

Avon and Wiltshire Mental Health Partnership NHS  
Trust

# Psychiatric Intensive Care Units and Health-Based Places of Safety

## Quality Report

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## Locations inspected

Name of CQC registered location	Location ID	Name of service (e.g. ward/unit/team)	Postcode of service (ward/unit/team)
Fountain Way	RVN9A	Ashdown Psychiatric Intensive Care Unit	SP2 7EP
Callington Road Hospital	RVN4A	Hazel Psychiatric Intensive Care Unit Elizabeth Casson House Psychiatric Intensive Care Unit	BS4 5BJ
Fountain Way	RVN9A	Place of Safety	SP2 7EP
Southmead Hospital	RVN3N	Mason Place of Safety	BS10 5NB
Sandlewood Court	RVN8A	Applewood Place of Safety	SN3 4WF

# Summary of findings

Green Lane Hospital

RVN6A

Place of Safety

SN10 5DS

This report describes our judgement of the quality of care provided within this core service by Avon and Wiltshire Mental Health Partnership NHS Trust. 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 Avon and Wiltshire Mental Health Partnership NHS Trust and these are brought together to inform our overall judgement of Avon and Wiltshire Mental Health Partnership NHS Trust.

# 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.

### **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

The psychiatric intensive care units (PICUs) are based in two hospital sites, one in Bristol and one in Salisbury. All provide inpatient mental health services for adults.

We were concerned to see potential ligature points and had concerns about the monitoring of temperatures in rooms where medicines were stored and medicines refrigerators.

Staff we spoke with were passionate about providing high quality care in a challenging environment. However, we were concerned that staffing levels were not sufficient on Elizabeth Casson House or Ashdown, particularly at night, to provide safe and therapeutic care for patients.

Overall, arrangements for reporting incidents and allegations of, or actual abuse, were in place, but were not completely effective in all units. Some learning had taken place from incidents.

People's needs, including their physical health needs, were assessed and care and treatment was planned to meet them. Overall we saw good multi-disciplinary working.

People's knowledge and involvement in their care plans varied across the sites as did the range of activities available. Staff had mostly received their mandatory training but had been unable to access more specialist training. Overall, most staff had received regular supervision but there were some gaps.

Systems were in place to ensure compliance with the Mental Health Act (MHA). However Mental Health Act

assessments following a section 136 were often delayed out of hours and we noted that two different section 136 protocols were being used in the different places of safety. We also found occasions where seclusion was not recognised and managed within the safeguards set out in the Mental Health Act Code of Practice.

Staff appeared kind and compassionate. We observed them treating patients with respect and communicating effectively with them. People were positive about staff, although some were concerned at the lack of time staff had to spend with them. Patients' cultural needs were generally being met.

The lack of available beds meant that some patients were waiting too long to be transferred between services, and others were being transferred from PICUs to acute beds too early. We also saw some significant delays in people moving on to the appropriate service once their assessment had been completed.

Staff members' knowledge of the vision and values of the trust varied, and they told us they did not feel they had had any input into them. Staff generally felt supported by the managers at ward level but felt isolated within the trust and did not feel that their views were encouraged. Staff, including some consultant psychiatrists, did not feel their concerns had been listened to or that appropriate action had been taken. Several meetings were held by the trust focusing on current provision and identifying concerns, but little if any action was taken to address some concerns.

# Summary of findings

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

### **Are services safe?**

We were concerned that staffing levels were not sufficient on Elizabeth Casson House or Ashdown, particularly at night, to provide safe and therapeutic care for patients. We were told that medical staffing for the Bristol PICUs had also been reduced and was having an impact on patient care. Staff had told senior managers their concerns about staffing levels, but they did not feel action had been taken or that they had been listened to.

Overall, arrangements for reporting incidents and allegations of, or actual abuse, were in place, but were not completely effective in all units.

Some learning had taken place from incidents, but they kept happening at Elizabeth Casson House and Ashdown. However, some improvement had been made at Ashdown on our return visit.

