Dudley and Walsall Mental Health Partnership NHS Trust

Dorothy Pattison Hospital

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Ambleside

Core service provided: Acute admission ward

Male/female/mixed: female

Capacity: 21

Langdale

Core service provided: Acute admission ward

Male/female/mixed: male

Capacity: 18 + 3 bed extra care area

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

Male/female/mixed: mixed

Capacity:

Grasmere

Core service provided: Longstay/forensic/secure services

Male/female/mixed: mixed

Capacity: 10

Dorothy Pattison Hospital is based in Walsall and provides assessment and treatment for people with mental health problems. It has three wards: Ambleside and Langdale wards are acute wards, while Grasmere ward provides longer-term rehabilitation for adult male and female patients.

We found that the services were safe and that there were enough staff in most wards. However, some wards were occasionally short of staff and relied on temporary staff who did not always have the skills and knowledge to fully meet people's needs.

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

We saw that people who use services were treated with dignity and respect and saw staff and people who use services interacting positively with each other. Some people were involved in developing their care plans.

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

We saw good examples of learning from audits and incidents being shared, and changes to practice being made as a result.

The hospital worked well with the general hospital (which was on the same site) regarding physical health needs.

The health based place of safety did not meet the recognised environmental standards.

We saw that the rehabilitation ward was mixed gender and placed people at risk of receiving care that compromised their dignity.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Mental Health Act responsibilities

We reviewed the detention papers for a number of detained patients across the two acute wards. These papers were easily accessible in each file and comprehensive; they included the Approved Mental Health Professional (AMHP) report that outlined the reason for detention.The proportion of patients who were detained under the Mental Health Act was low (only 20% on the day of our inspection on Langdale ward).People were regularly reviewed (in terms of observations and their detention status) to ensure that staff kept people safe and ensured that people were cared for in least restrictive ways.

The wards were locked. When we spoke with a group of informal patients at a focus group on Ambleside ward, many of the patients did not understand how they could exit the ward.We saw that Langdale ward had a three-bed extra care area to provide more intensive support for male patients who were acutely mentally unwell. Female patients would have to be transferred to the extra care area at Bushey Fields hospital. We saw that people were cared for in the extra care area for relatively short periods of time, mostly for up to 72 hours, but staff told us that people have been cared for longer periods – including up to two weeks.Our review of the records about the extra care area on Langdale ward showed that patients were nursed in isolation, were prevented from leaving the area, and were refused contact with other patients.

Acute admission wards

The clinical governance systems ensured that all incidents were reviewed and actions and learning points recorded. Staff told us that the feedback from the review of incidents was a regular agenda item at the ward meetings. We saw that changes were made due to a recent incident, as they were recorded in a meeting's minutes.The reception area at the main entrance to the hospital was staffed over the 24-hour period and people were requested to sign in and out. For additional security, an 'air lock' system was used at the entrance of the hospital, with two doors that cannot be opened at the same time.Staff told us that the staffing levels were increased when needed. All staff carried an emergency alarm to alert other staff that help was required. During this inspection we observed an emergency situation which was responded to quickly and effectively.Staff told us that a pharmacist visited the wards daily to check medication and offer advice to staff if this was needed. They told us they had problems with obtaining medicines if prescribed after 2pm. The medicine management policy dated July 2013 was not always followed. We found on Ambleside ward that medicines no longer required had not been disposed of.Staff told us that each person's level of risk was reviewed each day.

Health based places of safety

There was evidence of good working relationships between the many parties involved in the hospital based place of safety.

We spoke with managers and looked at the information we received from the trust and saw that there were no recent serious or untoward incidents in the hospital based place of safety.

Long stay services

Staff were aware of the electronic incident report system and told us that all incidents were recorded in this way.

People had to wait for staff to gain entry and exit to and from the ward. People who were on an informal basis were informed of their legal rights for leaving the ward or hospital.

Summary of findings

During the inspection, we were informed by the ward staff of a recent safeguarding concern that had been raised. We spoke with the head of the department who informed us that action had been taken to refer the concerns and they were following their own procedures for responding to it. The overall review of this matter was not yet concluded.

Staff we spoke with told us they were aware of the whistleblowing policy and that they felt comfortable and confident to report and escalate matters if it was needed.

Risk assessments were comprehensive and contained detailed strategies to reduce risks. Staff told us and we saw that risk evaluation and management was reviewed at regular intervals and with a team of clinicians.

We were told that staff are regularly moved from Grasmere to support other wards.

Are services effective?

Mental Health Act responsibilities

We found that staff were working in accordance with the MHA Code of Practice. Detention papers were properly scrutinised, attempts were made to ensure that patients were informed of their rights and the rules around consent to treatment were followed, including locally devised standard forms to record consent to treatment, rights and urgent treatment decisions

We spoke with representatives from the Independent Mental health Advocacy (IMHA) provider and heard that levels of engagement and referrals with statutory advocacy services for detained patients across the trust were inconsistent. We heard that the trust did not have an agreed comprehensive engagement protocol with the IMHA provider.

Detained patients were not receiving high dose anti-psychotics on a routine basis. We saw that people were frequently written up in advance for rapid tranquilisation treatment in the event that it becomes necessary principally due to the availability of medical and pharmacist support out of hours.

Acute Admission wards

Some people were unable to make informed decisions due to their health conditions. We saw evidence that the service had initiated a multi-agency meeting to make a decision for one person who did not have capacity.

Staff told us that clinical guidance, protocols and procedures were available through the trusts' intranet. Some staff could not access the intranet so were unable to consult the information within the guidance documents.

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

The provider and ward staff told us about the recent introduction of the 'Triangle of Care'.

A review of the documentation identified that some had been completed whilst others had not.

We saw that staff liaised with specialist services to ensure people's physical health needs were met where this was necessary, for example diabetic nurses, tissue viability nurses. When people were discharged from the hospital we saw clear and appropriate management plans which were sent to the GP.

We saw that staff had received training in basic life support including annual updates. There were well documented checks on the emergency resuscitation and equipment. This meant that staff and equipment were prepared should a medical emergency occur. Whilst we were on one ward, we witnessed a medical emergency and saw that the response to the medical emergency was timely and co-ordinated.

Health based places of safety

Summary of findings

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

Despite environmental work being carried out, the health based place of safety at Dorothy Pattison did not meet national guidance or standards.

Long stay services

Staff told us that clinical guidance, protocols and procedures were available through the trusts' intranet. Some staff could not access the intranet so were unable to consult the information within the guidance documents.

The care and support plans were completed where there was an area of need. People were included in the formulation and review of the plan and had signed to indicate their inclusion in the process. A record had been made where a person refused to sign or take part in the process. Staff told us that each week a multi-disciplinary meeting was held to discuss and review the care and support of each person.

Physical health checks and care were well documented on admission to the hospital and throughout the person's stay.

