Bradford District Care NHS Foundation Trust

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

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**
Are services effective?	**Inspected but not rated**
Are services caring?	**Inspected but not rated**
Are services well-led?	**Inspected but not rated**

Our findings

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

Inspected but not rated

Bradford District Care NHS Foundation Trust provides five inpatient wards for adults of a working age and one psychiatric intensive care unit. Services are provided from wards located at two sites; the Airedale Centre for Mental Health and Lynfield Mount Hospital.

The trust is registered to provide two regulated activities in relation to this core service:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder of injury.

We carried out this unannounced focused inspection because we were made aware of some serious incidents which had taken place on the wards, and this gave us concerns about the safety and quality of the services provided. We also followed up on the provider's progress with areas of improvements we identified during our last inspection of the service in March 2020.

This inspection was a focused inspection. We reviewed the safe key question and specific key lines of enquiry within the effective, caring and well-led domains.

As part of our inspection we visited four mental health wards for adults of a working age. The wards we visited were:

- Ashbrook ward – a 25 bed female acute ward with a one bed child and adolescent mental health service annex, located at Lynfield Mount hospital
- Maplebeck ward – a 21 bed male acute ward located at Lynfield Mount hospital
- Fern ward – a 15 bed male acute ward located at the Airedale Centre for Mental Health
- Oakburn ward – a 21 bed male acute ward with a one bed child and adolescent mental health service annex, located at Lynfield Mount hospital

We did not rate the service at this inspection. The previous rating of good remains. We found:

- The service provided safe care. The ward environments were safe and clean. The wards had enough nurses and doctors. Staff assessed and managed risk well. They minimised the use of restrictive practices, managed medicines safely and followed good practice with respect to safeguarding.
- Staff developed care plans informed by a comprehensive assessment. They provided a range of treatments suitable to the needs of the patients and in line with national guidance about best practice.
- Staff understood and discharged their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, and understood the individual needs of patients. They involved patients and families and carers in care decisions.
- The service was well led and the governance processes ensured that ward procedures ran smoothly.

Our findings

However:

- Staff on Fern ward did not always complete regular daily environmental reviews of the ward. On Fern ward the ward manager's office space was located within the clinic room.
- Staff compliance with some mandatory training courses on Oakburn ward (management of violence and aggression) and Ashbrook and Maplebeck wards (immediate life support) was below 75%. This was due to an initial pause on training delivery until Covid19 safe lesson plans and environments were identified in line with Government guidance. At the time of our inspection face to face training had resumed with restricted numbers. A prioritisation process to target staff for training was in place.
- Care plans were not always personalised. The recording of discharge planning was inconsistent. Patients and carers we spoke with were not all aware of independent mental health advocacy services.

How we carried out the inspection

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

During the inspection we visited four wards, looked at the quality of the environment and observed how staff were caring for patients. We spoke to the ward managers of the four wards we visited, and 16 other staff members including registered nurses, healthcare assistants, doctors, psychologists and occupational therapists. We spoke to eight patients using the service and to nine carers and family members of patients using the service. We reviewed 17 care records including observation and seclusion records and 40 medication charts. We attended four clinical meetings and reviewed a range of policies and procedures relating to the running of the service.

What people who use the service say

We received mostly positive feedback from patients using the service. Patients told us they felt safe in the service. Patients described staff as supportive and caring. Patients generally felt involved in their care and decisions around their care and treatment.

Is the service safe?

Inspected but not rated

We did not rate safe at this inspection. We found:

- Most wards were safe, clean, well equipped, well-furnished and well maintained. Staff completed annual health and safety and fire risk assessments. Staff completed ligature risk assessments and demonstrated a knowledge of ligatures and associated risk management plans on their wards. Blind spots on wards were mitigated by convex mirrors and the use of closed-circuit television. Cleaning and maintenance records were in place. There was no mixed sex accommodation.
- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. Senior management reviewed staffing levels on a daily, weekly and monthly basis. Wards used regular bank and agency staff where required. Ward managers could adjust staffing levels and skill mix in response to need.

Our findings

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff completed risk assessments for patients which were regularly updated. Risk was discussed in daily purposeful inpatient admission process meetings on each ward. Staff used and recorded observations appropriately to manage and mitigate risk.
- Staff used restraint and seclusion only after attempts at de-escalation had failed. Staff completed the required observations and assessments after the use of restraint or seclusion. Managers reviewed all incidents of restraint. The services' positive and proactive group reviewed the use of restraint and discussed themes and lessons learnt on a monthly basis. The ward staff participated in the provider's restrictive interventions reduction programme.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's physical health
- The service had processes and procedures to manage patient safety incidents. Staff recognised incidents and reported them appropriately. Incident reporting was monitored at location, service and trust level. Managers investigated incidents and there were forums to share lessons learnt and good practice. We saw examples of shared learning during our inspection. When things went wrong, staff apologised and gave patients honest information and suitable support

However:

- On one ward staff did not always complete regular daily reviews of the ward environment in line with the Trust policy. On Fern ward we found that between October 1 and December 10 daily environmental checks had not been completed on 37 occasions (out of 70). This reduced the ability of staff to keep patients and themselves safe.
- Facilities on wards were not always fit for purpose. On Fern ward the ward manager's desk and office space was located within the ward's clinic room. The ward manager was required to leave the room each time it needed to be used. This issue had been escalated by the service, and the Trust estates department was assessing alternative options.
- Staff compliance with some mandatory training courses on Oakburn ward (management of violence and aggression) and Ashbrook and Maplebeck wards (immediate life support) was below 75%. This was due to an initial pause on training delivery until Covid19 safe lesson plans and environments were identified in line with Government guidance. At the time of our inspection face to face training had resumed with restricted numbers. A prioritisation process to target staff for training was in place.

Is the service effective?

Inspected but not rated

We did not rate effective at this inspection. We found:

Our findings

- Staff assessed the physical and mental health of all patients on admission. Staff developed care plans for patients which they reviewed regularly through multidisciplinary discussion and updated as needed. We reviewed 17 care records and found that in each the patient had care plans in place. Care plans reflected the assessed needs.
- Staff worked with patients and carers around discharge. We reviewed 17 care records and found evidence that discharge had been discussed to varying degrees in each of them. Patients we spoke with were mostly aware of their discharge plans. Discharge was rarely delayed for other than clinical reasons.

However:

- Staff did not always ensure that all care plans were personalised or written from the patients' perspective. We reviewed 17 care records and found that four were not personalised. These care plans did not always capture patients' view and goals.
- The recording of discharge planning was inconsistent. Discharge planning was captured on daily patient notes rather than a specific discharge care plan. This meant that information around discharge could be difficult to locate in care records. The service was in the process of introducing a new template to better capture discharge planning.

Is the service caring?

Inspected but not rated

We did not rate caring at this inspection. We found:

- Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. Patients we spoke with were positive about staff, staff attitudes and the care they provided.
- Staff generally involved patients in care planning and risk assessment. We reviewed 17 care records and found evidence of patient involvement in 13 of the records. Patients we spoke with were aware of the contents of their care plan. Staff actively sought patient feedback on the quality of care provided.
- Staff generally informed and involved families and carers appropriately. However, one carer we spoke with told us that they had not been involved in their loved one's care and felt that they struggled to get information from staff.

However;

- Staff did not always ensure that patients and carers had easy access to independent advocates. One patient and four carers that we spoke with told us they were not aware of available advocacy services.
- Prior to the inspection we reviewed incidents which had taken place on the wards. We saw evidence of examples in two incidents where patients and/or their carers were not always treated with kindness and dignity and not always kept updated in relation to the care of their relative.

Is the service well-led?

Inspected but not rated

We did not rate well-led at this inspection. We found:

Our findings

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff.
- Staff knew and understood the provider's vision and values and how they were applied in the work of their team.
- Staff felt respected, supported and valued. They felt able to raise concerns without fear of retribution. Staff described an open and honest culture. Staff were aware of whistle blowing policies.
- Governance systems at ward, location and service level were effective. Wards were clean and environmental assessments were mainly up to date and completed. Environmental risks were managed. Managers planned staffing proactively and on a collaborative basis. Risk assessments, risk management plans, care plans and associated patient documentation were generally of a good standard. Performance was monitored and good practice was shared. Adverse incidents were reported, reviewed and where appropriate investigated. Learning was shared.
- Staff maintained and had access to risk registers at ward, service and trust level. Business continuity plans were in place. Policies and procedures to help manage service delivery and risks relating to Covid-19 had been introduced.

However:

- On one ward staff did not always complete regular daily reviews of the ward environment.
- Staff compliance with some mandatory training courses was below 75%. This was due to an initial pause on training delivery until Covid19 safe lesson plans and environments were identified to deliver the training in line with Government guidance. At the time of our inspection face to face training had resumed with restricted numbers. A prioritisation process to target staff for training was in place.
- Staff did not always ensure that all care plans were personalised or written from the patients' perspective. The recording of discharge planning was inconsistent.

Our findings

Areas for improvement

We found the following areas for improvement:

- The trust should ensure that daily environmental checks are completed.
- The trust should ensure a clear definition between office accommodation and the clinical room environment on Fern ward.
- The trust should ensure that staff are compliant with mandatory training requirements.
- The trust should ensure that all care plans are personalised.
- The trust should ensure there is a consistent approach to discharge planning and that plans are clearly documented and easily accessible.
- The trust should ensure that patients and carers are aware of and have access to independent mental health advocacy services.
- The trust should ensure that patients and their relatives are treated with kindness and dignity. Where the trust identifies that this has not taken place, appropriate investigation and action should be taken.

There was one additional area for improvement identified at our last inspection of this service that was not reviewed during this inspection:

- The trust should ensure that all staff receive regular supervision.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, two other CQC inspectors and two specialist advisors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation