Good

St Andrew's Healthcare

St Andrew's Healthcare - Birmingham

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
1-121538294	St Andrew's Healthcare - Birmingham	St Andrew's Healthcare - Birmingham	B30 2XR

This report describes our judgement of the quality of care provided within this core service by St Andrew's Healthcare - Birmingham. Where relevant we provide detail of each location or area of service visited.

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

Where applicable, we have reported on each core service provided by St Andrew's Healthcare - Birmingham and these are brought together to inform our overall judgement of St Andrew's Healthcare - Birmingham.

Summary of findings

Ratings

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

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

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

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

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

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

Summary of findings

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Summary of findings

Overall summary

We rated St Andrew's Healthcare - Birmingham as good because:

There were a range of measures in place throughout the hospital to ensure patient safety. There were policies in place to make sure patients and staff were safe. The hospital were committed to learning lessons from identified areas of risk and they had procedures in place to capture risk issues and made changes when needed.

Staff in all wards, at all levels, were caring and compassionate. We saw that there were a really good skills mix in all the wards to support the patients and staff. We saw that staff worked positively with patients and supported them well.

Staff said that they were supported by managers and senior managers, which helped them to feel valued. The hospital had a clear vision and this was understood by staff. The hospital also invested in their staff to ensure they were skilled to provide the best possible care to patients.

Summary of findings

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

Are services safe?

Good

We rated safe as good because:

- We saw that all ward areas were clean, spacious and that clinic rooms were secured.
- Each ward had an allocated safety nurse per shift and this was a protected role. For example, the safety nurse took responsibility for checking alarms and perimeters. Each ward was allocated a nurse dedicated to ensuring security checks were carried out and recorded daily.
- We saw that there were policies in place to support safety at the hospital and we saw staff adhere to those policies in practice. For example, we saw that there was a policy to use ligature cutters and we saw evidence of staff being trained at induction in their use.
- Overall evidence suggested that seclusion was a last resort and that the hospital primarily used de-escalation techniques. There were well documented seclusion reports and staff learned from difficult seclusion incidents to improve safety.
- There was a room for patients to meet visitors and we saw a patient take leave with a visitor escorted by a member of staff.
- All clinic rooms were suitably equipped, for example, examination couch and drugs cupboard with personalised self-medication boxes. There was also access to emergency bags and defibrillators. There were checking systems for equipment including fridge temperatures which were seen to be checked as scheduled.
- We saw data sheets and checking system relating to Control of Substances Hazardous to Health Regulations (COSHH). These Regulations require employers to control exposure to hazardous substances to prevent ill health. COSHH items. COSHH is the law that requires employers to control substances that are hazardous to health. There were also cleaning rotas and allocated deep cleaning rotas, all of which were clearly signed and within schedule.
- The hospital had a recent recruitment drive and staffing levels were good. Each ward had a well complemented multi-disciplinary team, for example, a dedicated consultant, psychologist and occupational therapist.
- Agency staff received a thorough induction to the wards. We saw a robust local induction review document that was used to induct all staff to the hospital.

Summary of findings

- On every ward, all members of staff interviewed told us that they received annual safeguarding training.
- All patients had a risk assessment on admission.
- The site had a health and safety advisor who also attended the monthly health and safety meeting. The hospital had recently completed a ligature audit and we saw evidence of identified risks and that the hospital were mitigating those risks.
- The hospital observed the MIND campaign to ban face down restraints and provided prevention and management of violence and aggression (PMVA) training annually for staff.
- The hospital had good infection control systems and processes. There were identified leads, for example, in Hazelwell ward there were two infection control leads. There was an infection control forum and all sites met monthly. There were additional training opportunities and a range of related audits, for example, hand washing and spillage/contamination.
- The hospital had a system to manage responding to incidents. We saw a very robust recording system outlining those risks. The hospital wrote to the patient about risk, investigations and outcomes. The recorded incidents were discussed at monthly meetings to explore lessons learned.

Are services effective?

Good

We rated effective as good because:

- All staff, including visiting GP's, agency staff, healthcare support workers had access to the hospital data recording system electronic care records. This meant that staff could access and enter up to date information about patients which could affect care and treatment.
- We saw a focus on pre-discharge, step down approaches, one to one community assessments, all of which were based on the individual's needs.
- Occupational therapy worked closely with patients in planning community leave and staff reported feeling very much part of this process. We saw evidence of this in care plans which were updated weekly to include planning for leave.
- The hospital tried to involve all staff in clinical audits, for example, involving healthcare support workers in infection control audits by observing them in hand washing techniques.