The ward is a mixed gender unit. The privacy and dignity of some people may be compromised because men have to walk through the female bedroom, toilet and bathroom areas to access the communal areas of the ward.

Are services caring?

Mental Health Act responsibilities

Under the Mental Health Act detained patients must be informed about their rights whilst they were detained. Patients we spoke with confirmed that they had received their rights orally and in writing.

Detained patients have a right to access Independent Mental Health Advocacy Services (IMHA). We saw that the detained patients were routinely informed of the availability of the IMHA service. Television screens across the hospital also had revolving messages which included information about the IMHA service.

We saw that people had individualised care plans including detailed care plans relating to detention under the Mental Health Act.

We saw that at times, staff used over restrictive or blanket policies to help manage risks.

Acute Admission wards

People were fully involved with the planning and review of their care. Some people we spoke with told us they were involved in making decisions and choices about the support they needed.

People who used the service and we spoke with were generally positive about the staff, commenting that the staff were helpful, friendly and supportive. On the wards we visited we observed staff and most people looked relaxed and comfortable.

Following comments made by people on Langdale ward regarding the availability of refreshments, we were told a beverage bay was planned to be fitted.

Staff told us that time was allocated at each shift change for there to be an effective handover of information.

People told us they felt safe in the environment and that staff listened to them. We saw good interactions between staff and people who used the service on the wards that we visited.

Summary of findings

Health based places of safety

Patients were positive about their experiences despite being subject to compulsion and did not raise any complaints for example about the way they were conveyed to the health based place of safety.

People were involved in decisions about their care where this was possible, for example through agreeing to informal admission at the end of the assessment.

Under the Mental Health Act people brought in to the hospital based place of safety under police powers must be informed about their rights whilst they were there.

On this inspection, we saw that the hospital had a leaflets and pro-forma to record that these rights had been given. We heard that staff made attempts to assist patients to understand their rights.

Long stay services

People were fully involved with the planning and review of their care. Some people we spoke with told us they were involved in making decisions and choices about the support they needed.

People who used the service and we spoke with were generally positive about the staff

People told us they felt safe in the environment and that staff listened to them. We saw good interactions between staff and people who used the service on the wards that we visited.

Are services responsive to people's needs?

Mental Health Act responsibilities

We saw that people were admitted into hospital or assessed under the Mental Health Act, their detention was regularly reviewed at ward rounds.

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

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

The lack of any strategic commissioning decision over Grasmere ward to be reprovided into the community has affected managers' ability to plan, invest in and improve the existing environment. This impacted on patient care for example through not being able to fully address the poor gender separation.

Patients on the wards had more complex needs .There was a lack of the full range of therapeutic interventions for people with personality disorder in line with national guidance

Acute Admission wards

We were told and saw records that people admitted to Langdale ward had to sleep on Grassmere ward because no bed was available on the admitting ward. The document recorded this had happened over a five day period. This meant that on occasions the bed occupancy was over 100%.

Very few leaflets, information and guidance were readily available in other languages apart from English. There was no reference on the leaflets we saw that they could be available in other formats or languages.

Summary of findings

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

Staff told us that they did not always receive feedback from senior management when complaints had been made. Other staff told us that regular meetings and forums were organised where they received feedback from complaints and incidents.

Health based places of safety

At Dorothy Pattison Hospital, response times were reported as being longer due to the levels of out of hours medical cover not being as robust and the Approved Mental Health Professional (AMHP) service being located in the emergency duty team rather than integrated within the Crisis Resolution Home Treatment team. However people were rarely in the place of safety for longer than 4 hours and frequently in the place of safety for considerably shorter periods of time.

Information we saw showed that people were able to access an in-patient bed in the relevant acute psychiatric service in the locality from which they came in most circumstances when a decision was reached to admit to hospital.

Long stay services

Staff on this ward told us that there were times when finding follow-on accommodation for people could be an issue due to funding constraints in social care

We saw that the menu available had a choice of food to meet the religious or cultural needs of people who used the service.

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

Are services well-led?

Mental Health Act responsibilities

We saw that there were good systems in place for the receipt and scrutiny of detention papers when patients were first admitted under the Mental Health Act including good checklists.

There was good evidence of administrative and medical scrutiny to ensure that people were detained lawfully and appropriately in accordance with the Mental Health Act.

The trust had not recognised that the practices in relation to the extra care areas may meet the threshold of seclusion as defined by the MHA Code of Practice. There were no proper reporting mechanisms or audits of the use of the extra care areas to ensure that these areas were used as a last resort, that the guiding principles of least restrictive care was met and that appropriate safeguards were in place.

The policies and protocols relating to the extra care area were not robust.

Acute Admission wards

Acute Inpatient Mental Health Services (AIMS) accreditation had been awarded to Ambleside and Langdale wards. Accreditation was also awarded for the provision of Electro-convulsive Therapy (ECT).

Staff gave examples of where the learning from incidents and complaints had improved working practices

People told us that a weekly meeting was arranged where they were able to discuss ward issues.

Staff told us that business meetings took place each month which were open to all levels and grades of staff.

Summary of findings

Staff explained to us the 'Ask Gary' e-mail system. 'Ask Gary' is a dedicated mailbox set up to encourage staff to e-mail the Chief Executive.

Health based places of safety

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

The refurbishment of the environment of the health based place of safety has not had full regard to guidance on the environment of health based places of safety.

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

Long stay services

Some staff stated that they felt engaged and involved in the recent transition of services. Other staff felt the transition of services was not communicated well and they received little information.

People who used the service told us that a weekly meeting was arranged where they were able to discuss ward issues. We saw that minutes of the meeting were completed and available on the ward.

Staff generally knew the chief executive officer and members of the trust board. They confirmed that the senior staff visited the wards at intervals.

Staff told us they feel supported by immediate managers

Summary of findings

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

Mental Health Act responsibilities

When we visited the hospital on this occasion, we saw that there were number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward. We found that where it was necessary to use the Mental Health Act, people were lawfully detained and that the staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights on admission. There were only a small number of people who had been receiving treatment for mental disorder for long enough for special rules in the Mental Health Act to be followed but where this was the case, the appropriate certificates had been completed to ensure that treatment was properly and legally authorised with one exception. We saw the the use of the extra care area could mean that patients were secluded according to the definition of the MHA Code of Practice. There were safeguards in place whilst patients were in this area but these did not meet the safeguards of the Code. The policy framework for the use of the extra care area needed improvement.

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

Acute admission wards

Dorothy Pattison Hospital provided inpatient acute services to people in the Dudley and Walsall areas.

People told us that they felt safe and if they had concerns about their safety they would be able to speak with staff on the wards.

Risk assessments were completed and reviewed at regular intervals. The action was determined by the presenting level of risk.

Staff were clear about their responsibilities for reporting incidents and concerns but did not always receive feedback from their line managers in a timely way.

Staffing levels were variable with staff reporting shortages on the wards. Bank and agency staff were used to cover these shortfalls but we were told that they did not always have the skills and knowledge to fully meet the needs of people.