We were very concerned to see potential ligature points, including in two of the four places of safety. We raised these potential risks to patients' safety with staff on the day of our visit.

We had concerns about the monitoring of temperatures in rooms where medicines were stored and the medicines refrigerators on Elizabeth Casson House and Ashdown.

Emergency lifesaving equipment was not readily available and fit for purpose and training of staff in the use of medical devices was not up to date at Fountain Way.

Staff we spoke with demonstrated a good understanding of their patients' needs and assessed risks.

### **Are services effective?**

People's needs, including their physical health needs, were assessed and care and treatment was planned to meet them. Overall, we saw good multi-disciplinary working. People's knowledge and involvement in their care plans varied across the sites and some care plans were not completed at Ashdown. Patients and staff told us that there was a lack of appropriate activities on Elizabeth Casson House and Ashdown but there was a good range of activities on Hazel.

Some performance information, such as patient readmissions, was used to help improve the quality of the service.

Most staff had received their mandatory training but had been unable to access more specialist training. Overall, most staff had received regular supervision but there were some gaps.

# Summary of findings

Systems were in place to ensure compliance with the Mental Health Act (MHA). However Mental Health Act assessments following a section 136 were often delayed out of hours and we noted that two different section 136 protocols were being used in the different places of safety. We also found occasions where seclusion was not recognised and managed within the safeguards set out in the Mental Health Act Code of Practice.

## **Are services caring?**

Staff appeared kind and compassionate. We observed staff treating patients with respect and communicating effectively with them. They showed their desire to provide high quality care despite the challenges of staffing levels and the needs of the patients on the ward, which was associated with volatility of behaviour.

People we spoke with were positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

Patients' cultural needs were being met in the PICUs in Bristol but we found some concerns about patients' religious needs being met and incidents where their privacy had not been respected in Ashdown. The environment at Green Lane did not promote people's treatment or dignity.

We saw that patients' families were able to visit and that, where necessary, visiting times were arranged at a time to suit them.

## **Are services responsive to people's needs?**

Bed availability appeared to be a trust-wide issue with intensive care beds always in demand. The lack of available beds meant that there were delays in transferring a patient who was ready to move from a PICU to an acute psychiatric bed. Staff also reported that patients were transferred from PICUs to acute beds too early due to the pressure on beds.

Mental Health Act assessments following a section 136 were often delayed out of hours, on bank holidays and at weekends. We also saw some significant delays in people moving on to the appropriate service once their assessment had been completed.

Both staff and patients knew how to make a complaint. Some patients and staff felt managers did not always take their concerns seriously and actions were not always taken or seen to be taken as a result.

# Summary of findings

## **Are services well-led?**

Staff members' knowledge of the vision and values of the trust varied, and they told us they did not feel they had had any input into them.

Staff generally felt supported by the managers at ward level but felt isolated within the trust and did not feel that their views were encouraged. Staff, including some consultant psychiatrists, did not feel their concerns had been listened to or that appropriate action had been taken. Consultant psychiatrists in Bristol told us they did not feel supported in their role by the trust.

Several meetings were held by the trust focusing on current provision and identifying concerns, but little if any action was taken to address some concerns.

The trust-wide governance and information system measures compliance with key issues such as records and supervision. Staff have access and can compare performance across wards.

# Summary of findings

## Background to the service

The psychiatric intensive care units (PICUs) are based in two hospital sites, one in Bristol and one in Salisbury.

All provide inpatient mental health services for adults. One PICU in Bristol is for women only, while the other two are for men only.

The health-based places of safety are based in four hospital sites. These sites are located in Bristol, Salisbury, Devizes and Swindon respectively.

Avon and Wiltshire Mental Health Partnership NHS Trust has been inspected 28 times since registration in April

2010. Out of these, there have been three inspections at Callington Road Hospital and one at Fountain Way. There have been no inspections of health-based places of safety.