Summary of findings

- The hospital had an evidence based approach and used 'Model of Creative Ability' and they used NICE guidelines for schizophrenia and personality disorder when planning therapies.
- We saw evidence of a best interests meeting. There was adherence to least restrictive practice, compliance of MHA, patient choice and reviews of patients at the fortnightly ward reviews.
- We saw that there was a cohesive senior team and there were a good range of multi-disciplinary staff, qualified and unqualified nurses on all of the wards. The hospital had just one part time pharmacist and were in the process of recruiting one more full time pharmacist.
- Regular management and clinical supervision took place across all wards. Appraisals were carried out annually.
- We saw a commitment from the hospital in developing their staff, for example, one occupational therapist (OT) told us that the hospital had supported their advancement in occupational therapy.
- There was a multi-professional and multi-disciplinary team approach to the service. We saw this in the staff skills mix across all wards.
- There was an Independent Mental Health Advocate (IMHA) service available and detained patients had direct access to this service.
- On Edgbaston ward we saw that there were clear observation of least restrictive approaches and clear rationale for decisions around seclusion.

Are services caring?

Good

We rated caring as good because:

- We observed staff treated patients with dignity, kindness and respect.
- We saw that patients rooms were clean, tidy and personalised.
- On all wards we saw that staff were caring and pleasant to patients.
- Each ward had community meetings and on the day of our inspection Northfield ward had a community meeting where patients discussed issues on the ward.

Summary of findings

- We saw that patients were involved in their care planning and that they were offered a copy of their plan. This was evidenced on RIO.
- All new patients were allocated a buddy to show them around the hospital. There was also a formal induction by ward staff to orientate new patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- We saw that the hospital had a central referral system. Teams were sent to meet with patients to access suitability and the target for assessment from the time of referral was one week.
- We saw each ward had a private space with a phone accessible by patients.
- There were a wide range of facilities available to patients on each ward. There was access to cooking areas and an art room that patients used with the art therapist. There were two gyms in the court yard.
- Wards were spacious, there was comfortable seating, a TV area and recreational facilities.
- There were group sessions facilitated by occupational therapists.
- There were quiet rooms and a visitors room. If children visited they had to access the visitors room in the main building, this meant children were removed from any potential risks within the main hospital.
- On each ward there were information boards with information available about advocacy, Care Quality Commission, complaints, Patient Advice and Liaison Service (PALS), timetables for drinks and solicitor details were advertised in the phone booths.There were activity timetables and there were staff duty rotas so that patients could see which staff were on duty and when.
- Patients dietary requirements were being met. There were opportunities for group eating and the option to sit alone to eat.
- There was a sensory room and quiet areas that patients could access.
- The hospital had a dedicated faith room available to all patients. We met with the hospital chaplain who was employed on a full time basis at the hospital and accommodated all religions.

Summary of findings

- The hospital had two wheelchair users and there were no constraints in them accessing the hospital grounds and facilities.
- We saw complaints procedures displayed on notices boards and investigations results were shared with patients and staff teams. We saw evidence of regular complaints from a range of people on the hospital complaints system and there was a clear monitoring, reviewing and investigation with outcome identified on the system.

Are services well-led?

Good

We rated well-led as good because:

- The vision of the hospital was a drive for excellence and this could be seen, for example, in their commitment to developing opportunities for staff advancement and developing leadership skills among the leadership team.
- The hospital used key performance indicators to measure performance.
- We saw that incidents and safeguarding issues were discussed at ward level to learn lessons to support improved care for patients.
- Staff told us that they felt supported by senior management. One member of staff told us they loved working on the team and that the team were very patient centred.
- We saw that the senior management team had good relationships with staff and patients. For example, we saw that patients from across the hospital greeted the operational director in a warm and friendly manner, asking him questions about their treatment and general conversation. It was clear from our visit that the hospital director spent time with patients and engaged with them regularly.
- One member of staff on Edgbaston ward told us that they were involved in research with a South African organisation and the aim was to support quality and improvement across services.

Summary of findings

Information about the service

St Andrew's Healthcare is a charity providing specialist mental health care which was established 176 years ago. The Charity provides services for adolescents and young adults, women, men and elders, with 1000 inpatient beds. Additionally it provides community and in-reach services, private therapy services for GP-referred patients and

medico-legal expertise. There are eight long stay/ forensic/secure wards on the site of St Andrews, Birmingham. They are purpose built facilities and provide inpatient mental health services for up to 128 adults aged 18 years and over.

· Northfield ward is a low secure ward for up to 16 men. There were 12 patients on the day of our inspection.

· Hawkesley ward is a medium secure ward for up to 15 men. There were 15 patients on the day of our inspection.

· Speedwell ward is a low secure ward for up to 18 men who have an autistic spectrum condition. There were 16 patients on the day of our inspection.

· Edgbaston ward is a medium secure ward for up to 15 men. There were 14 patients on the day of our inspection.

· Hazelwell ward is a low secure ward for up to 16 men. There were 15 patients on the day of our inspection.

· Hurst ward is a low secure ward for up to 16 men. There were 16 patients on the day of our inspection.

