Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Bernards and Ealing Community Services

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14 October 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Staffing	✓ Met this standard
Supporting workers	✓ Met this standard
Complaints	✓ Met this standard

Details about this location

Registered Provider	West London Mental Health NHS Trust
Overview of the service	The St Bernard's Hospital and Ealing Community Services location of West London Mental Health NHS Trust provides care and treatment to people with mental health needs through inpatient and community services. Some people who use the service are nursed within the secure units on the site, including the regional secure unit. This is to provide safety to the person and others. The trust has a number of community based services within the London Borough of Ealing which support people who live within the community. These services are attached to this location of the trust.
Type of services	Acute services with overnight beds Doctors consultation service Doctors treatment service Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Prison Healthcare Services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury

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Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 14 October 2013 and 15 October 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We spoke with one or more advocates for people who use services, talked with people who use the service, talked with carers and / or family members and talked with staff. We received feedback from people using comment cards, reviewed information given to us by the provider, reviewed information sent to us by other regulators or the Department of Health and talked with other authorities. We were accompanied by a specialist advisor and used information from local Healthwatch to inform our inspection.

We were accompanied by a Mental Health Act commissioner who met with patients who are detained or receiving supervised community treatment under the Mental Health Act 1983.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

Attended three service user forums

What people told us and what we found

The visits to St Bernard's Hospital and Ealing Community Services took place over two days. During the inspection we visited 12 wards and three community services. We also attended three service user groups where there were approximately 30 people who use the service and/or their representatives. We received comment cards from 18 people who attended the community services during our visits. We also received feedback from some of the independent advocacy services and from a carers network group.

During the inspection we spoke with a minimum of 37 people who use the service and a minimum of 56 staff from various disciplines.

The majority of feedback we received from people who use the service was positive and showed people valued the service they received. Comments we received from some people were: "the service I have been receiving here has been excellent. Staff are friendly. It has done wonders for me", "good help. They are very nice people", "the staff are working miracles" and "the service here is excellent."

We found that people felt respected and involved in their care and treatment. Risks to people were identified and plans were in place to minimise risks to themselves and others. Similarly, staff knew how to respond to safeguarding issues that they came across as part of their work to protect people from abuse.

The provider took information about complaints seriously, though information of how to make a complaint was not always readily available to people.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People's views and experiences were taken into account in the way the service was provided and delivered in relation to their care.

Reasons for our judgement

People expressed their views and were involved in making decisions about their care and treatment. People who use the service told us that they had been involved in planning their care and treatment. They said their views had been listened to and that they were supported to make decisions. All the people we spoke with told us they were involved in the development and review of their care plan and were always asked about their views on care, treatment and support. The care records we viewed detailed people's views and what support they required to meet their needs.

People's diversity, values and human rights were respected. People told us they were supported to practice their religion and attend places of worship, where possible. People also told us that any specific cultural food needs were met, such as Halal or where people were vegetarian. Staff told us that if people's first language was not English then they were either encouraged to bring a relative to meetings to translate or if there were not staff working at the service who could do this then staff had access to interpreters. We observed a member of staff talked with a person in their first language. We also spoke with this person who confirmed they were happy to talk in either language but appreciated that some staff could communicate with them in their first language.

On the wards which were for females only, the male staff were aware that they needed to be chaperoned when dealing with the people on the ward. The staff rota for the ward also showed that there were always an equal number, or a majority, of female staff on duty to ensure that female staff were available to support people.

Feedback we received from some people was that "the staff are caring and very good at listening", "the staff are fantastic for listening to me and things are done immediately, which I am grateful of" and "all the staff are very helpful and treat everyone with respect." We observed that staff interacted with people who use the service in a professional and courteous manner. They listened to people and responded to their comments and questions appropriately. Findings from the CQC Community Mental Health Survey (2013)

showed that the majority of respondents felt staff listened to them, took their views into account and treated them with respect and dignity. This meant that people generally felt respected by the staff and were able to express their views in relation to the support they received.

