Mary Seacole House

Quality Report

Mary Seacole House
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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 and a review of all information available to CQC including information given to us from patients, the public and other organisations

Overall summary

- We were assured from our inspection that the trust were managing a serious allegation of patient abuse in line with trust policy.
- We did not find any evidence to suggest that the incident was part of a culture of abusive practice. It appeared to be a one off incident which the police had begun to investigate.
- Staffing levels on the day of the incident were low due to unexpected sickness. However, rotas and staff confirmed that this was not usual.
- The trust had sought independent reviews and conducted internal assurance visits over the last six months to monitor safeguarding concerns raised.

However

- We found two out of five risk assessments had not been completed.
- Staff told us that since the no smoking policy was implemented in May 2106, there had been an increase in the amount leave granted to detained patients for the purpose of leaving the premises to smoke. This impacted upon direct patient care, as it generated extra paperwork.

Summary of findings

Contents

Ward 2 Mary Seacole House

Services we looked at

Acute wards for adults of working age

Summary of this inspection

Our inspection team

The team was comprised of one CQC inspector and one CQC inspection manager.

Why we carried out this inspection

This was unannounced inspection to follow up on a specific incident of alleged staff misconduct and safeguarding processes.

We did not complete a comprehensive inspection; instead, we focused on concerns shared with the CQC.

How we carried out this inspection

Before the inspection visit, we reviewed information that we held about the service, asked a range of other organisations for information and sought feedback from patients.

During the inspection visit, the inspection team:

- visited ward 2 at Mary Seacole House and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with three patients who were using the service
- spoke with one patient recently discharged from the service
- spoke with the manager of the ward and the matron for the unit
- spoke with three other staff members; including doctors and nurses
- looked at five treatment records of patients.
- looked at a range of policies, procedures and other documents relating to the running of the service

Information about Mary Seacole House

The acute admissions wards for adults of working age are based across five sites within Birmingham and Solihull Mental Health Trust.

Mary Seacole House has two acute wards: ward 1 and ward 2. Ward 2 is a female only ward for up to 14 women. On the day of inspection there were 11 inpatients.

The CQC had undertaken a comprehensive inspection of Birmingham and Solihull Mental Health Foundation Trust in May 2104. Ward 2 had been inspected as a part of the core service 'Acute admissions' and was rated over all as requires improvement.

What people who use the service say

The patients we spoke with on the ward said they felt safe and supported by staff.

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

Safe

Are acute wards for adults of working age and psychiatric instensive care unit services safe?

Safe and clean environment

- The ward was visibly clean and well maintained.
- We observed housekeeping staff undertaking cleaning throughout the day.
- The ward only admitted females and was compliant with the Department of Health guidance on mixed gender accommodation.
- We observed good hand hygiene and infection control in practice. There were laminated hand hygiene posters displayed in clinic and toilet areas. Hand gel dispensers were available to staff and patients.
- Staff had personal alarms to call for assistance if needed.

Safe staffing

- The ward had an agreed staffing establishment. This was five staff during the early and late shifts, and four staff at night.
- The manager told us that staff rotated through day and nights shifts.
- The ward manager was part of the staffing numbers during the day.
- There were three qualified nursing vacancies and two health care assistant (HCA) vacancies. The trust used bank staff to cover vacancies. One HCA was on suspension and the trust was managing the process in line with trust guidelines.
- Staff shared their frustrations with the recruitment processes. They reported that it could take up to six months for staff to start working with the trust following job offers. The slow recruitment impacts upon the functioning of the ward as it can potentially leave the ward short staffed. It also means that there is an increase in the use of bank staff.
- We reviewed the staffing rotas for August 2016. They showed that staffing levels on each shift met the agreed establishment for all shifts except on the day of the alleged incident. That day rotas showed the ward had one qualified nurse and three HCA on duty during the late (afternoon) shift due to unexpected sick leave.
- Staff reported that day was very busy due to a combination of being short staffed, acutely unwell patients and an admission.
- The ward manager was able to adjust staffing levels daily to take account of case mix. However, on the day of the incident staff cover was not obtained due to short notice and it being a bank holiday.
- We noted that staff completed advanced rotas. They had highlighted all unfilled shifts for the coming weeks. This allowed shifts to be allocated to bank staff in a good time. This meant that staff were planning ahead where they could to meet the staffing levels required.
- Prior to the inspection, patients and other agencies had shared dissatisfaction with access to doctors. Three staff confirmed there had been constant changes with the consultant psychiatrist provision and this had impacted upon patient care in different ways. Examples given by staff and patients were; Patients were not seen in a timely manner, delays in signing of leave forms, inconsistent days for ward rounds. We raised these concerns with management on the unit. We were informed of plans in place to address these issues. On a follow up meeting with the modern matron it was confirmed that psychiatrist provision had been addressed as a substantive psychiatrist was in place.

Assessing and managing risk to patients and staff

- We reviewed five patient care records. Two of five records did not have a risk assessment that had been completed during or on admission. We informed the ward manager of this who said that they would be completed immediately.

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

- Three of the five records had risk assessments in place. These were up to date and signed. The risk assessments linked up with the care plans and were comprehensive, including risk indicators, protective factors and management plans.
- Staff told us they completed 'leave' risk assessments before anyone left the ward. This was to check if the patient was safe to leave. Records we reviewed had completed leave risk assessments present.
- However, one member of staff told us that they questioned how thoroughly leave risk assessments were completed. Staff told us that since the no smoking policy had been introduced in April 2016 there had been an increase in patients leaving the ward to smoke cigarettes. Each patient leaving the ward is risk assessed. Staff told us on one occasion, 50 section 17 leaves had been had been granted to a number of patients detained under the Mental Health Act. These were mainly for 15 minutes, for the purpose of patients being able to leave the ward to smoke a cigarette. This had increased the amount of paperwork staff needed to complete and they felt that it distracted from direct nursing care. One nurse told that they questioned how thoroughly these leave risk assessments could be completed as there were so many.
- Patients and staff confirmed that escorted leave and activities were rarely cancelled.
- Staff confirmed that there were enough staff to carry out any physical interventions if necessary.
- Figures obtained from the trust showed that 95% of staff were trained in safeguarding children levels 1, 90% of staff were trained in safeguarding children level 2 and 95% of staff trained in safeguarding vulnerable adults. This is above the NHS 75% target.

Reporting incidents and learning from when things go wrong

- Between December 2015 and September 2016, eight safeguarding alerts had been made to the local authority by an outside agency. These alerts concerned ward 1 and ward 2 and alleged physical and verbal abuse from staff towards patients.
- In May 2016, in response to alerts raised, the trust safeguarding team conducted an unannounced assurance visit to Mary Seacole house. This was undertaken by a member of the trust safeguarding team and independent practitioner from the clinical commissioning group safeguarding team. In addition to this they had also commissioned an independent review of the reported incidents. The outcomes were shared with the CQC and at the time we were assured that there was not a culture of systematic abuse towards patients at Mary Seacole house. Trust reviews recommended that processes should be put in place to ensure staff reported any incidents in a timely manner and that incidents were also reported to the trust safeguarding team in conjunction to the local authority.
- The most recent incident on ward 2 triggered this unannounced inspection from the CQC. We were assured from our visit that the management at Mary Seacole house had dealt with the alleged incident appropriately including completing documentation, liaising with the local authority, police and executive level management within the trust. At the time of inspection, police were undertaking an investigation. The outcome of which will be shared with the CQC. We felt assured that the alleged incident was an isolated event and not related to previous reported incidents.
- Patients and staff we spoke with confirmed that they were offered support following the incidents.
- A CQC inspector also attended a multiagency meeting following the inspection. This focused on sharing information and reviewing actions taken by the local authority, Clinical Commissioning group, Birmingham and Solihull Mental Health Trust and the CQC.

Outstanding practice and areas for improvement

Areas for improvement

Action the provider SHOULD take to improve

- The trust should ensure that all patients have an up to date risk assessment.
- The trust should ensure that all leave is thoroughly risk assessed.