At the time of our visit there were compliance actions in place regarding Callington Road Hospital that we reviewed during this inspection. We had last visited this location in February 2014 and it was found to be non-compliant in two areas. These were: Assessing and monitoring the quality of service provision and records.

## Our inspection team

Our inspection team was led by:

**Chair:** Prof. Chris Thompson, Consultant Psychiatrist

**Team Leaders:** Julie Meikle, Head of Inspection  
Lyn Critchley, Inspection Manager

The team included CQC managers, inspection managers and inspectors, and a variety of specialists including: consultant psychiatrists, specialist registrars, psychologists, registered nurses, occupational therapists, social workers, Mental Health Act reviewers, advocates, governance specialists and Experts by Experience.

## Why we carried out this inspection

We inspected this core service as part of our comprehensive Wave 2 pilot mental health inspection programme.

## How we carried out this inspection

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

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

Before visiting, we reviewed a range of information we hold about the core service and asked other

organisations to share what they knew. We carried out announced visits between 9 and 13 June 2014. During the visits we held focus groups with a range of staff who worked within the service, such as nurses, doctors, therapists and allied staff. We observed how people were being cared for and talked with carers and/or family members and reviewed care or treatment records of people who use services. We met with people who use services and carers, who shared their views and experiences of the core service. We also carried out unannounced visits between 24 and 26 June 2014.

# Summary of findings

## What people who use the provider's services say

People told us they generally felt safe but that there were not enough staff at times to keep them feeling safe. They did, however, praise the staff for managing some very difficult situations.

Most people we spoke with were aware of their care plans and some said they had contributed to them. They said there was a lack of appropriate activities on Elizabeth Casson House and Ashdown but they were positive about activities on Hazel.

Patients told us staff listened to them and had one to one time, often on a daily basis. They said staff were well trained and knowledgeable. Some people were concerned at the lack of time staff had to spend with them.

## Good practice

The Child and Adolescent Mental Health services (CAMHS) had a two hour target to complete assessments at Mason place of safety in Bristol. This target was being met both

in the day and out of hours. Young people under the age of 18 years old were nursed automatically on 1:1 observations and had a separate part of the unit to access if required.

## Areas for improvement

### Action the provider **MUST** or **SHOULD** take to improve

#### Action the provider **MUST** take to improve

- The trust must ensure that ligature and environmental risks are addressed.
- The trust must ensure staffing shortages for Elizabeth Casson House and Ashdown are addressed.
- The trust must improve medical cover for the PICUs in Bristol.
- The trust must ensure appropriate recording and reporting of room and refrigerator temperature where medicines are stored and the seclusion room at Fountain Way.
- The trust must ensure that emergency lifesaving equipment is readily available and fit for purpose and training of staff in the use of medical devices is up to date.
- The trust must work with commissioners to ensure that there are sufficient beds so that people receive the right treatment at the right time.

- The trust must increase engagement with staff, including consultants in Bristol, and ensure their concerns regarding patient safety are addressed.
- The trust must ensure that seclusion is recognised and managed within the safeguards set out in the Mental Health Act Code of Practice.
- The trust must ensure all staff receive regular supervision.
- The trust must ensure all patients are involved in care planning and risk assessments and are offered a copy of their care plan.

#### Action the provider **SHOULD** take to improve

- The trust should work with partner agencies to reduce the waiting time for MHA assessments in places of safety.
- The trust should ensure the section 136 protocol is consistent and meets the MHA Code of Practice.

## Avon and Wiltshire Mental Health Partnership NHS Trust

# Psychiatric intensive care units and health-based places of safety

### Detailed findings

#### Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ashdown Psychiatric Intensive Care Unit	Fountain Way Salisbury
Hazel Psychiatric Intensive Care Unit Elizabeth Casson House Psychiatric Intensive Care Unit	Callington Road Hospital
Place of Safety	Fountain Way Salisbury
Mason Place of Safety	Southmead Hospital
Applewood Place of Safety	Sandlewood Court
Place of Safety	Green Lane Hospital

#### Mental Health Act responsibilities

Systems were in place to ensure compliance with the Mental Health Act (MHA). Legal documentation was routinely scrutinised within the trust. We reviewed a

sample of records for patients who were detained under the MHA and found that all paperwork was in place. All treatment appeared to have been given under an appropriate legal authority.

# Detailed findings

We saw that staff had regularly explained their rights to detained patients. People we spoke with were aware of their rights under the MHA.

A standardised system was in place for authorising and recording section 17 leave of absence.

Improvement was needed in the recording of the Approved Mental Health Professional's decision to support the revocation of a Community Treatment Order.

We found incidents of patients being nursed on a one to one or two to one basis in the de-escalation areas in the

PICUs in Bristol and being prevented from leaving that area. These incidents were not recorded as episodes of seclusion. We saw that this had been addressed on our return visit to Elizabeth Casson House.

Mental Health Act assessments following a section 136 were often delayed out of hours, on bank holidays and at weekends. We noted that two different section 136 protocols were being used in the different places of safety one of which contained a set target time for people to be assessed as required by the MHA Code of Practice and one of which did not.

## Mental Capacity Act and Deprivation of Liberty Safeguards

All patients in the units were detained under the Mental Health Act. We looked at paperwork relating to

assessments of patients' capacity and found it to be in order. Capacity was reassessed regularly. Staff were knowledgeable about the Mental Capacity Act and Deprivation of Liberty Safeguards.

# 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

## Summary of findings

We were concerned that staffing levels were not sufficient on Elizabeth Casson House or Ashdown, particularly at night, to provide safe and therapeutic care for patients. We were told that medical staffing for the Bristol PICUs had also been reduced and was having an impact on patient care. Staff had told senior managers their concerns about staffing levels, but they did not feel action had been taken or that they had been listened to.

Overall, arrangements for reporting incidents and allegations of, or actual abuse, were in place, but were not completely effective in all units.

Some learning had taken place from incidents, but they kept happening at Elizabeth Casson House and Ashdown. However, some improvement had been made at Ashdown on our return visit.

We were very concerned to see potential ligature points, including in two of the four places of safety. We raised these potential risks to patients' safety with staff on the day of our visit.

We had concerns about the monitoring of temperatures in rooms where medicines were stored and the medicines refrigerators on Elizabeth Casson House and Ashdown.

Emergency lifesaving equipment was not readily available and fit for purpose and training of staff in the use of medical devices was not up to date at Fountain Way.

Staff we spoke with demonstrated a good understanding of their patients' needs and assessed risks.

## Our findings

### Callington Road Hospital - Elizabeth Casson House and Hazel PICUs

#### Track record on safety

Arrangements for reporting safety incidents and allegations of, or actual abuse, were in place. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an on-line electronic system to report and record incidents and near misses. Where serious incidents had happened we saw that investigations and a root cause analysis were carried out.

#### Learning from incidents and Improving safety standards

Some learning had taken place from a number of incidents of patients going absent without leave across the trust. Operating procedures and staff practices had been reviewed with some changes made to reduce the likelihood of a similar serious incident. The new policy on patients being absent without leave had been shared with staff. We saw that two incidents of patients going absent whilst on escorted leave from Hazel ward had been reported and reviews of the patients' care completed.

Patients and staff told us, and we saw, that incidents of self-harm and violence and aggression kept recurring on Elizabeth Casson House. Staff concerns regarding staff staffing levels had been communicated verbally and in writing to senior managers but action had not been taken.

#### Reliable systems, processes and practices to keep people safe and safeguarded from abuse

Systems were in place for keeping people safe and safeguarded from abuse. We saw that staff had completed training in safeguarding vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and knew how to raise any safeguarding concerns. We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely. We saw that safeguarding alerts had been made where appropriate.

# Are services safe?

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

People told us they generally felt safe on the PICUs but that there were not enough staff at times to keep them feeling safe. One person told us they felt scared by the alarms going off frequently and that at those times it would be easy to harm themselves.