People were involved with the planning and review of their care. Some people commented they were fully involved with making decisions and choices about their care. Others felt they were not involved or did not wish to be involved.

Capacity assessments were completed when people were unable to make informed decisions and choices. Best interest decisions were made by the main care giver and fully documented.

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

People were supported to make a complaint when they felt the need to do so. Information was available on the wards to support people who wished to complain.

Some staff were very positive about the recent changes within the teams and how they worked. Some staff were not so positive.

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

Summary of findings

Psychiatric intensive care units and health-based places of safety

Health based places of safety

We found that where it was necessary to use the HBPOS, people were kept safe and assessed quickly. Staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights when they were placed in the hospital based place of safety.

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

Long stay/forensic/secure services

People told us that they felt safe and if they had concerns about their safety they would be able to speak with staff.

Risk assessments were completed and reviewed at regular intervals. The action was determined by the presenting level of risk.

Staffing levels were variable with staff reporting shortages on the ward. Bank and occasionally agency staff were used to cover these shortfalls but we were told that they did not always have the skills and knowledge to fully meet the needs of people.

People were involved with the planning and review of their care. Some people told us they were fully involved with making decisions and choices about their care. Other people did not feel so involved.

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

People were supported to make a complaint when they felt the need to do so. Information was available on the wards to support people who wished to complain.

Summary of findings

What people who use the location say

We left comment cards at Dorothy Pattison hospital and some people completed these before and during the inspection. The results were analysed at trust level, which included three hospital sites and community locations.

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

Areas for improvement

Action the provider MUST take to improve

- Ensure that the mixed gender units comply fully with the national guidance.

Action the provider SHOULD take to improve

- Ensure that specialist training is provided to all staff working in specialist areas of the trust.
- Risk management plans should be developed and implemented from individual risk assessments, and people should be involved in developing these plans. 'Advance decisions' should be included where appropriate.
- Develop and implement audits to check practice against the Mental Health Act Code of Practice, as well as the legal documentation in use. Ensure the Mental Health Act scrutiny committee are informed of the outcomes of these audits and develop action plans where needed.
- Identify ways in which informal patients can leave the ward and understand their rights to leave.
- Ensure that the environment of the health based places of safety reflect national guidance to make sure people using services are protected against the risks of potentially unsafe or unsuitable premises.

Action the provider COULD take to improve

- The trust should agree and implement a plan to provide access to the full range of evidence based psychological therapies that are provided through the trust, as these are an integral part of people's care and treatment.

Good practice

Our inspection team highlighted the following areas of good practice:

We witnessed a medical emergency and saw that the response to the medical emergency was timely and co-ordinated.

Good examples of where the learning from incidents had improved working practices.

We saw that there were good systems in place for the receipt and scrutiny of detention papers when patients were first admitted under the Mental Health Act including good checklists.

Dorothy Pattison Hospital

Detailed Findings

Services we looked at:
Mental Health Act responsibilities; Acute admission wards; health-based places of safety; Long stay services;

Our inspection team

Our inspection team was led by:

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

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

The team included CQC Inspectors, Mental Health Act commissioners, a pharmacist inspector and two analysts. We also had a variety of specialist advisors which included consultant psychiatrists, psychologists, senior nurses, student nurses, social workers, senior managers and a GP.

We were additionally supported by two Experts by Experience who have personal experience of using or caring for someone who uses the type of services we were inspecting.

Background to Dorothy Pattison Hospital

Dorothy Pattison Hospital is located in Walsall

Dorothy Pattison Hospital has two gender specific inpatient wards (Ambleside ward and Langdale ward) and a residential rehabilitation unit (Grasmere ward.)

Ambleside ward for females and consists of 21 beds. Langdale ward has 18 beds and an additional 3 beds that make up an extra care area.

Grasmere ward is a mixed gender ward and provides 10 beds.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?

Detailed Findings

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

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

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

We carried out an announced visit on 25 and 26 February 2014. We undertook site visits at all the hospital locations.

We inspected all the acute inpatient services and crisis teams for adults of working age and older people. We also visited the specialist inpatient services and a sample of the community teams.

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

Mental Health Act responsibilities

Information about the service

Dorothy Pattison Hospital provides assessment and treatment for people with mental health problems. It has three wards. Ambleside ward provides assessment and treatment for adult women patients and has 21 acute inpatient beds. Langdale ward provides assessment and treatment for adult male patients and has 18 acute inpatient beds and three extra care area beds. Grasmere ward provides longer term rehabilitation for adult male and women patients and has ten beds. This location is registered with us to assess and treat people under the Mental Health Act 1983 (MHA), so all the wards can accept detained patients if needed and all wards serve the community of Walsall.

Ambleside and Linden wards were last visited by our Mental Health Act Commissioner to monitor the use of the MHA in November 2011. Grasmere ward was last visited by our Mental Health Act Commissioner in July 2013 as well. We saw positive practice during these inspections but also raised issues on compliance with the Mental Health Act Code of Practice which we report on in the well-led section of this report.

Summary of findings

When we visited the hospital on this occasion, we saw that there were a number of people who were (or who had recently been) detained under the Mental Health Act 1983 on each ward. We found that where it was necessary to use the Mental Health Act, people were lawfully detained and that the staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights on admission. There were only a small number of people who had been receiving treatment for mental disorder for long enough for special rules in the Mental Health Act to be followed but where this was the case, the appropriate certificates had been completed to ensure that treatment was properly and legally authorised with one exception. We saw that the use of the extra care area could mean that patients were secluded according to the definition of the MHA Code of Practice. There were safeguards in place whilst patients were in this area but these did not meet the safeguards of the Code. The policy framework for the the use of the extra care area needed improvement.

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

Mental Health Act responsibilities

Are Mental Health Act responsibilities safe?

We spoke with detained patients to ask them if they felt safe on the wards. One detained patient stated: "Initially I didn't feel safe – I've never been in such an environment. It's okay now. I'm used to it now."

Learning from incidents and improving standards of safety

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

Safe and proportionate systems

Information showed that the hospital was working within or just above recommended bed occupancy levels. We saw that the wards had low levels of detained patients, for example on the day of our inspection on Langdale ward only 20% of the patients were detained under the Mental Health Act. This meant that most patients were informal on each ward as they had made the capacitated decision to stay informally. The wards were regularly locked to keep people safe. We were given assurance that people were regularly reviewed in terms of observations and detention status to ensure that the staff kept people safe and ensured people were cared for in the least restrictive way. When we spoke with a group of informal patients at a focus group on Ambleside ward, many of the patients did not understand how they could exit the ward. The trust may wish to consider improved arrangements for ensuring that all informal patients, who are legally free to leave the wards, are regularly informed of their right to leave.

