of young people being monitored following rapid tranquilisation where young people had been monitored for the first thirty minutes or less, then this had stopped without explanation. This was not in keeping with the provider's rapid tranquilisation policy and procedure. This meant young people's physical needs were not monitored consistently following rapid tranquilisation.

Best practice in care and treatment

We saw that a variety of treatments were available to patients and young people, many of whom were detained under the Mental Health Act 1983. Treatments included psychiatric assessment and medication, individual therapy, group therapy, occupational therapy, and a range of behavioural therapies and education. Occupational therapist (OT) and social worker input were available on site and activities which were OT led on and off the wards. Patients had input from other disciplines which could be accessed if this was relevant. Patients had direct access to psychology input within the hospital.

We saw that all wards used 'My Shared Pathway' to ensure all the needs of patients and young people were assessed, identified and care and treatment delivered accordingly to meet those needs. Patients on the adult wards had 'My Shared Pathway', which centred on providing a recovery and outcomes-based approach to the secure care pathway. My Shared Pathway is a recognised outcome measure used in secure care which utilises booklets of questions that clinicians and patients use to focus discussions in a number of important areas including awareness of the events leading to admission into secure care, health, relationships, safety, risks and recovery. We saw patients were at varying stages of engagement with the 'My Shared Pathway' process but where appropriate staff had worked to engage patients in this process.

Skilled staff to deliver care

We looked at the recruitment procedures to see how the provider ensured staff were of good character, had appropriate qualifications and were physically and mentally fit for work.

The organisation had a staff turnover of 42.3% for the year ending December 2014. This meant there were approximately 244 leavers out of the head count for that year. We discussed this with the acting Hospital Director who shared with us a Recruitment and Retention strategy document which detailed how the organisation had planned to address these concerns.

The strategy outlined what the organisation wanted to achieve with an action plan on how they would approach each identified task. The action plan did not include evidence of key performance indicators referred to in the progress updates of the project. We discussed with the acting hospital director that there was no clear monitoring of achievements in the position statement to support how successful the action plan had been. They advised they would review the updates and include additional evidence where appropriate.

Are services effective?

The organisation had human resources policies and procedures in place to cover the management of leave, absence, grievance, capability, supervision and appraisal, and recruitment and selection.

We reviewed the recruitment and selection process in more detail to understand how the process meets the requirements of this outcome. We reviewed the staff files of six members of staff to track the recruitment and selection process using their files.

A job application, record of the interview and signed contract was on file for each staff member. During the interview, questions and selection tests relevant for the post were used. Checks to ensure suitability to work with vulnerable adults had been made prior to the staff commencing employment. We observed that two references had been obtained for each new recruit. In addition, photographic identification was contained in the personnel files.

At the front of each staff file was a summary record and recruitment audit list which was completed during the recruitment process. This included details of the Disclosure and Barring Service (DBS -criminal check service) number, job specification, contract of employment, medical screening completion and PIN number where applicable.

We found one of the six staff records had details of concern which showed on the DBS report. We asked the organisation for their risk assessment of employment for this person. The risk assessment did not outline the scope of their decision to employ the person and how the risks would be managed or mitigated within the role they had applied for. We spoke with the acting Hospital Director about this matter who said they would address it immediately with a full risk assessment review.The organisation had a corporate induction programme which all staff attended.

A process was in place to record and manage professional registration numbers for the nursing staff.

The organisation had service level agreements or contracts in place with agencies who supplied temporary staff to them on request. The service level agreements detailed assurances of agency staff's pre-employment checks, identification validation and training. To support the service level agreement each agency staff member had a pro-forma which was provided to the organisation to outline the actual details for that person prior to allocation of a shift at the hospital. This meant that the organisation had assurances from the agency that their staff met the pre-requisite standards.

The manager explained the recruitment and induction programme to us. As part of the recruitment process new staff had a 6 month probation period. As part of the probation period, staff had an appraisal with human resources and thereafter with their own line manager on an annual basis.