· Lifford ward is a low secure ward for up to 16 men. There were 15 patients on the day of our inspection.

Moor Green ward is a low secure ward for up to 16 patients for women. There were 16 patients on the day of our inspection.

Our inspection team

The inspection team was comprised of one inspection manager, eight Care Quality Commission inspectors, a Care Quality Commission pharmacist, an expert by experience and four specialist advisors who consisted of a consultant psychiatrist, a social worker and two specialist registered nurses.

Why we carried out this inspection

We inspected St Andrew's on 6 October 2015. This was an inspection which was announced the day before the inspection because of the size of the inspection team to allow the provider to support the inspection process.

This was a follow up visit in order to check the actions the provider had taken to safeguard people who lived at the hospital.

How we carried out this inspection

During the inspection visit, the inspection team:

· visited eight inpatient ward areas; looked at the quality of the ward environment and observed how staff were caring for patients

· spoke with twenty of the patients across each of the wards visited

· spoke with four occupational therapists

· spoke with one student nurse

· spoke with one technical assistant

· spoke with two healthcare support workers

· spoke with one psychologist

· spoke with six nurse managers and nine qualified nurses

Summary of findings

· we also interviewed the operations director with responsibility for the service and the hospital director and deputy director of quality and compliance

· we attended one multi-disciplinary team meeting

We also:

· Looked at eighteen treatment records of patients

· carried out a specific check of the medication management and looked at a range of policies, procedures and other documents relating to the running of the service.

St Andrew's Healthcare

St Andrew's Healthcare - Birmingham

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
St Andrew's Healthcare - Birmingham	St Andrew's Healthcare - Birmingham

Mental Health Act responsibilities

- All qualified staff received mandatory Mental Health Act (MHA) training and this was reviewed and updated. We saw on Moor Green ward that qualified staff had a good understanding of the guiding principles of the (MHA) and code of practice, for example, family contact, patient rights, supporting patients in applying to tribunals, managers hearings and patient choice.
- There was a (MHA) office at the hospital and there were two (MHA) administrators based in Birmingham (or at the hospital).
- All patients had access to independent mental health advocacy and we saw a clear advertisement of these services on the walls in each ward.
- Unqualified support workers did not have (MHA) training as mandatory and one staff member spoken with did not have a very good understanding of the Act.
- We saw that there were checks when people were detained under the Mental Health Act (1983) to ensure that the correct legal documentation for treatment for mental disorder was completed and available. Any concerns or advice about medicines were highlighted to the patient's doctor or nursing staff by the pharmacist. Various clinical audits were carried out by the pharmacist.

Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff were trained in how to apply MCA at induction and there is a range of material available via e learning.

Detailed findings

Staff gave us examples of decision specific capacity assessments and least restrictive practice, we also saw this demonstrated at a multi-disciplinary team meeting and in one to one discussions with medical staff.

Good

Are services safe?

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

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

Our findings

Safe and clean environment

- We saw that all ward areas were clean, spacious and that clinic rooms were secured.
- We saw on Moor Green ward that they had a site ward plan for all wards and that there were daily security ward check lists, for example, for doors, windows and ligature risks. We also saw that there were related annual ligature audits available alongside the security checklists. We saw a fire risk assessment for the hospital with recommendations and action plans.
- Any blind spots had been mitigated by the use of mirrors, placement of staff and in some cases CCTV cameras. On Northfield ward which is a low secure ward, there was a blind spot in the corridor leading to patient bedrooms and there were ward staff available in that area at all times. On Hawksley ward there were two rooms with blind spots when the internal doors in the room were open. These blind spots were mitigated by strategically placed mirrors.
- Ligature cutters were accessible in a number of areas throughout the wards, for example, we saw them in the locked laundry room. We saw that there was a policy to use ligature cutters and we saw evidence of staff being trained at induction in their use.
- We looked at all of the seclusion rooms in the hospital. On Moor Green ward we saw that the seclusion room was in the same room as extra care areas. This meant that the extra care area could not be used if there was a patient detained in the seclusion room. On Moor Green ward there were no shower facilities in the seclusion room. However, two staff told us that the seclusion room on Moor Green was rarely used and we saw this evidenced in seclusion room records.
- The seclusion room in Northfield ward was very cold. We were assured there was an external heating system. There was a two way communication system. There was a shower room attached and there was CCTV in the seclusion area. The last time a patient had been detained in the seclusion room was July 2015 and there had been a total of three patients detained there since the build. This meant that the seclusion room was rarely used.
- On Hawksley ward the seclusion room did not have a shower, just a toilet and patients could be observed through a peep hole. We looked at seclusion room records and saw that the seclusion room was rarely used.
- On Lifford ward we saw that the seclusion room had no outside view except for one small window with frosted glass, it also had external temperature control and was found to be a cold room. One member of staff told us that they hardly ever used seclusion and that they primarily used de-escalation techniques.
- On Northfield and Lifford wards all patients had keys to their rooms and they were free to access their rooms throughout the day. On Hurst ward, the patient's rooms were locked during the day for safety reasons but patients could request staff to open the rooms at any time.
- There was a room for patients to meet visitors and we saw a patient take leave with a visitor escorted by a member of staff.
- Each patient's bedroom had en-suite facilities. However, we were told by a patient that showers were controlled by the provider at their central location in Northamptonshire and that they were time limited which meant they didn't get to control how long they spent in the shower. We spoke with the management team about this and they told us that they individualised patient's showers were timed to reduce the potential for flooding. We were given assurance by management that the patient's individual needs would be assessed and supported.
- All clinic rooms were suitably equipped, for example, examination couch and drugs cupboard with personalised self-medication boxes. There was also access to emergency bags and defibrillators. There were checking systems for equipment including fridge temperatures which were seen to be checked as scheduled except for Moor Green.

Good

Are services safe?

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

- We saw data sheets and checking system relating to COSHH items. There were also cleaning rotas and allocated deep cleaning rotas, all of which were clearly signed and within schedule.
- At Moor Green ward we found that there were three missing clinic checks since 9 September and although the emergency bag checks were indicated as weekly, there were only four checks since June 2015.We checked the handover file and this clearly indicated there should be weekly checks. This meant that there may have been out of date or ineffectual emergency kit in the emergency bag. We discussed this matter with the hospital management team who assured us the system would be audited regularly to ensure there were no omissions and that the checking system was being monitored.
- One clinic room had a fridge that was not in use and a new fridge had been ordered awaiting delivery. Medication was stored on another ward temporarily.

Safe staffing

- Staffing establishment records indicated there were 6 vacancies on Northfield ward, 8 vacancies on Hurst ward, 4 vacancies on Hawksley ward, 2 vacancies on Hazelwell ward and 6 vacancies on Edgbaston ward.
- Across all wards, staff told us they were sometimes short staffed, if, for example, a nurse had to take a patient offsite for a bloods appointment. We looked at hospital records for the month of August 2015 and saw that across all wards there had been some cancelled therapies as a result of staffing availability, for example, on Northfield ward 18% of therapies had been cancelled by staff.
- Staff and the hospital management team told us that there was a recruitment drive and as a result they were starting to see improvements in staffing.
- The Operations Director told us that there had been a recent recruitment drive and each ward had a well complemented multi-disciplinary team, for example, a dedicated consultant, psychologist and occupational therapist.
- The hospital shared access to an education provision which included a technical instructor and qualified teacher supported by an assistant.
- On Northfield ward there were two junior doctors, an on call 24 hour access to a consultant and associate, an on call site coordinator who was a qualified nurse and at night there was always a senior staff nurse and deputy ward manager.

Assessing and managing risk to patients and staff

- On Lifford ward we saw that a patient had a personal alarm to support their physical health needs. The alarm went off during inspection and we saw that this was promptly managed by nursing staff.
- On Edgbaston ward we saw that there were well documented seclusion reports and staff learnt from difficult seclusion patients, the reports were accessible by all staff on the ward.
- Each ward had an allocated safety nurse per shift and this was a protected role. For example, the safety nurse took responsibility for checking alarms and perimeters.
- Agency staff received a thorough induction to the wards. There was a checklist available on the wards.
- We saw and experienced staff alarm checks on entry to every ward and on every occasion. We also saw that there were posters reminding all staff to report to the lead nurse upon entry to the ward.
- On every ward, all members of staff interviewed told us that they received annual safeguarding training. The Operations Director also told us that all staff received level two safeguarding training and we saw evidence of this in the organisations training records and related policy.
- All staff interviewed across every ward told us that all patients had a risk assessment on admission. We saw evidence of risk assessments on electronic care records and on Moor Green we crossed referenced this with two sets of notes where risk assessments were observed and within date.
- The hospital operations director told us that the site had a health and safety advisor who also attended the monthly health and safety meeting. The hospital had recently completed a ligature audit and we saw evidence of identified risks and that the hospital were mitigating those risks. For example, mirrors and staffing available at all times in the identified areas. We also saw health and safety specific risk assessments.

Good

Are services safe?

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

- Two staff across two different wards told us that two staff, of the same sex as the patient, searched patients when they returned from leave.
- One staff told us that they breathalysed, did urine screening and used search dogs randomly which followed policy. We saw an organisational search policy and there was a random search system in place at reception for all persons entering the hospital.
- On Moor Green ward, one member of staff explained the process of assessing and managing physical health problems. For example, we saw evidence of one patient requiring support around nutritional needs. We saw that their diet and fluid needs had been documented, monitored and reviewed on diet and fluid charts and recorded on electronic patient records.
- One staff on Northfield ward explained nutritional screening to us and showed us an example on electronic care records, which also included physical health checks and there were multi-disciplinary team reviews on the notes on a weekly basis.
- On Moor Green ward, two staff told us that they used de-escalation techniques in the quiet room, if this did not work they might try as required prescribed medication depending on the patient's individual needs and plan. The same member of staff had no experience of rapid tranquilisation in the hospital and told us that physical restraint was used only as a last resort and that they had not seen prone restraint used in the hospital.
- One member of staff spoke with us about the hospital's awareness of the MIND campaign to ban face down (prone) restraints and told us that the hospital provided prevention and management of violence and aggression training annually for staff.
- On the Lifford ward we saw that patient bank cards were kept in a safe on the ward and that the duty nurse had a key. There was a signing in and out book and each signature had to be witnessed. There was also a section to highlight concerns, however staff told us that there should be cross referencing option with electronic care records to avoid any errors or omissions that could mean they less effectively managed the risk.
- Housekeeping and domestic staff told us they did not receive mandatory safeguarding training which meant they might overlook safeguarding issues.
- The hospital had good infection control systems and processes. There were identified leads, for example, in Hazelwell ward there were two infection control leads. There was an infection control forum and all sites met monthly. There were additional training opportunities and there were a range of related audits, for example, hand washing and spillage/contamination.
- Medicines on the wards were stored securely; room and fridge temperatures were recorded daily and were within safe range. Controlled drug records and stock monitoring were all recorded appropriately. Emergency medicines were available for use and there was evidence that these were regularly checked, including oxygen cylinders.
- The pharmacist informed us that they completed a medicines reconciliation check on the wards and appropriate clinical checks, high-lighted drug interactions and allergies. The pharmacist told us that they provided advice when requested on rapid tranquilisation and checked that the medication dosages were appropriate on medication cards.
- We looked at the prescription and medicine administration records for 45 patients across three wards. We saw appropriate arrangements were in place for recording the administration of medicines. These records were clear and fully completed. The records showed people were getting their medicines when they needed them. If people were allergic to any medicines this was recorded on their medicine prescription card.
- Some people were prescribed medicines to help with extreme episodes of agitation and anxiety. These medicines were prescribed to be given only when other calming techniques had been used by staff. This is known as rapid tranquillisation. Arrangements were in place to provide guidance to medical and nursing staff for this treatment. The pharmacist told us that they provide advice when requested on rapid tranquilisation and checked that the medication dosages were appropriate on medication cards. The pharmacist informed us that they complete a medicines reconciliation check on the wards and appropriate clinical checks, high-lighted drug interactions and allergies.

Reporting incidents and learning from when things go wrong

Good

Are services safe?

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

- We saw a very robust recording and reporting system in place at the hospital to manage incidents and learn lessons from when things go wrong.
- Six members of staff told us that there was reporting system in place for incidents called DATIX. They told us that they reported in detail on the system which then went to the manager. The manager identified if there a safeguarding referral was required and that they made sure that there was a thorough handover highlighting issues following all incidents.We saw an incident reporting system which clearly identified incidents, those responsible for managing incidents, review dates, action points, outcomes and lessons learned.
- One member of staff on Moor Green told us that if restraint was used, an incident report was completed and documented in the clinical notes. Another member of staff told us that they recorded incidents on DATIX and feedback was given via the manager.
- On Moor Green one staff told us that the last time seclusion had been used was one month prior to the inspection. We saw that this was recorded on electronic care records and that there was an entry on DATIX and the patient's medication chart.
- One staff in Moor Green told us that they had a team debrief following a patient seclusion and that a lessons learned folder was kept on the ward.
- Two members of staff gave us examples of when following an incident they carried out an investigation and had reflective meetings to learn lessons from incidents.
- Staff across all wards told us that they had weekly peer supervision to reflect on current issues and that the ward social worker supported staff in being reflective in their practice and we saw this on the ward. We also saw records and supporting emails to highlight any gaps in supervision, for example, in September, 3 members of staff failed to have their management supervision, however the hospital still achieved 98.5% completion rate during this period and we saw this recorded on their ward 'dashboards'.
- Hazelwell ward staff told us that every incident prompted a learning and debrief exercise. We saw that the hospital had terms of reference for these learning lessons groups to support a structured format.
- On Northfield ward one staff member told us that the ward referenced lessons learned at their daily handover meeting and that there was reflective practice meeting every three weeks. All lessons learned were published and distributed via email and staff meetings. All serious and untoward incidents and root causes analysis were with the multi-disciplinary team and nursing team.
- Safecall was a secure system for staff to report concerns. We saw that the hospital monitored concerns reported by staff and used the information to support staff in resolving issues. Staff told us they felt confident in using Safecall to confidentially whistle blow or to resolve problems.
- RIDDOR stands for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. The hospital are required under **RIDDOR** to report some work-related accidents, diseases and dangerous occurrences to the Health & Safety Executive. We saw a RIDDOR reporting checklist indicating where and what incidents had taken place and when the Health and Safety Executive were informed.

Are services effective?

Good

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

Our findings

Assessment of needs and planning of care

- The Operational Director told us that all staff, including healthcare support workers had access to their electronic care records and could enter information on to the case notes, but had no privileges to amend care plans. Visiting GP's also had access to electronic care records which helped in assessment of needs and care planning.
- Agency staff could also access electronic care records and training was included in their induction. We saw evidence of this on the agency staff checklist.
- On Northfield ward we saw a focus on pre-discharge, step down approaches, one to one community assessments, all of which were based on the individual's needs. For example, we saw that there were patients from Wales and there were good joint planning among agencies and the needs of the patients based on geographical area.
- Occupational therapy worked closely with patients in planning community leave and staff reported feeling very much part of this process. We saw evidence of this in care plans which were updated weekly to include planning for leave.
- Lifford ward staff told us that patients could bring up issues at one to ones and at ward rounds. They also told us that patients were involved and contributed to their care plans.

Best practice in treatment and care

- The Operational Director told us that they tried to involve all staff in clinical audits, for example, involving healthcare support workers in infection control audits by observing them in hand washing techniques.
- The Speedwell ward was not designed to meet the needs of people with autistic spectrum disorders. We saw that the lounge areas were too big and this impacted on noise levels. There were few quiet areas. The hospital Director and operations Director told us that this was an identified area of improvement and they had plans to rectify the problem.
- An occupational therapist we spoke to told us about the clinical model they used at the hospital, 'Model of Creative Ability' and that they used NICE guidelines for schizophrenia and personality disorder when planning therapies.
- The hospital followed NICE guidance and made reference to 'Consent to Treatment National Institute of Health and Care Excellence (NICE 25') and other professional guidance, for example, the British National Formulary (BNF). The BNF is a reference book that contains information and advice on prescribing and we saw on records at the hospital referencing drug charts and limits of medication in line with BNF guidance.
- We saw evidence of a best interests meeting for a patient with physical health needs.
- On Moor Green ward we saw that there was adherence to least restrictive practice, compliance of the Mental Health Act, patient choice and reviews of patients at the fortnightly ward reviews.
- All treatment records had good and up to date risk assessments, a care plan present and evidence of consent.

Skilled staff to deliver care

- We saw that there was a cohesive senior team and there were a good range of multi-disciplinary staff, qualified and unqualified nurses on all of the wards. The hospital had just one part time pharmacist and were in the process of recruiting one more full time pharmacist.
- Supervision notes were scanned on to the hospital electronic recording system and we saw records for all staff on every ward and their recorded levels of achievement for clinical supervision. The hospital were meeting their supervision targets.Staff on Hawksley, Moor Green and Hazelwell wards told us they received regular management and clinical supervision. We saw a copy of the clinical supervision contract that all staff signed. This indicated a commitment to clinical supervision within the hospital.
- In addition to clinical supervision, there were monthly meetings for specific disciplines within the hospital, for example, a monthly occupational therapy and education meeting.

Are services effective?

Good

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

- The operational director told us that appraisals were carried out annually. Staff across all wards told us about their regular appraisals and we saw evidence of this in the hospital monitoring system of personal appraisals.
- We saw a commitment from the hospital in developing their staff, for example, one occupational therapist (OT) told us that the hospital had supported her advancement in occupational therapy. The OT started with the hospital as a band 4 support worker and is now a senior occupational therapist. Another staff member started as a befriender with the hospital, then progressed to bank support worker and is now a permanent support worker.
- We spoke to newly qualified staff who told us that they had received an induction locally and at the provider's head office.
- One staff member told us that the pharmacist visited Hazelwell ward weekly and had a very robust approach to the safe management of medication.

Multi-disciplinary and inter-agency team work

- There was a multi-professional and multi-disciplinary team approach to the service. We saw this in the staff skills mix across all wards.
- During our inspection we observed a multi-disciplinary team (MDT) meeting. In attendance, there was a consultant psychiatrist, a middle grade psychiatrist, and occupational therapist, a social worker, staff nurse and a student nurse. We saw that the notes taken were very comprehensive and there was a good composition of the MDT. Patients were asked to attend and expressed their views and patient requests were given appropriate consideration.
- There was an Independent Mental Health Advocate (IMHA) service available and detained patients had direct access to this service. We saw this evidenced in the form of posters on the wall. Phones on the wards had a direct hotline to an advocacy telephone number.
- On Edgbaston ward we saw that there were clear observation of least restrictive approaches and clear rationale for decisions around seclusion.
- Hospital housekeeping staff told us that they had no system of support if they wished to discuss patient issues.