Risk management and Management in the Extra Care Area

We saw that when people were admitted under the Mental Health Act, they had a medical examination which considered any risks to people's physical health and a mental state examination which considered if people's mental health presented a risk to themselves or others. Staff would also use information from community staff where people were using community services. In most circumstances, people were cared for in the community and in hospital by the same Consultant Psychiatrist so they got to know people well helping to manage risks.

We saw that many patients on the wards had more complex needs including forensic or dependency issues and some had diagnosis of personality disorders. Ward staff had a range of measures to address disturbed and aggressive behaviour and manage risk. These measures included engaging patients in activities, making best use of the ward environment (for example by using the quiet areas of the ward), verbal de-escalation and where necessary PRN medication was used.

We saw that Langdale ward had a three bedded extra care area to provide more intensive support for male patients who were acutely mentally unwell. Female patients would have to be transferred to the extra care area at Bushey Fields Hospital. We looked at the records relating to people who had recently been cared for in the extra care area. We saw that the rationale for placing someone within this area, due to the acute phase of their illness, was well recorded and provided a clear explanation of why it was necessary to provide intensive nursing care input.

We saw that people were cared for in the extra care area for relatively short periods of time, mostly for up to 72 hours, but heard from staff that people had been cared for over longer periods, including up to two weeks. The care and interventions patients received whilst placed in the area were detailed in comprehensive records showing that people were kept safe in the area and were nursed by two staff. We saw that there were regular reviews of the need to continue with the care in the extra care area, for example there were daily medical reviews. We saw that many of the people cared for in the extra care area were transferred to psychiatric intensive care units (PICU) and these decisions were taken when it became obvious that people required

Mental Health Act responsibilities

more specialist psychiatric input. The trust does not have a PICU at any of its locations. This meant that when patients needed to be admitted or transferred to a PICU, patients were taken out of area to neighbouring trusts.

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

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

The trust should also ensure that there is a clock in the extra care area so patients can orientate themselves to the time. There was no-one being cared for in the extra care area at the time of our inspection. The rooms were not made to admit people in an emergency. For example the area was not fully clean and had unmade beds.

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

Information from the trust showed that Langdale ward had higher levels of patients going absent without leave (AWOL). More recently, we heard that incidents of patients going AWOL at Dorothy Pattison Hospital had reduced. This showed that where people needed to be detained in hospital, staff were working to keep people safe.

Are Mental Health Act responsibilities effective?

(for example, treatment is effective)

Adherence to the Mental Health Act Code of Practice

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

We spoke with the IMHA provider and heard that levels of engagement and referrals, with statutory advocacy services for detained patients across the trust, were inconsistent. We heard that the trust did not have an agreed comprehensive engagement protocol with the IMHA provider setting out expectations on each side, such as the sample engagement protocol outlined in the most recent guidance document IMHA: Guidance for Commissioners produced by NIMHE.

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

Mental Health Act responsibilities

properly and legally authorised. We did see one example where prescribed 'as required' medication was not included on the appropriate legal certificate. The medication had not been administered for this patient because it was not currently required. We drew this to the attention of the staff to ensure that the Mental Health Act Code of Practice was followed as this states that all relevant drugs should be on the certificates including 'as required' medication.

Detained patients were not receiving high-dose anti-psychotics on a routine basis. We saw that people were frequently written up in advance for rapid tranquilisation treatment in the event that it become necessary principally due to the availability of medical and pharmacist support out of hours.

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

Are Mental Health Act responsibilities caring?

Choices in decisions and participation

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

Detained patients have a right to access Independent Mental Health Advocacy Services (IMHA). We saw that detained patients were routinely informed of the availability of the IMHA service. Television screens across the hospital also had revolving messages which included information about the IMHA service.

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

Dignified care and avoiding restrictive practices

When we visited the acute wards we spoke with a small number of people who were detained. We spoke with them to ask them if they were treated with dignity and respect. One patient told us: "Initially I didn't feel safe – I've never been in such an environment but I am used to it now" and went on to say that staff were "respectful". Two patient's comments on the restrictions on knives stating they felt "it was undignified – knives not allowed on the ward but we used to have before moved from upstairs. We have to use spoons".

Patients were positive about their experiences despite being subject to compulsion and did not raise any complaints for example about the way they were conveyed. Detained patients' confirmed they were treated with dignity and respect and were complementary about the staff providing care to them. We saw that people had individualised care plans including detailed care plans relating to detention under the Mental Health Act.

We saw that at times, staff used over restrictive or blanket policies to help manage risks. For example one person on Ambleside ward was found to present significant risk and therefore the availability of knives on the ward was restricted for all patients. This meant that patients on the ward had to eat with plastic cutlery and at times were only allowed spoons, which was confirmed by staff. The trust should consider how it can provide more individualised risk management strategies.

Are Mental Health Act responsibilities responsive to people's needs?

(for example, to feedback?)

Responding to people's needs and reviewing care

We saw that where people were admitted into hospital, or assessed under the Mental Health Act, their detention was regularly reviewed at ward rounds. We saw that these

reviews included representatives of the medical and nursing teams. Family and patients were encouraged to attend and to a lesser degree there was also involvement of community teams.

We observed the care provided to detained patients and saw there was a limited range of activities, provided by the staff, to encourage and support people. Patients commented on the lack of meaningful activities especially in the evenings and at weekends. Staff reported that they were regularly reallocated to cover shortages across the unit which prevented activities from taking place. We heard that the gym had recently been improved and refurbished, however patients commented that they could not use the gym due to the lack of trained staff being available to supervise use of the gym equipment.

Transition of patients

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

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

We saw that where patients required continuing detention under the Mental Health Act, but had severe and enduring and/or treatment resistant mental health needs requiring slower rehabilitation; patients would be transferred to Grasmere ward for longer term and intensive nursing support. And over time manage their condition and work towards recovery and eventually discharge. The lack of any strategic commissioning decision over Grasmere ward to be reprovided into the community has affected managers' ability to plan, invest in and improve the existing environment. This impacted on patient care for example through not being able to fully address the poor gender separation.

We saw that many patients on the wards had more complex needs including forensic or dependency issues together with a diagnosis of personality disorders. Ward staff had a range of measures to care for these patients. Staff had received some initial training in caring for people with a personality diagnosis but recognised the need for more intensive training to ensure they provided consistent and appropriate care to this group of patients. There was a lack of the full range of therapeutic interventions for people with personality disorder in line with national guidance, such as the chapter in the Code of Practice about the care of people with a personality disorder diagnosis, and the guidance document 'Personality Diagnosis: No longer a Diagnosis of Exclusion'. For example it was reported there was a lack of specialist clinical psychology input which is recognised as effective for the ongoing treatment of people with personality disorder.

Are Mental Health Act responsibilities well-led?

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

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

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

Mental Health Act responsibilities

ratified, did not properly reference the MHA Code of Practice and did not properly guide or prescribe the standards of care that patients can expect in the extra care areas. The policy did not detail the current actual arrangements such as the necessity for the current regularity of medical reviews and the expected levels of observations was not properly reported. The trust had a draft visiting policy for people in the extra care areas which was overly restrictive and did not afford respect for family life. For example the policy required patients to provide a list of visitors and their addresses. Detailed exclusion of visitors without stating that such decisions were a serious interference with the rights of the patients and decisions should be regularly monitored by the hospital managers as required by the MHA Code of Practice.

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

We saw that although we had pointed out issues and trust MHA audits were continuing to identify similar issues, when we returned these had not been properly resolved or progressed. For example Grasmere ward was last visited by our Mental Health Act Commissioner in January 2012 to monitor the use of the MHA. The commissioner saw positive practice in relation to a number of areas including staff working within the Mental Health Act, care planning, risk assessments and cleanliness. However we raised issues which included lack of viewing panels in bedroom windows, poor gender separation, lack of meaningful activity and therapeutic engagement working towards discharge and lack of momentum to reprovide the service into the community. On this inspection, we saw little improvement in these areas due to the lack of decision over commissioning intention. There were also delays in responding to MHA Commissioner reports from the trust, for example we did not receive a response to our visit to Grasmere ward and had to chase the trust to provide an action statement.

The audit carried out by the trust at this location in January and February 2013 looking at progress against the issues raised showed that the items we raised on MHA monitoring visits as well and had not been fully progressed. For example the trust's audits identified that on Ambleside and Langdale ward patients had not signed their care plans, section papers were not available on all patient files and that out of date leave forms had not been struck through. The audit did not fully detail what specific and measurable action would be taken in these cases to ensure compliance with the MHA and Code and to prevent reoccurrence in the future. We saw some of these issues reoccurring on this inspection. The trust audits were identifying and assessing issues with departures from the MHA Code of Practice but weren't fully managing the risks of departing from the Code as issues were still occurring on an ongoing basis. The trust had identified the need to improve the quality and uptake of MHA training for all staff.

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

Acute admission wards

Information about the service

The are two acute inpatient wards located at the Dorothy Pattison Hospital, Walsall.

Summary of findings

Dorothy Pattison Hospital provided inpatient acute services to people in the Dudley and Walsall areas.

People told us that they felt safe and if they had concerns about their safety they would be able to speak with staff on the wards.

Risk assessments were completed and reviewed at regular intervals.

Staff were clear about their responsibilities for reporting incidents and concerns but did not always receive feedback from their line managers in a timely way.

Staffing levels varied – with staff reporting shortages on the wards. Bank and agency staff were used to cover these shortfalls but we were told that they did not always have the skills and knowledge to fully meet people's needs.

People were involved with the planning and review of their care. Some people commented they were fully involved with making decisions and choices about their care. Others felt they were not involved or did not wish to be involved.

Capacity assessments were completed when people were unable to make informed decisions and choices. Best interest decisions were made by the main care giver and fully documented.

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

People were supported to make a complaint when they felt the need to do so. Information was available on the wards to support people who wished to complain.

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

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

Acute admission wards

Are acute admission wards safe?

Learning from incidents

Staff were aware of the electronic incident report system and told us all incidents were recorded in this way. The clinical governance systems in place ensured that all incidents were reviewed and actions and learning points recorded. Staff told us that the feedback from the review of the incidents was a regular agenda item at the ward meetings. We saw copies of the minutes of the ward meetings which were also available for staff to look at. As an example, following a recent incident, we were told of the introduction of a cigarette lighter and razor policy. This meant that learning took place following the incidents and action was taken to reduce the risk to people who used the service.

Safe environment

The reception area at the main entrance to the hospital was staffed over the 24 hour period and people were requested to sign in and out. For additional security an 'air lock' system was used at the entrance to the hospital. An air lock security system comprises of an outer and inner door with partitioning to form an entrance lobby. The two doors are electronically interlocked which means they cannot be opened simultaneously. Staff told us this was for the safety of people within the hospital.

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

The wards were clean and comfortable. Staff told us that the wards were 'anti-ligature'. The trust completed a suicide prevention strategy in 2013 where it detailed a rolling programme to 'address ligature points within the inpatient environments'. The action plan recorded that 'a ligature audit would be completed'. Ligature points are items or equipment that can be used to cause compression of airways, resulting in asphyxiation and death. The trust should be aware that we saw some potential ligature points in areas on Langdale ward.

Safeguarding

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

Risk management

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

All staff carried an emergency alarm which could be activated alerting other staff that help was required. During this inspection we observed an emergency situation which was responded to quickly and effectively.

Risks and risk management were monitored through regular reviews and audits which were completed at ward level. These were then analysed by the heads of departments and any action needed to reduce the level of risk was taken. Environmental risk assessments and audits were completed and analysed by the heads of departments.

Medication

Staff told us that a pharmacist visited the wards daily to check medication and offer advice to staff if this was needed. They told us they had problems with obtaining medication if prescribed after 2pm. One person who used the service told us they had previously been discharged from hospital during the afternoon without a supply of medication. This meant they had missed medication due to it not being available for them to take home. The medication was available for them to collect the following day.

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

We found that the medicine management team were actively involved in all aspects of a person's individual

medicine. Nursing staff also told us that if they had any medicine queries they had access to pharmacist advice at all times including an out of hour's pharmacy service. We found that the medicine management team provided a good clinical service to the hospital.

People's medicines were continuously reviewed and checked by the medicine management team during their stay. Any concerns or advice about medicines were highlighted to the person's doctor in writing. However, we found that sometimes the advice or recommendations given by the medicine management team were not always followed up. One doctor told us: "I find the advice notes very helpful but I am not sure where to write that I have actioned anything". This meant that although people's medicines were checked, monitored and reviewed for safety by a clinical pharmacist the advice was not always taken and no reason was recorded.

We saw that there were checks when people were detained under the Mental Health Act (1983) ensuring the correct legal documentation for treatment for mental disorder was completed and available. However we did see one example where prescribed 'as required' medication was not included on the appropriate legal certificate. The medication had not been administered for this patient because it was not currently required. We drew this to the attention of the staff to ensure that the Mental Health Act Code of Practice was followed as this states all relevant drugs should be on the certificates including 'as required' medication.

Medicine administration records were not always accurately completed to document if people had been given their prescribed medicines. We noted on Ambleside ward that there were short gaps in four people's medicine administration records. We noted that the medicine management team had highlighted this on 17 and 19 February 2014: 'Please ensure all administration boxes on drug charts are signed/filled in with the appropriate code'. The ward manager agreed that this would need to be raised in staff team meetings. This meant it was not possible to determine if people had been given their prescribed medicines or a reason documented to explain why they had not been given them.

The safe disposal of medicines was not always undertaken following the medicine management policy dated July 2013. We found on Ambleside ward that medicines no longer required had not been disposed of. The ward manager agreed that the 'medicines should have been disposed of'. There was an increased risk of the medicines being given in error due to their availability for the patient.