The manager informed us staff received formal individual supervisions or group supervisions. The manager told us that staff had an annual appraisal. The organisation had achieved 89.9% completed appraisals within the last 12 month period. The organisation's target for appraisals was 85%. As part of the inspection process we reviewed six staff files to check the records for supervision and appraisals and found appraisals and supervision were completed as per the provider policy and procedure.

The induction programme covered roles and responsibilities; it included Alpha culture, security key induction, security, fire safety, safeguarding adults and children, information governance, mental health act awareness and duty of candour, health and safety, moving and handling, escorted leave, food hygiene, infection control, risk assessment, suicide prevention, observations, immediate life support and management and prevention of aggression (MAPA). There were workbooks provided to staff to support their induction process.

We looked at the training matrix (monitoring record for staff training) which confirmed there was an induction and mandatory training system in place. We reviewed the training matrix which showed the organisation had an overall 91% compliance for mandatory training at January 2015. This did not meet the organisation's target of 95% compliance. Doctors' compliance was low at only 35% at January 2015. Ward based staff achieved 94% for mandatory training and MAPA and 92% for immediate life support. We did note that mental capacity and deprivation of liberty safeguarding training was not included in the mandatory training programme.

There was a good programme of continued professional development to ensure staff were able to meet the regular training requirements of their professional bodies, for example the nursing and midwifery council.

Are services effective?

Staff we spoke with felt well supported and received on going support and supervision.

The service had a range of policies in place to support staff; these included the performance and development (supervision and appraisal), disciplinary, recruitment and selection, health and attendance policy and whistle blowing policy. The whistle blowing policy did not have any signposting to the Care Quality Commission or the Ombudsmen.

Sickness records for January 2015 showed the organisation had an overall sickness rate of 4.23%.

In the young peoples' services, staff told us they were supported to develop their roles. For example senior support workers were able to undertake additional training so they could do physical health checks on young people. We spoke with two recently qualified registered nurses who said they had been involved in preceptorship with their ward managers to support their learning and development post registration. Staff said they were supported by their ward managers and service manager.

Multi-disciplinary and inter-agency working

We observed two multi disciplinary team meetings on Blueberry and Mulberry wards. We noted staff had differing understanding of the needs of young people diagnosed with learning disabilities and autistic spectrum disorders (ASD). One senior nurse fed back in one meeting that a young person did not have a learning disability despite a diagnosis confirming the diagnosis in the young person's care records. Also staff were completing assessments of capacity to consent to care and treatment of young people with ASD that had or lacked capacity, but were not recording any further corroborating information as to how they reached this judgement. This meant staff may not be appropriately skilled or experienced in understanding young people with autistic spectrum disorders.

We observed handovers where detailed information for the nursing and care teams coming on shifts was handed over from the previous shift. Specific care or treatment needs and daily arrangements for each individual patient were identified and discussed. This demonstrated that the service took appropriate steps in planning patients' care and treatment.

Adherence to the MHA and the MHA Code of Practice

Adherence to the Mental Health Act, compliance was overall good. We sampled the patient records for a total of 12 patients across four wards and found evidence that there were effective systems in place for the administration of the Act.

There was evidence that patients were in receipt of section 17 leave and that on some wards (Primrose) there was an emphasis on supporting patients to engage with community based activities. However one patient on Mulberry ward complained that there were times when leave had to be cancelled due to staffing levels.

There were old and superseded leave forms in the patient's files which meant that it was not always immediately apparent what leave had been granted and this could lead to mistakes being made.

It was not clear whether patients (and where relevant, carers) had been given copies of the section 17 leave form. The form itself stated this should happen, but there was nowhere for the responsible clinician (RC), patient or carer to sign to say that this had been done. This is especially relevant where the carer was assuming legal custody of the patient until their return. (Mental Health Act Code of Practice 21.27).

Patients were given their rights in accordance with section 132 and the Mental Health Act Code of Practice. We found one example where there had been a delay in providing this information. Otherwise there were clear systems in place and patients were reminded of their rights at three monthly intervals.

Seclusion records were, in the main, well completed. Contemporaneous notes recorded 15 minute observations two-hourly independent nursing reviews and four-hourly medical reviews.

In the young people's services seclusion rooms were used interchangeably and male patients could be secluded on female wards and vice versa. A number of patients who had been assessed as needing an alternative service due to their unique and challenging needs, were secluded in their own bedrooms or as part of a "bespoke package". The Mental Health Act Code of Practice paragraph 15.45 clearly states that seclusion should not be used as part of a treatment plan, yet these plans were in place for a number of patients.

Are services caring?

Our findings

Kindness, dignity, respect and support

Patients commented favourably on the quality of care and support they received, including both medical and nursing care. Patients were aware of their rights as detained patients.

Staff we spoke with were positive about the standard of treatment and care provided by the service. Staff we spoke with demonstrated their awareness of the likes, dislikes and care needs of the patients who used the service. We saw many positive interactions between staff and patients and young people across the wards we visited.

We saw that staff engaged patients and young people in a variety of activities and groups. In the young people's services staff were able to describe barriers to providing appropriate care and welfare. For example a recently qualified registered nurse told us communication had been a particular issue for them, elaborating they had experienced difficulty gaining trust and respect from the young people on the ward when they started. This has improved over time as they had focussed on building relationships gradually, demonstrating an awareness of non verbal communication and used this to identify when it was appropriate to engage with young people.

The involvement of patients in the care they receive

We saw in the care records sampled that patients and young people had their cultural, religious and communication needs identified and recorded. This meant that patients and young people experienced care, treatment and support which protected their rights. For example one adult patient was being supported with their gender needs in supportive ways and commented positively on the care and treatment they had received that met their individualised needs. However, where young people had diagnosed learning disabilities or autistic spectrum disorders we saw only one example of a person centred plan being used on Blueberry ward. This was in the form of a booklet about a young person on the unit with communication difficulties. This was created with input from the young person, their family and psychologist. This meant young people with learning disability or autistic spectrum disorders or their families were not routinely involved in the assessment and planning around their communication needs.

Are services responsive?

Our findings

Access, discharge, and bed management

We saw that the hospital staff carried out assessments of patients who were usually already in another hospital to consider the appropriateness of admission to this hospital.

We saw that the hospital worked with NHS staff to coordinate the transfer of patients into this hospital, including transferring patients who were already detained under the Mental Health Act.

In the younger people's services when patients became 18 years of age, we were informed that they could no longer mix with the other young people on the ward as they were now adults and the other patients would be vulnerable to them. For one patient who was secluded as a response to his behaviour, we were informed that he "Couldn't be on the ward anyway because he turned 18 last week". This meant there were no flexible transitional arrangements in place between services for young people and adults of working age.

For some patients, there was a decision taken that they should remain in seclusion / long term segregation until they were transferred to a more appropriate service elsewhere. This means the safeguards of seclusion, such as the independent nursing and medical reviews were ineffective in this context.

We saw an unusual seclusion practice used for one male patient. At the point at which the patient fell asleep, seclusion was terminated because staff unlocked the bedroom door and the patient became "long term segregated". When they woke up, this became seclusion. Whilst this was strictly recorded and monitored it was an unusual practice. We were told this patient will remain segregated from the rest of the population until transfer to a medium secure unit.

Meeting the needs of all people who use the service

Many patients commented that activities, leave and access to fresh air were sometimes cancelled or curtailed due to staff vacancies and sickness levels.

The ward environment optimises recovery, comfort and dignity

The standard of the communal areas and bedroom areas of the adult wards were generally good. Some of the wards included murals and artwork from patients. Some wards had opened up areas of the ward such as the kitchen areas as part of a reduction in restrictive practices. In the younger peoples services there was a stark contrast between the personalisation of the environment on the male and female wards. We noted on the female wards there was a range of murals and art work completed by the young people that gave the environments a homelike appearance.

Patients had their own individual bedrooms with shared communal areas. The bedrooms had en suite facilities and patients were able to have their own personal items and furniture in their rooms if they wanted. The hospital was clean and organised. The communal areas were comfortable and there was a range of activities that patients could participate in. There were identified areas for patients to have visits with family, friends or professionals for privacy.

Patients could make telephone calls in privacy. Patients had access to mobile phones and told us they had regular contact with family/friends.

Patients were encouraged to complete their weekly activity plans and indicate what therapeutic groups they were attending inside and out of the hospital.

Listening to and learning from concerns and complaints

Patients and young people knew how to raise concerns or complaints. People knew how to contact advocacy services and we saw posters advertising details of the independent advocacy service available. We also saw that the advocacy service regularly visited each of the wards in addition to people using services being able to refer themselves directly.

Ward policies and procedures minimise restrictions

Restrictions on mobile phone use were causing some patients on the low secure wards problems and patients felt this was unfair. Patients felt that the relational security arrangements between low and medium secure needed better clarity.

Are services responsive?

The provider had steps in place to reduce restrictive practices and may wish to note comments from patients from the low secure wards as part of this process to ensure appropriate relational security arrangements.

Are services well-led?

Our findings

Good governance

During this inspection we looked at the systems and processes the service had in place to continuously monitor the quality of the service being provided, the identification and management of risks, how they managed compliments and complaints, investigated incidents of poor practice and managed the records for staff and patients.

The acting hospital director explained how the organisation had a group compliance report which was produced on a monthly basis. This report covered all the organisational sites compliance assessment and update with regards to the areas monitored by the Care Quality Commission regulations.

The report had an organisational set target RAG rating grid of 0-79.9% red, 80-94.9% amber and 95-100% green. The report looked at audits of patient files, medication, safeguarding, incidents and serious untoward incidents, CQC notifications made, complaints, duty of candour, supervision of staff, training for staff, appraisals for staff, least restrictive practice, internal inspections and an update on recruitment and retention.

For the month of October 2014, the report showed five out of six of the Child and Adolescent team files were amber with one being red. Out of the ten adult team files six were green and four were red. Bury reported three serious untoward incidents in October 2014 with the relevant 24/72 hour notifications to NHS England not being recorded.

The report showed that in the adolescent service whilst the clinical service manager was on annual leave a small number of safeguarding concerns were not reported in a timely manner. An action plan had been put in place to address this gap in reporting.

The report outlined that the hospital received 14 complaints in October. There were 11 which remained open, three were closed and seven did not have holding letters. The report outlined that the response letters were factual, to the point but did not demonstrate significant empathy. The report stated that in some cases the letters could be regarded as defensive. There was a complaints policy in place. The policy listed details of how to make a complaint, the timescales for a response from the organisation and contact details for other agencies should the complainant need them if they don't feel satisfied with the response.

The group compliance report did not have an action plan to support how the monitoring of the services would drive improvements to meet their internal targets.

We reviewed the audit programme and sample audits for the hospital. Audit tools had been developed to monitor particular objectives such as psychotropic care planning audit and patient file analysis for adolescent services, personality disorder services, deaf services, men's and women's services.

The men's service November 2014 report showed that the overall compliance for the file analysis was red at 75% compliance. The men's personality disorder file analysis was red at 63% overall compliance for November 2014. The deaf service file analysis was amber at 87% overall compliance for November 2014.The adult service psychotropic care planning audit was amber at 82% for April 2014. The adolescent service psychotropic care planning audit was green at 100% for April 2014.With each of the audit outcomes there was no proper action plan to drive improvements to meet the organisation's target rating of green.

We were advised that where possible the individual staff member responsible for maintaining individual patients care files, would have improvements to review and amend them monitored through their supervision. This meant the organisation was not taking appropriate action to continuously review the monitoring of their processes to drive improvements to meet their compliance targets.

There was good evidence that incidents were reported internally by ward and the service. These incidents were formulated into reports for the adult and adolescent services. The reports highlighted the number of incidents that had occurred and noted any increase or decrease compared to previous periods. It was not always clear that proper oversight and understanding of incidents was occurring at senior manager level to manage risks, understand how and when these incidents occurred, or robust benchmarking of incidents between similar services. For example, the reports for the adult wards for January 2015 clearly showed a significant rise in incidents between the hours of 7.00 and 8.00 pm and 9.00 and 10.00pm but

Are services well-led?

there was no clear plan to further analyse these incidents by senior managers to consider the antecedents to these incidents and manage the risks identified in better ways to reduce incidents. The reports on incidents were mainly analysed for quantitative data and some provided little or no analysis of the incidents. There were no clearly articulated plans for reducing incidents, for example through detailing arrangements for oversight and escalation contained within appropriate policies and associated practices.

There was a business continuity plan in place to support safe care planning and delivery in the event of an emergency incident or accident. The plan looked at possible incidents and how to deal with the situation, for example in the event of a flood, gas leak, or pandemic, terrorist threats. The plan outlined alternative accommodation arrangements, key contact details for suppliers and management of the organisation. This meant the organisation had procedures in place to support such an emergency situation to enable the care and treatment to be maintained either on that site or at an alternative site. The group compliance report lacked detail to understand some of the identified risks and there was no action plan, for example there was little or no detail to understand the shortfalls in inpatient file recording or PRN medication recording to understand the specific details.

The organisation had a Board Assurance Framework which was a key assurance tool to ensure the board were properly informed about the risks to achieving the organisation's strategic objectives. The board assurance process ensured that risks to achieving those strategic objectives were identified and managed. The Board Assurance Framework (BAF) was not a stand-alone document but part of wider organisational corporate governance procedures. The action plan stated these higher level risks were monitored on a monthly basis but when we looked at the minutes of the appropriate sub committees it was not always clear that these risk were being managed as stated within the BAF document. The BAF did not include key risks associated with providing secure mental health services such as risks of serious security breaches, secure perimeter breaches, risk of absconding or concerted indiscipline from groups of patients and the controls in place to manage these risks.

There were a number of committees that fed into the hospital governance processes. From speaking with staff and looking at the minutes it was not always clear that all of these groups or committees were operating effectively to help oversee the clinical governance arrangements within the hospital. For example some groups had not met for some time, there were no formally recorded minutes available or they were not sufficiently detailed to understand the issues, evidence of no reports being tabled, attendance was poor so there was a lack of proper discussion. On some occasions, there was little or no evidence they were providing proper oversight and challenge with no or limited action plans associated. For example there was little evidence that episodes of restraint were robustly considered on an on going basis by the restraint and seclusion committee. Evidence of staff sleeping whilst observing in seclusion in November 2014 was not properly addressed, monitored at subsequent meetings or escalated in line with hospital policy. It was not always clear how concerns were escalated or overseen by higher level committees, for example it was not fully clear whether the identified shortfalls in the committee meetings, records, action plans or unresolved systemic issues were escalated to improve clinical governance arrangements and manage the risks within the hospital. It was not clear that there were appropriate representation at these groups and in particular many groups had no representative regularly attending from the medical workforce.

It was not clear that the hospital had appropriate arrangements to consider overall themes from our Mental Health Act monitoring reports were considered fully to identify trends and address issues fully. For example, the medical director was not aware of any recent issues raised following Mental Health Act monitoring visits.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk of unsafe care. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12:12(2)(a) The provider must ensure that physical health checks on young people are undertaken following the use of rapid tranquilisation.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment We found that the registered person had not protected people against the risk of unsafe premises. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15. 15(1)(c). The provider must ensure that individual using the toilet facilities whilst in seclusion are afforded appropriate levels of privacy and dignity.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed We found that the registered person had not protected people against the risk of inappropriate care or abuse. This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19. 19(1)(a) The provider must ensure that risk assessments are undertaken for staff where concerns have been identified in the recruitment process.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Nursing care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance We found that the registered person had not protected people against the risk of unsafe care or treatment. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17. 17(2)(a). The provider must ensure that the governance system is used effectively to provide a system of safe, effective care.