However, there was an area of concern around safety and monitoring on Northfield ward which was identified and discussed with the responsible clinician. We identified that ECG and blood monitoring should be every three months in line with national guidelines and local policy and this was not always being done.

The hospital police liaison officer had recently changed and staff reported that there might be gaps in accessing police national computer checks. We discussed this with the senior management team at the hospital and they recognised this was an area of concern and they were looking to address this.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

- All qualified staff received mandatory Mental Health Act (MHA) training and this was reviewed and updated. We saw on Moor Green ward that qualified staff had a good understanding of the guiding principles of the (MHA) and code of practice, for example, family contact, patient rights, supporting patients in applying to tribunals, managers hearings and patient choice.
- There was a (MHA) office at the hospital and there were two MHA administrators based in Birmingham (or at the hospital).
- All patients had access to independent mental health advocacy and we saw a clear advertisement of these services on the walls in each ward.
- Unqualified support workers did not have MHA training as mandatory and one staff member spoken with did not have a very good understanding of the Act.
- We saw that there were checks when people were detained under the Mental Health Act (1983) to ensure that the correct legal documentation for treatment for mental disorder was completed and available. Any concerns or advice about medicines were highlighted to the patient's doctor or nursing staff by the pharmacist. Various clinical audits were carried out by the pharmacist.

Good practice in applying the Mental Capacity Act

Are services effective?

Good

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

- All staff were trained in how to apply the Mental Capacity Act at induction and there is a range of material available via e learning. Staff gave us examples of decision specific capacity assessments and least restrictive practice, we also saw this demonstrated at a multi-disciplinary team meeting and in one to one discussions with medical staff.
- On Moor Green ward we saw that one patient had complex physical health needs and the principles of best interests were followed by, for example, involving their family when they were refusing treatment that would have a serious impact on their wellbeing.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

- On Moor Green ward we looked at a patient's room with their permission. We saw that their room was personalised and there was a lockable drawer for storage. One staff member told us that they respected the privacy of patients and always knocked on patient's bedroom doors before entering.
- In Northfield ward we saw personalised, clean and tidy rooms.
- Patients had access to well-maintained grounds and gardens and we saw evidence of patient involvement in the maintenance of the grounds in the form of wall art.
- On all wards we saw that staff were caring and pleasant to patients.
- One staff spoke to us about dignity for a patient who was wheelchair bound and that they respected his voice in all of his care.
- On Hawksley ward, one patient told us that they felt safe, staff were caring but occasionally they would enter their room without knocking.

The involvement of people in the care that they receive

- Each ward had community meetings and on the day of our inspection Northfield ward had a community meeting where patients discussed issues on the ward.
- We saw that patients were involved in their care planning and that they were offered copies.This was evidenced on RIO where patient involvement was indicated and that they were given a copy of their care plan.
- We saw that the hospital had completed a patient experience survey in July 2015 and we saw that a patient had kept a copy for their information.
- All new patients were allocated a buddy to show them around the hospital.There was also a formal induction by ward staff to orientate new patients.
- Patients were involved in the decoration of the hospital including choosing their own room colour.
- One patient told us they felt very involved in their care and treatment and there was good access to advocacy if needed.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

- We saw that the hospital had a central referral system. Teams were sent to meet with patients to access suitability and the target for assessment from the time of referral was one week.
- We saw there were 24 discharges in the past 12 months from the hospital. The hospital told us that they had two delayed discharges. We saw emails and electronic casenotes relating to the two delayed discharge patients. One patient's delayed discharge was associated with accommodation issues and housing benefit. All of which were being addressed with the local authority. The second delayed discharge was awaiting panel to discuss community placement and funding issues. Commissioners and local authority were involved.

The facilities promote recovery, comfort, dignity and confidentiality

- We saw each ward had a private space with a phone accessible by patients. Moor Green ward had a payphone available in a private area, however we could hear patients conversations. This meant that patients were not always afforded the privacy that they want.
- On Moor Green ward there was access to a cooking area and patients had scheduled cooking time with the occupational therapist on a weekly basis. There was an art room that patients used with the art therapist and we saw that there were three regulars patients who used the facilities.
- On Moor Green ward there was a small gym that we were told was not used as much as the bigger gym in the court yard. One patient told us that staff were always encouraging and engaging them in therapeutic activities.
- On Moor Green ward we saw a dialectical behaviour skills session taking place and most patients on the ward were in attendance.This intervention is evidence based and designed to help change unhelpful behaviours.
- On Moor Green ward two patients told us that staff were respectful, caring and always knocked on their bedroom door before entering.
- Northfield ward was spacious, there was comfortable seating, a TV area and a pool table where we saw patients and staff playing pool together. We also saw patients and the occupational therapist playing table tennis. A quiet room was available. All bedrooms were en suite with no restrictions. Those patients with keys were appropriately risk assessed. One patient told us that their primary nurse would always leave what they were doing to support them when it was needed.
- On Hurst ward we saw a group session taking place facilitated by the occupational therapist. It was well attended and patients were engaged in the process. Patients told us that there good facilities, for example, access to the internet café, gym sessions and access to a ward situated exercise bike.
- On Lifford ward there was a quiet room and a visitors room. If children visited they had to access the visitors room in the main building.
- Staff on Lifford ward told us about a wide range of activities for patients which included supporting two patients to attend college and promoting access to community activities. We also saw evidence of scheduled activities advertised on the ward.
- During morning meetings patients on Lifford ward would put requests to staff to attend activities and this would be facilitated as much as was practicable. For example, one patient had an individualised plan outlining a fitness programme.

However, two patients told us they would like more activities and that they sometimes get bored.

Meeting the needs of all people who use the service

- On each ward there were information boards with information available about advocacy, Care Quality Commission, complaints, Patient Advice and Liaison Services, timetables for drinks and solicitor details advertised in the phone booths. There were activity timetables and there were staff duty rotas so that patients could see which staff were on duty and when.

Are services responsive to people's needs?

Good

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

- On Lifford ward we saw that patients dietary requirements were being met and that as well as group eating there was also the option to sit alone to eat.
- On Hazelwell ward there was a sensory room and quiet areas that patients could access.
- The hospital had a dedicated faith room available to all patients. We met with the hospital chaplain who was employed on a full time basis at the hospital.
- The hospital had two wheelchair users and there were no constraints in them accessing the hospital grounds and facilities.
- Phones on the wards had direct hotline to an advocacy telephone number.

However, when the pharmacy was closed, senior staff on site had access to an emergency drug cupboard. When medicines were not available on site then a postal or courier system operated to collect medicines from the Northampton location, which increased the time to obtain medicines. These were delivered directly to the wards.

Listening to and learning from concerns and complaints

- We saw complaints procedures displayed on notices boards and investigations results were shared with patients and teams. We saw evidence of regular complaints from a range of people on the hospital complaints system and there was a clear monitoring, reviewing and investigation with outcome identified on the system.
- The hospital operated a 24 hour whistleblowing line and email address. Staff were encouraged to use this and staff told us that they had used it and would do so again. One staff member told us they felt very confident in their complaints or concerns being responded to and that they were happy to approach managers for support.

Are services well-led?

Good

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

Our findings

Vision and values

- The Operational Director told us that the vision of the hospital was a drive for excellence and this could be seen, for example, in their commitment to developing opportunities for staff advancement, for example, developing leadership skills among leadership team. We saw the hospital's 'Personal Leadership Programme' which was an accredited three day course for staff with leadership responsibilities.
- We saw that the hospital had a clear 'Our Strategy' booklet available to all staff and within this promoted their targets and 'CARE' – Compassion, Accountability, Respect and Excellence values.

Good governance

- The Operational Director told us that ward managers used key performance indicators to measure performance.
- We saw that incidents and safeguarding issues were discussed at ward level and that there were a range of formats for delivery, reporting and recording.
- The hospital had a proposed new governance structure and we saw this in the form of a flow chart indicating clear leads with specific areas of accountability.
- The hospital had recently completed a data protection audit report and this was one of a range of audits within the hospital which indicated a clear commitment to ensuring good governance.

Leadership, morale and staff engagement

- Two members of staff on Edgbaston ward told us they were a happy staff team and that they felt supported by senior management.One member of staff told us they loved working on the team and that the team were very patient centred.
- A team member on Hurst ward told us that they felt confident that they could escalate problems to senior leadership and that there was senior executive team presence on the ward at regular intervals.
- On Moor Green ward one member of staff told us that they felt confident about whistleblowing, and would happily escalate concerns to their manager.
- We saw that the senior management team had good relationships with staff and patients. For example, we saw, patients from across the hospital greeted the operational director in a warm and friendly manner, asking him questions about their treatment and general conversation. It was clear from our visit that the hospital director spent time with patients and engaged with them regularly.
- A newly qualified member of staff told us that their team were a good team.
- One staff member on Lifford, Hazelwell and Moor Green wards told us that they felt happy to discuss concerns with their leadership team and that they felt they worked as a good team.
- We saw that the hospital had completed a staff survey and used the data to inform improvements.

Commitment to quality improvement and innovation

- One member of staff on Edgbaston ward told us that they were involved in research with a South African organisation and the aim was to support quality and improvement across services.
- We saw that the hospital had introduced a 'Positive and Safe' initiative to encourage culture change within the organisation.This included how to develop a cultural move from restraint to other less restrictive practice and workshops to look at practices to improve culture within wards.
- A senior pharmacist based in Northampton provided alerts in a bulletin and a newsletter cascaded changes in guidance. There was a monthly conference call for pharmacists for discussion on relevant issues and a weekly dispensary meeting for the St Andrews pharmacy staff.