Whistleblowing

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

Managing risk to the person

Risk assessments were comprehensive and contained detailed strategies to reduce risks. These included: moving and handling assessments, skin care and nutrition assessments. Further indicators of risk had been documented in regard to the individual needs of the person. These included risks of suicide, neglect, aggression and violence. This meant that staff had details of the individual risks for people and the action needed to reduce the risk.

People who used the service were on different levels of observations based on their individual needs. Staff told us that the level of risk a person presented was reviewed each day. A joint decision by the medical and nursing staff established the level of observations that were required. Each observation was recorded on a monitoring document so that staff had full details of the actions and behaviours of the person to ensure their safety. This meant that systems were in place to ensure the safety of people who used, visited and worked at the service.

Safe staffing levels

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

One person who used the service told us: "Sometimes they [the staff] try to give me my medication early of an evening because staff are busy. They seem to take too long to assist me sometimes. I think more staff are needed".

People who used the service told us that they felt safe on the wards and that staff were quick to intervene if and when problems and incidents occurred.

Are acute admission wards effective?

Acute admission wards

(for example, treatment is effective)

Use of clinical guidance

Some people were unable to make informed decisions due to their health conditions. Where this is the case the law provides a checklist of key factors which decision makers must consider when working out what is in the best interests of a person who lacks capacity. Other people can be authorised to make decisions on their behalf as long as they are in the person's best interests. We saw evidence that the service had initiated a multi-agency meeting to make a decision for one person who did not have capacity.

Staff told us that clinical guidance, protocols and procedures were available through the trust intranet. Some staff could not access the intranet so were unable to consult the information within the guidance documents. This meant that some information would not be readily available in a timely way for staff to refer to. This may have a significant impact when agency staff were used in terms of their ability to follow the ward protocols.

Collaborative working

Multi-disciplinary meetings were held each week with the consultant, junior doctors, ward staff, the person, and/or their representative. Other professionals such as the occupational therapist or psychologist did not routinely attend these meetings. We were told that people had the opportunity to meet with the occupational therapist and psychologist when the need arose. We saw notes of the meetings with these professionals in the case files we looked at.

Staff told us that they had access to the community records and paperwork which assisted them with developing the risk assessments when admission to hospital was necessary.

Care coordinators worked closely with the hospital staff, and people who used the service, with preparations for extended leave and discharge arrangements. We saw that the notice of discharge from the hospital included details of the person's doctor and consultant, their medication at the point of discharge and their after care plan. This meant that systems were in place for the sharing and passing of information between different disciplines.

Monitoring of care

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

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

Physical health checks and care were well documented on admission to the hospital and throughout the person's stay. Staff used nationally recognised guidance, standards and assessment tools to monitor and assess physical health. This meant that staff ensured that physical health assessments were made to get a baseline and ongoing physical health checks to direct continuing physical healthcare. We saw discussions were held to ensure that treatment for physical health needs was given in least restrictive ways. For example, we saw the way in which the multi-disciplinary team worked with one person when an issue with their anti-coagulation medication was identified.

We saw that staff liaised with specialist services to ensure people's physical health needs were met where this was necessary, for example diabetic nurses or tissue viability nurses. When people were discharged from the hospital we saw clear and appropriate management plans which were sent to the GP.

We saw that staff had received training in basic life support including annual updates. There were well documented checks on the emergency resuscitation and equipment. This meant that staff and equipment were prepared should

a medical emergency occur. Whilst we were on one ward, we witnessed a medical emergency and saw that the response to the medical emergency was timely and coordinated.

Are staff suitably qualified and competent?

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

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

Adherence to MHA code of practice

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

Are acute admission wards caring?

Choice in decisions and participation in reviews

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

Effective communication with staff

People who used the service and who we spoke with were generally positive about the staff, commenting that they were helpful, friendly and supportive. On the wards we visited we observed staff and most people looked relaxed and comfortable. People were in a variety of activities either in a group setting or spending time alone. Staff we spoke with were knowledgeable about the care and support needs of the people on the wards.

Regular meetings for people on the wards were arranged, facilitated by the ward managers. Following comments made by people on Langdale ward regarding the availability of refreshments, we were told a beverage bay was planned to be fitted. This meant that people had the opportunity to discuss issues of the ward management.

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

Communication sheets, daily reports and the diary were used to communicate the activities of the wards to staff on the following shifts. Staff told us that time was allocated at each shift change for there to be an effective handover of information.

Do people get the support they need?

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

Privacy and dignity

Each bedroom door was fitted with an observation screen; so that people could be discreetly observed during the night without being disturbed. People's levels of observation were assessed regularly and determined according to the presenting level of risk. The observation screens could be opened or closed from inside the bedroom so that people could have some degree of privacy.

Acute admission wards

People told us they were not offered a key to their bedroom door but on request staff would lock the door when needed. People could lock the door using the door fob when inside their bedroom but staff had the ability to override this in the event of an emergency. Staff told us that previously people had been provided with a key to their bedroom but this had caused difficulties with lost or misplaced keys.

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

Restraint

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

Are acute admission wards responsive to people's needs?

(for example, to feedback?)

Service meeting the needs of the local community

We were told, and saw records, that people admitted to Langdale ward had to sleep on Grassmere ward because no bed was available on the admitting ward. The document recorded this had happened over a five day period meaning on occasions the bed occupancy was over 100%.

Work of the trust reflects equality, diversity and human rights

We were told that information on the service was provided in alternative languages to help people whose first language was not English. Very few leaflets, information and guidance were readily available in other languages apart from English. The trust may wish to note that we did not see reference on the leaflets that they could be made available in other formats or languages.

Weekly religious services were held at the hospitals. Prayer Centre's, quiet rooms and multi faith rooms were available at other locations within the local area. We saw that the menu available had a choice of food to meet the religious or cultural needs of people who used the service.

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

Providers working together during periods of change

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

Learning from complaints

The trust had a complaints policy and procedure which included the basic principles for managing complaints, the investigation processes and the time scales for handling complaints. Staff told us that they did not always receive feedback from senior management when complaints had been made. Other staff told us that regular meetings and forums were organised where they received feedback from complaints and incidents.

Information was available on the wards we visited on how people can make a complaint. People who used the service told us they were aware of how and to whom they would complain if they felt the need to do so.

Are acute admission wards well-led?

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

assessment and treatment for working age adults was awarded to Dorothy Pattison Hospital, Ambleside and Langdale wards. Accreditation was also awarded for the provision of Electro-convulsive Therapy (ECT).

Governance arrangements

Staff on the wards were able to tell us with confidence how the governance arrangements impacted positively on future planning and the provision of care. They gave examples of where the learning from incidents and complaints had improved working practices. Following concerns and comments from people who used the service, visitors have now been requested not to use the ward gardens when visiting but to use the café areas.

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

Engagement with people who used the service

People we spoke with said they felt able to speak with staff openly and comfortably. One person who used the service told us: "The staff are very approachable they have helped me a lot and I have improved since being here".