However, the provider might find it useful to note that feedback we received from an advocacy group for people who use the inpatient forensic services was that people did not always feel respected by staff. They did not feel listened to in ward rounds and they were not given enough time in their ward rounds to discuss their treatment. An example given was that "often ward rounds run late and the first thing people are told is that they only have five minutes to discuss their issues." Some people also were only given reports about their meeting one day before the meeting took place, or in the meeting itself, which meant they were not given time to review the reports.

People told us that they had many opportunities to give feedback about the service. There were community meetings on the wards to enable people to express their opinions. They were encouraged to fully participate in these meetings. We saw from one meeting held in early October 2013 that some people had requested that music was played during the day. Whilst we were on the ward we found this had been acted on, and music was being played instead of the television being on. One person told us they liked to hear music and were glad this was available to them.

On the wards a daily ward meeting was held with the staff and people who use the service. We attended the daily meeting on Hope ward during our inspection. We saw that people were involved in planning their day, this included what activities they wanted to take part in and whether people wanted any one to one time with staff. There were fortnightly 'service user' forums within the community and inpatient settings for people who use the service. These meetings were supported by a service user involvement group, so people had the opportunity to express their views and make suggestions about daily life on the ward or the way the wards were run. This meant that people were empowered to make choices about their care and treatment, and given opportunities to express their views about the service.

Within the community services we observed staff made contact with people who had been referred to the community service. Staff explained who they were and why they were phoning the person. We saw that staff gave people the opportunity to consider if they needed support and a home visit and that they would be contacted again once they had time to think about what help they required. One person who uses the service told us that they had a home visit and that staff were "professional and kind". They confirmed they were asked many questions but it was done at their own pace and enabled them to talk about their concerns and needs.

Staff in the community services told us how they involved both the person and their relatives as soon as they received a referral. This was to gather as much information from everyone as part of the assessment process. We saw that people's relatives, who were often their main carers, were provided with information on how they could receive support in their role as carers. This included information on social benefits and carers support groups. The feedback we received from a carers' network was that the carers' groups were well regarded and appreciated by carers of people who use the service.

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Within the care records we saw that staff assessed and reviewed people's capacity to give consent. The records we viewed demonstrated that people's capacity and ability to give consent to their care and treatment was considered throughout their stay on the ward. An example of this was where people had consented to have their information shared with other agencies and professionals and certain relatives. People told us that they were also consulted about day to day decisions in relation to activities they could be involved in. A staff member told us that this was an important part of supporting the person as they needed to ensure the person or their relatives had the understanding to make decisions about the person's life.

Within the cognitive impairment and dementia (CID) community service the staff told us that people or their relatives were consulted about giving consent for their details to be shared with the research and development team. This was so that they could be contacted to answer questions as part of a particular piece of research that might help and contribute towards understanding cognitive impairments such as dementia.

Staff also spoke about giving people time and the right information to make decisions such as knowing the benefit of having a scan, so that doctors could make a clear diagnosis. Sometimes where people might not be able to make decisions staff were clear that best interest meetings needed to take place. Within the CID service we saw in one person's care records that a best interest meeting had taken place with relevant professionals and relatives. This enabled everyone to contribute their views on what was considered to be the most appropriate care for the person. The records of the meeting showed health professionals looked at the person's ability to make decisions about their life whilst ensuring the person was supported safely.

Similarly, within the inpatient services the care records showed us that capacity assessments were carried out and decision specific assessments were recorded. For example we viewed records for a person who did not have the capacity to consent to treatment. We saw that best interest assessments were carried out with the involvement of clinicians, nurses, the person, family members and carers. Staff that we spoke with told us

that capacity assessments were kept under regular review to reflect changes in people's mental health condition.

Where people did not have the capacity to consent, the provider acted in accordance with legal requirements. We looked at whether people who were not detained under the Mental Health Act (MHA) 1983 were deprived of their liberty, as the CQC had not been notified of any deprivation of liberty safeguards in relation to people who use the service. However, this was not significantly different to other mental health NHS trusts. During our inspection we found that nobody was deprived of their liberty, or were restricted from leaving the wards, where they had not been detained under the MHA 1983.

However, the provider might find it useful to note that findings from recent visits to the wards by the Mental Health Act (MHA) Commissioners was that some legal requirements in relation to the MHA 1983 and associated Code of Practice were not always complied with. They found that on some wards there was no evidence that people had been reminded of their rights, or where they had been, the forms used to record this were out of date and used incorrect language. In some cases the recording did not give an indication of any meaningful discussion that had taken place when the person had been reminded of their rights.

During our inspection we found that the content of the records relating to people being reminded of their rights varied. Some were quite brief, whereas others included the content of the discussion and responses of the person who uses the service, to demonstrate they understood their rights. We also found that some people in Butler House had not been explained their rights on an on-going basis, or where they had been transferred to a different care setting. This did not ensure that people were always aware of their rights in relation to consent to treatment. The provider told us that they would carry out a review of all the records relating to people being reminded of their rights to ensure this complied with the Mental Health Act 1983.

In one recent visit by the MHA Commissioners it was found that the legal authority to provide treatment, in accordance with the MHA 1983 had not been obtained. Whereby, people had consented to treatment, this had not been authorised by a current approved clinician, which meant the provider had no legal authority to provide treatment. The trust remedied this matter promptly when this was brought to their attention.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. Care records we viewed were up to date and had been reviewed regularly. We saw that people's needs had been assessed and care plans developed that detailed the individual treatment and support the person required.

Care plans had been drawn up in areas such as people's physical health, psychological health, relationships and safety needs. All the people we spoke with told us they had a care plan and they were always involved in the care plan review.

The staff on the assessment ward told us they worked in collaboration with the Crisis Resolution Home Treatment team and community mental health team when they discharged people or monitored people in the community. This ensured as seamless a discharge as possible for people to prevent re-admissions and to ensure that people whose mental health had deteriorated received rapid treatment. Where people were discharged into the community, we noted that their care coordinators were invited for the discharge meeting. We saw email contacts that had been initiated by the ward staff to ensure care coordinators were kept informed of people's discharges so they could arrange to visit or make arrangements to monitor people.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare. Within the community services we found that all referrals were reviewed on receipt by the service and triaged based on risk, so high risk cases were prioritised. Within the inpatient settings we saw that risks to people and risks they presented to others had been assessed and reviewed to ensure staff supported people appropriately. If people required one to one support from staff we saw this had been arranged. In addition, if people required regular checks to ensure they were safe and well then this was carried out by staff and recorded.

We found where people expressed their views regarding the care and treatment they needed, this had also been recorded. Records also included comments where people did not agree with the care the staff had planned for them, which demonstrated that, where possible, people had been asked to contribute their views. Some people said that risks to

their safety and well-being were regularly discussed and documented. Risk management plans we viewed detailed the actions that were required to minimise the risk to the individual. Staff told us that risks were reviewed regularly in the handover between shifts, and ward rounds, so that the level of support and treatment people received were tailored to changes in the person's condition. We saw evidence of the discussion relating to this in the daily progress notes and care plans.

We found that appropriate incidents and accidents records were completed when these occurred. We checked some records and looked at whether people's care records had been amended in line with the incidents so action could be taken to prevent these. We noted that risks assessments and care plans had been amended where required to reflect the incidents that had occurred. However, the provider might find it useful to note that on Jubilee Ward we found in a person's care records that risks had been identified but the risk management plan had not been updated to reflect the change in the person's needs. Similarly, we found that where a person made a number of allegations, there was no care plan in relation to this, and so therefore it was not clear how staff would respond to the comments made by the person.

The feedback we received from an inpatient advocacy service was that those people who didn't have leave from the ward felt there was nothing for them to do but watch television, or where activities were provided, these were "mediocre and not stimulating." The provider might find it useful to note that during our inspection we found that on some wards there was little activity provision for people who were unable to leave the ward. For example, on Starlight ward we did not see any activities.

We were informed that an occupational therapist was involved in people's care and in supporting people to maintain independent living skills. We saw a plan for some activities which included music therapy and attending a drumming group. The ward had an occupational therapy room which was well equipped so people could engage in this therapy. However, during the time we spent on the ward people sat and watched television or rested in their rooms. People that were not detained under the MHA 1983 could go out independently for walks.

Within The Orchard there was an atrium, which had a range of activity facilities. These included a cafeteria, shop, gymnasium, hairdressing salon and an 'Activities of Daily Living room'. However, the staff told us that access to these facilities was limited and they were not open every day, with some available only one day per week.

In Brunel House there was one activity planned for the afternoon, which was music therapy. However, when the music therapist arrived, this did not take place. We were later told that was cancelled by staff due to the inspection that took place on the ward. These findings did not demonstrate that people's welfare and wellbeing was always promoted through the provision of daytime activities.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

People who use the service were protected from the risk of abuse because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. People told us they felt safe on the wards. One person said, "I would tell the staff if I didn't feel safe but that has never happened", whilst others commented that "the staff always listen to me and make me feel safe" and "I feel safe here, there are some aggressive patients that can cause you anxiety but on the whole it is safe".

We were shown records to confirm that staff had received safeguarding training and we saw they had access to the PAN London safeguarding policies and procedures. All of the staff spoken with demonstrated an understanding of the safeguarding policies and procedures and knew the action they should take if they were concerned about a person's welfare. Staff we spoke with told us they regularly reviewed risks that people posed in order to safeguard them. For example staff risk assessed people that went on leave to family settings to ensure that it was safe for them to go into the community.

On some of the wards we also found evidence that safeguarding referrals had been made to the local authority safeguarding teams. The London Borough of Ealing safeguarding team told us that they received appropriate safeguarding referrals from the inpatient and community settings of St Bernard's and Ealing Community Services.

However, on Starlight ward we found records of an incident between two people that resulted in one of them being assaulted. This was not reported to the safeguarding team. When we asked staff what kind of incidents between people were reportable, we were informed that it was a matter of judgement depending on the circumstances. We were concerned there was a lack of protocol in place to ensure staff made consistent decisions.

The provider might find it useful to note that whilst there was information on safeguarding and the reporting procedure on display in the staff areas of the wards and community settings we visited, there was no information available for people using the service to raise their awareness about abuse. We asked staff how people who use the service would raise concerns if they were worried about their safety and/or that of other people. Staff told us

that people could raise issues with their key workers during one to one session, who would then follow up their concerns. However, they acknowledged that some people might not fully understand the safeguarding adults process and what constituted abuse, and what they could do if they were concerned about their safety because information about this was not explicit.

During our inspection we attended a service user forum for inpatients from the local services (non-forensic wards). Some people who use the service raised concerns regarding the attitude of night staff on three of the wards, one of which was a safeguarding concern. When we spoke with senior managers involved in safeguarding on the second day of the inspection, we were informed that these allegations were being investigated.

Whilst we visited one ward there was a person who became restless. We observed that all the staff who engaged with the person remained calm, professional and spent time with the person, which appeared to de-escalate the situation. We found that staff were trained in the Prevention and Management of Violence and Aggression and in Enhanced Engagement and Observation so they were familiar when dealing with people whose behaviour could challenge the service.

We spoke with staff about the use of restraint to nurse people. The staff told us they used restraint as a last resort, and used de-escalation techniques to try and resolve situations. Staff told us the processes they followed and the records they kept if a person had been subject to restraint, so that a clear audit trail was maintained for the safety of the person. Where restraint had been used the records had appropriately documented and provided information on the rationale for need to restrain the person. The holds applied in the restraint process, and the position of the person's body when restrained were documented.

However, on Tom Main ward we found that the recording of the section of the form titled 'Immediate actions taken after the incident and actions taken to prevent a similar incident form happening again' had not been completed in six of the ten records of restraint that we viewed for August and September 2013. Where there were entries, they did not give clear details of how to prevent a similar incident happening again.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough qualified, skilled and experienced staff to meet people's needs.

Reasons for our judgement

The findings from some visits by the MHA Commissioners over the past year found that the on some wards the Section 17 leave away from the ward (which some people detained under the Mental Health Act 1983 were entitled to) did not always take place, or was cancelled at short notice.

The feedback we received from one of the service user forums we attended raised concerns about lack of staffing to facilitate leave and time for people off wards. Similarly, information from an advocacy group was that people who did have escorted leave were not always able to use all the time they were allowed. They said that this was because there were not enough staff to take them out. Some people said that whilst they were entitled to have two escorted leaves a day, they sometimes only had one.

During our inspection the people who use the service said they always managed to get the Section 17 leave off the ward that they were entitled to. The staff showed us evidence that people's leave off the ward was planned each morning in the 'daily planning meeting' to ensure that leave was spread throughout the day and that there were staff available to escort people. Staff told us that leave generally always took place, though if an incident happened on the ward, then this could affect people being able to have their leave.

There were enough qualified, skilled and experienced staff to meet people's needs. Within the inpatient and community services of there were a number of nurse vacancies, and some wards also did not have an occupational therapist or activity co-ordinator. Nurse vacancies were covered through the use of regular bank staff, to ensure people received consistent care and support from staff that were familiar to them. We were told that there was occasional use of agency staffing.

The ward staff rotas showed that additional staff were rostered to work if a people needed to be nursed at a higher level, such as on a one-to-one basis, or where people had to be escorted to appointments. We also found that staff were able to raise concerns if they were worried about the staffing levels. On Starlight ward the staffing was increased after staff had raised concerns. The ward manager confirmed that more staff were provided at busy times such as when there were ward rounds. In response to this change one staff member commented to us that "we now have the skills to manage people with complex

needs and it is not so draining on staff".

However, we did find there was inconsistent cover of the occupational therapy and activity vacancies. The provider might also find it useful to note that on Butler House, there was only one staff member on duty when we inspected the ward, instead of the two staff that were rostered to work. The nurse on duty told us that cover had not been put in place for the second member of staff who was on a training course. The nurse said they constantly risk assessed the unit and felt it was safe. However they acknowledged that situations could change quickly on the unit.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Towards the later part of 2012 the Department of Health carried out a survey of NHS Staff which was published in February 2013. The findings from this were that West London Mental Health Trust scored above the national average on areas such as staff motivation and staff feeling satisfied with the quality of work and patient care they were able to deliver. Other findings from the survey were that the trust was also in the lowest 20% of trusts for staff who experienced harassment, bullying or abuse from other staff and of the percentage of staff who felt able to contribute towards improvements at work. However, this information was not specific to the locations of the trust or settings in which staff worked.

These findings coincided with the timing and findings of the last inspection of St Bernard's and Ealing Community Services, in October 2012, where we found that staff did not feel supported. Some felt bullied and were de-motivated in their work. Staff said they were worried about the impact this had on their ability to provide a quality service, and as a result, people could be put at risk. In response to these findings we asked the trust to make improvements ensure that staff were appropriately supported in their work.

Since this time the trust set up a number of processes to get feedback from staff about how it could better support them and how to increase their involvement in the way decisions were made. One of the attempts included setting up a system of 'trust reporters'. These were members of staff who volunteered to go and talk to a number of their colleagues about a list of issues including what it was like to work for the trust, what was positive and negative, to report back. They reported in a group among themselves with the board members as spectators (a 'fish bowl' exercise), so they could listen to what the feedback was. A number of areas were identified for improvement and action plans were drawn up. Staff said they enjoyed doing this exercise because it demonstrated the trust's commitment to listen to them and to improve the way it supported staff.

During this inspection we spoke with a number of different disciplines of staff across almost half of the St Bernard's Hospital inpatient wards and most of its community settings. The staff spoke positively about their work and said they felt more consulted about changes that took place and were able to express their views. They enjoyed their work and

they felt supported by their team and managers. Staff commented that "the mood is much better among staff and things are improving" and "they [staff] work very hard and the staff satisfaction has increased". Other comments we received from staff included "staff morale is much better" and"staff have stopped hiding and can come forward if they want to discuss an issue." Staff reported that they felt valued within the organisation and were confident that they were being supported by senior managers. All staff spoken to conveyed a commitment to working with the people who use the service and their different needs.

Staff told us that there was good team work on the wards and that they received regular support from their manager through individual 'supervision' sessions and an annual appraisal to assess their performance and identify any areas for development. One member of staff said "you don't have to wait for supervision, if you need to speak with the manager before that you can".

A minority of staff we spoke with on one ward said that they did not feel supported by senior managers, and that they were not always told about changes in their work. However, none of the staff we spoke with said they felt bullied or fearful in their work, or that there was a negative impact on the people who use the service, as they had previously. This meant that staff received sufficient support in their work to ensure people received safe and appropriate care.

Staff received appropriate professional development. The majority of people who use the service told us they were happy with the care and support they received and that staff had the skills and knowledge to care for them effectively. Comments we received included "everything that I have asked for they have supported me", "somebody is always available to talk to, they are very good", "they are always open to listen to what you have to say" and "I have no concerns about the staff".

We were shown the systems that were in place to monitor the training the staff had undertaken and when training updates were required. We saw that bank staff were also provided with training to ensure they were able to fully support permanent staff when on shift. Staff spoke about training they had undertaken, in areas such as health and safety, suicide prevention and breakaway techniques, and were shown the training records to evidence this. We also saw evidence on the staff rota that staff were given the time to attend these training courses.

Staff were able, from time to time, to obtain further relevant qualifications. The majority of staff we spoke with said they were able to undertake training to support them in their work and to progress them in their professional development. Staff told us they had "plenty of opportunities" to attend training courses internally and externally. Some staff told us the Trust had supported them to obtain further qualifications which helped their professional development and had allowed them to bring new ideas to the work place to improve care that was provided to people.

On some wards we saw that regular presentations and learning sessions were made available to staff. These were on subjects such as tissue viability or medicines management. In the community services we saw these also took place and on the day of the inspection a presentation took place on 'Early signs of dementia'. This meant that staff received appropriate support and training to care for people.

Complaints ✓ Met this standard

People should have their complaints listened to and acted on properly

Our judgement

The provider was meeting this standard.

There was an effective complaints system available. Comments and complaints people made were responded to appropriately.

Reasons for our judgement

People had their comments and complaints listened to and acted on. Most of the people we spoke with said that they felt able to raise complaints about their care and these were listened to. Some people told us that they used the support of an advocate when they required assistance from someone outside of the ward. The staff we spoke with said they would listen to people if they raised a concern and if they could not address it themselves they would refer the person to the senior member of the staff team. We did see some evidence where staff responded to issues raised by people using the service. For example, on one ward a rota had been developed for who was served meals first, as people had complained that some people received their meals before others.

Within the community services and local services we saw posters on display of how people could make a complaint. However, the provider might find it useful to note that some people we spoke with in the forensic inpatient services did not know how to make a complaint. They said they had not been given information of how they could make a complaint. When we visited the forensic wards there was no information on display of how people could make a complaint or raise issues about the service. The staff told us that the community meetings were an opportunity for people to raise a complaint, however we viewed some records of these meetings and they did not record that complaints were an on-going agenda item or that there was any discussion around complaints. This meant that people were not provided with full information and opportunities to raise a complaint if they were dissatisfied with the service.

The feedback we received from some advocacy groups of people who use the inpatient services was that they did not feel that complaints they made ended up in their favour, particularly when the complaints were about staff. In looking at this we found information from the WLMHT board papers for July 2013 which showed that there had been an increase in complaints and that common themes had been identified in relation to all aspects of care and treatment, staff attitude and communication.

We spoke with senior managers within the trust who oversaw the management of complaints. They said that complaints were often difficult to prove where there was no evidence to support the complaint, and therefore could not be substantiated. They told us about work that was underway to monitor the themes of complaints and the settings in

which they were received, to identify patterns and to alert service managers to their findings for issues to be addressed. This meant that the provider took complaints seriously and appropriately managed and investigated these to ensure that, where required, lessons were learnt and improvements made to the service and to the care people received.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

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