Another person commented: "Sometimes we have to wait to see the doctor at other times they come very quickly. It is good to speak with the doctor when something is wrong".

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

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

People who used the service told us they a weekly meeting arranged where they were able to discuss ward issues. We saw that minutes of the meeting were completed and available on the wards.

Engagement with staff - ward to board

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

Staff generally knew the chief executive officer and members of the trust board. Staff explained to us the 'Ask Gary' e-mail system. 'Ask Gary' is a dedicated mailbox set up to encourage staff to e-mail the Chief Executive. This meant that systems of communication were in place.

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

Effective leadership

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

Psychiatric intensive care units and health-based places of safety

Information about the service

Dorothy Pattison Hospital provides assessment and treatment for people with mental health problems. It has three wards – two adult acute in-patient beds and a longer term rehabilitation ward.

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

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

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

Summary of findings

We found that where it was necessary to use the HBPOS, people were kept safe and assessed quickly. Staff were working within the Mental Health Act Code of Practice. We saw that attempts were made to inform people of their rights when they were placed in the hospital based place of safety.

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

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units safe?

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

The trust does not have a psychiatric intensive care unit (PICU) at any of its locations. This meant that when people needed to be admitted or transferred to a psychiatric intensive care unit; people were taken out of area to neighbouring trusts. We spoke with staff about how quickly and safely people were taken to PICU care when they required it. We heard that whilst on most occasions a bed could be found in the local area there were at times delays and people were also sent to wide geographical areas. This was illustrated by one person we saw on the acute wards who told us that they had been admitted as an in-patient to the trust in June 2013 and during this time they had been transferred to two PICUs including spending three months in a PICU in Essex and two months in a PICU in Worcester.

Are psychiatric intensive care units effective?

(for example, treatment is effective)

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

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

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

When we visited in July 2012, we asked that action was taken because the environment of the hospital based place of safety did not meet the current national guidance on the hospital based place of safety. In response the trust told us that there have been monies set aside for refurbishment and improvement of the HBPOS at both hospital sites and the refurbishment would be undertaken following consultation with Expert Service Users. On this inspection, we saw that there had been environmental improvements to the HBPOS at both locations. For example the HPBOS at Dorothy Pattison Hospital had been relocated to the ground floor. However each HBPOS environment was still not meeting the good practice guidance of the Royal College. For example at one or both locations the furniture was not fixed to the floor, there were potential self-harm hazards (for example a mirror or electrical sockets), there was no clock for people to orientate themselves to time and there was no CCTV installation or panic alarm system. We also saw that the HBPOS had discrete access from a back door to the area. Designated or allocated parking for the police or ambulance vehicles outside the HBPOS helped to ensure people were safely conveyed especially if they are presenting with disturbed behaviour and promoted people's privacy and dignity.

Psychiatric intensive care units and health-based places of safety

Are psychiatric intensive care units caring?

Choices in decisions and participation

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

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

Are psychiatric intensive care units responsive to people's needs?

(for example, to feedback?)

Responding to people's needs and reviewing care

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

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

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

Are psychiatric intensive care units well-led?

Governance arrangements and effective leadership

We saw that there were good systems in place for administration under the Mental Health Act including good checklists. Compliance with the statutory requirements of

Psychiatric intensive care units and health-based places of safety

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

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

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

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

We found that there were audits carried out to consider how well the HBPOS was being used. Audits undertaken included key demographic details, issues such as transfers between places of safety and the outcome of the use of the hospital based place of safety. There was a good analysis of quantitative data in the report. However the audit was limited in scope in relation to qualitative data, for example it did not fully consider the differential use of the places of safety at the different geographical localities. The audit did not look at the possible inappropriate use of section 136 when people were not admitted to hospital to consider and establish whether the police power may have been used unnecessarily. In addition, when we visited in June 2012, we asked that action was taken because it was not clear that people were routinely given their rights when they were brought in under police powers. In response the trust told us that they would improve practice in this area and audit the giving of rights when people were under police powers. During this inspection we looked at the audits on the use of the Mental Health Act in relation to the use of the Mental Health Act and section 136 provided by the trust and spoke with the managers. It was not clear that the audit of the giving of rights had occurred.

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

Long stay/forensic/secure services

Information about the service

Grassmere Ward is the rehabilitation ward within this hospital.

Summary of findings

People told us that they felt safe and if they had concerns about their safety they would be able to speak with staff.

Risk assessments were completed and reviewed at regular intervals.

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

People were involved with the planning and review of their care. Some people told us they were fully involved with making decisions and choices about their care. Other people did not feel so involved.

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

People were supported to make a complaint when they felt the need to do so. Information was available on the wards to support people who wished to complain.

Long stay/forensic/secure services

Are long stay/forensic/secure services safe?

Learning from incidents

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

Safe environment

The hospital operated a locked door policy on the ward. People had to wait for staff to gain entry and exit to and from the ward. One person told us that they could go out of the ward whenever they wished to do so but as the door was locked they had to ask a member of staff to open the door.

Leaflets were available on the ward which offered information to people who used the service and visitors on the locked door policy. People who were on an informal basis were informed of their legal rights for leaving the ward or hospital. Notices were placed on the doors to the ward advising people to see a staff member if they wished to leave the ward.

On Grassmere ward staff told us there was limited outdoor space for people to use. The small garden area was accessed via a dedicated fire escape within the ward. Staff told us this was used because the passenger lift close to the ward was not working and hadn't done so for a period of time. The courtyard area had a small shelter where people could smoke. No seating had been provided. One person told us that they found this area to be small and unsuitable if a number of people used the area at any one time. This arrangement was also unsuitable for anyone with poor vision or mobility.

Safeguarding

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

During the inspection, we were informed by the ward staff of a recent safeguarding concern that had been raised. This is where one or more person's health, wellbeing or human rights may not have been properly protected and they may have suffered harm, abuse or neglect. We spoke with the head of the department who informed us that action had been taken to refer the concerns and they were following their own procedures for responding to it. The overall review of this matter was not yet concluded.

Risk management

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

All staff carried an emergency alarm which could be activated to alert other staff that help was required. During this inspection we observed an emergency situation which was responded to quickly and effectively.

Whistleblowing

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

Managing risk to the person

Risk assessments were comprehensive and contained detailed strategies to reduce risks. These included: moving and handling assessments, skin care; and nutrition assessments. Further indicators of risk had been documented in regard to the individual needs of the person. These included risks of suicide, neglect, aggression and violence. This meant that staff had details of the individual risks for people and the action needed to reduce the risk.

Staff told us, and we saw, that risk evaluation and management was reviewed at regular intervals and with a team of clinicians.

Safe staffing levels

Staff were allocated to work on the ward. On Grassmere ward we saw that a trained nurse was requested to cover in another ward of the hospital following a medical emergency. This meant that the planned activities for people had to be postponed or cancelled due to these staff changes.

Long stay/forensic/secure services

The nurses told us that it was a regular occurrence for staff to be removed from this ward to cover other areas of the hospital. One person who used the service told us that sometimes the staff shortages affected the activities that had been planned and arranged.

Are long stay/forensic/secure services effective?
(for example, treatment is effective)

Use of clinical guidance
Staff told us that clinical guidance, protocols and procedures were available through the trusts' intranet. Some staff could not access the intranet so were unable to consult the information within the guidance documents. This meant that some information would not be readily available in a timely way for staff to refer to. This could have a significant impact when agency staff were used in terms of their ability to follow the ward protocols.

Collaborative working
Multi-disciplinary meetings were held each week with the consultant, junior doctors, ward staff, the person, and/or their representative. Other professionals such as the occupational therapist or psychologist did not routinely attend these meetings. We were told that people had the opportunity to meet with the occupational therapist and psychologist when the need arose. We saw notes of the meetings with these professionals in the case files we looked at.

Care coordinators worked closely with the hospital staff and people who used the service with preparations for extended leave and discharge arrangements. We saw that the notice of discharge from the hospital included details of the person's doctor and consultant, their medication at the point of discharge and their after care plan.

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

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

Physical health checks and care were well documented on admission to the hospital and throughout the person's stay. One person required regular blood tests to ensure they kept well whilst they were prescribed a certain medication. This meant that the physical health care needs of people were met.

We saw that staff had received training in basic life support including annual updates. Staff we spoke with confirmed they regularly received this training meaning staff were prepared should a medical emergency occur.

Are staff suitably qualified and competent?
Staff we spoke with told us they were up to date with the mandatory training for 2013/14. For example, equality and diversity, fire safety awareness, health and safety, information governance, infection control and safeguarding vulnerable adults and children. Additional specialist training was available when required and requested for example, management of actual and potential aggression, the Mental Capacity Act 2005 and the deprivation of liberty safeguards. We were provided with a staff training matrix that was dated February 2014. This indicated the topics available, the number of staff that had completed the training and the number of staff due to undergo the training. This meant that staff had opportunity to develop their skills and knowledge to meet the needs of people who used the service.

Staff told us that they had opportunity to meet with their line manager for individual supervision and although this did not happen on a regular basis they felt they could approach their line managers and request supervision when it was needed.

Adherence to MHA code of practice
We saw that the ward operated a locked door policy. People we spoke with told us they could ask to leave at any

time if they were not detained under the Mental Health Act (MHA). We saw leaflets were readily available to inform people of their rights to leave the ward when they wished to.

Are long stay/forensic/secure services caring?

Choice in decisions and participation in reviews

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

Effective communication with staff

People who used the service who we spoke with were generally positive about the staff, commenting that they were supportive. Staff we spoke with were knowledgeable about the care and support needs of the people on the wards.

Meetings for people on the wards were arranged at regular intervals and were facilitated by a member of staff. Staff had regular ward meetings and we saw minutes of the meetings available in the ward office. This meant staff who were unable to attend would be aware of the findings of these meetings.

Communication sheets, daily reports and the diary were used to communicate the activities of the ward to staff on the following shifts. Staff told us that time was allocated at each shift change for there to be an effective handover of information.

Do people get the support they need?

People we spoke with told us they felt safe in the environment and that staff listened to them. We saw good interactions between staff and people who used the service on the ward when we visited. Staff were visible and ready to offer support when it was needed. One person who used the service told us how staff had encouraged and supported them to make a complaint when they felt the need to do so.

Privacy and dignity

Grassmere ward provided accommodation for both male and female people. The privacy and dignity of some people may be compromised because men have to walk through the female bedroom, toilet and bathroom areas to access the communal areas of the ward.

Ensuite facilities were not available in the single occupancy bedrooms. On this mixed sex ward, toilets and bathrooms were allocated for male and female use only. Signs were positioned on the outside of the doors to indicate this. There was a potential that people's privacy may be compromised when using these facilities as the vacant/engaged signage was not fully suitable for the purpose.

Each bedroom door was fitted with an observation screen, so that people could be discreetly observed during the night without being disturbed. The level of observations were assessed regularly and determined according to the presenting level of risk. The observation screens could be opened or closed from inside the bedroom so that people could have some degree of privacy.

People told us they were not offered a key to their bedroom door but on request staff would lock the door when needed. People could lock the door using the door fob when inside their bedroom however staff had the ability to override this in the event of an emergency. Staff told us that previously people had been provided with a key to their bedroom but this had caused difficulties with lost or misplaced keys.

Restraint

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

Long stay/forensic/secure services

Are long stay/forensic/secure services responsive to people's needs?
(for example, to feedback?)

Service meeting the needs of the local community
We were told, and saw records, that people admitted to another ward of the hospital had to sleep on Grassmere ward because no bed was available on the admitting ward. The document recorded this had happened over a five day period.

Staff on this ward told us that there were times when finding follow-on accommodation for people could be an issue due to funding constraints in social care.

Work of the trust reflects equality, diversity and human rights
Information on the service was not provided in alternative languages to help people whose first language was not English. Very few leaflets, information and guidance were readily available in other languages apart from English. The trust may wish to note that we did not see reference on the leaflets that they could be available in other formats or languages.

Weekly religious services were held at the hospitals. Prayer Centre's, quiet rooms and multi faith rooms were available at other locations within the local area. We saw that the menu available had a choice of food to meet the religious or cultural needs of people who used the service.

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

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

Learning from complaints
Information was available to inform people how they could make a complaint. People who used the service told us they were aware of how and to whom they would complain if they felt the need to do so. One person told us the staff were very supportive and helped them to make a complaint when they felt they had course to do so.

Are long stay/forensic/secure services well-led?

Governance arrangements
Staff on the wards were able to tell us with confidence how the governance arrangements impacted positively on future planning and the provision of care. Some staff stated that they felt engaged and involved in the recent transition of services. Other staff felt the transition of services was not communicated well and they received little information.

Engagement with people who used the service
People we spoke with said they felt able to speak with staff openly and comfortably. One person who used the service told us: "The staff are fine, but I am looking forward to discharge when I can return to my own home. Staff are helping me with this".

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

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

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

A student nurse we spoke with told us: "I felt well supported through my placements at the hospital; the trust had progressed significantly in terms of reflecting the needs of the community".

Long stay/forensic/secure services

Staff generally knew the chief executive officer and members of the trust board. They confirmed that the senior staff visited the wards at intervals.

Effective leadership

Staff working on the ward told us that they worked together and felt well supported by their immediate line managers. They told us the line managers were readily available and support and guidance was available when required.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983. Treatment of disease, disorder or injury	Regulation 17(1) (a) 17.—(1) The registered person must, so far as reasonably practicable, make suitable arrangements to ensure— (a) the dignity, privacy and independence of service users; How the regulation was not being met: We found that people's privacy and dignity was not respected because men had to walk through the female bedroom, toilet and bathroom areas to access the communal areas of the ward.