We were very concerned to observe potential ligature points. Examples include bathroom fittings and, door and window handles on Hazel ward. We raised these potential risks to patient safety with staff on the day of our visit.

We saw that medicines were stored securely on Elizabeth Casson House. A clinical pharmacy service was provided daily. Checks on controlled drugs were in place and staff were aware of when and how to report medicine errors and the action required. Prescription charts were audited monthly by staff and there no gaps on prescription charts. High dose anti-psychotic medication was being prescribed and we saw that this was for individual patients with complex needs

We found that the temperature of the room where medicines were stored on Elizabeth Casson House was not recorded. The temperatures of the medicines refrigerators were being recorded daily but had been over the required temperature every day since early May 2014 with no report or action taken.

## Assessing and monitoring safety and risk

We observed a nursing handover. We saw that this was well planned and organised with all staff used effectively to share relevant information about the patients to ensure continuity and safety of care. Staff spoke about patients with respect and demonstrated a good understanding of their needs and assessed risks. All staff were clearly allocated tasks for the shift ahead in order to use their time effectively and ensure key tasks were completed. However on our return visit we saw that the nursing handover had not been completed due to the acute nature and risks on the ward and lack of staff.

Staffing levels and skill mix had been set for the ward as part of the trust's safer staffing initiative. However we were concerned at Elizabeth Casson House that these levels were not sufficient, particularly at night, to provide safe and therapeutic care for patients when there were high acuity levels on the ward. We observed on two separate shifts that staff were not able to take a break and that staff were staying longer than their designated shift in order to maintain safety on the ward. We observed several incidents

of attempted self-harm and verbal and physical aggression that were handled well by staff but required additional staff to those allocated to the shift. Staff told us that they regularly pulled their alarm to summon support from other wards in the hospital in order to maintain safe observation of the other patients whilst an incident was taking place. We noted that advocates expressed concern at the amount of time patients had to wait to be attended by staff at times.

Staffing records showed that staff were regularly working beyond their contracted hours on shift. Approximately 20 per cent of shifts were regularly covered by bank or agency staff. However there were no clearly identified triggers for requesting additional staff on a shift and staff told us they felt in any case that such requests would not be granted.

Staff concerns regarding staffing levels had been communicated verbally and in writing to senior managers but action had not been taken. We raised our concerns about lack of staffing at times of high levels of acuity with senior managers on both occasions we inspected Elizabeth Casson House and additional staff were brought in from bank/agency on these occasions. Following our return visit to the ward the trust increased staffing levels at the unit.

Consultant psychiatrist input to the PICUs had been reduced from 18 sessions to 10 sessions shared across both wards. There were no junior doctors attached to the PICUs and the staff grade doctor worked part time. This meant the consultant psychiatrist was only able to devote two days per week to each ward and that a patient admitted on Hazel ward for example on a Friday would have to wait to see a consultant psychiatrist until the next Tuesday. We heard that the work load on the wards along with the numbers of tribunals meant that the consultant psychiatrist was not always able to review the prescription charts. Medical staff had raised concerns about the level of medical staffing to senior managers of the trust but did not feel action had been taken or that they had been listened to.

We found that on two occasions nursing staff had not recorded physical observations of a patient in seclusion, simply recording 'appears asleep'. As both patients had high levels of medication the patient could in fact have been physically unwell and there was no evidence checks were made of their physical health.

# Are services safe?

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

## **Understanding and management of foreseeable risks**

Risk assessments were carried out and management plans developed for patients. Identified risks were displayed for each patient on the ward board in the office. Staff demonstrated a good understanding of patients' needs and assessed risks.

Staff shortages meant that staff were on occasion reporting incidents several hours or even days late and were amalgamating a number of incidents during a day into one. This meant that the trust could not be confident there was an accurate and up to date picture of incidents on the ward.

## **Fountain Way - Ashdown PICU Track record on safety**

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an on-line electronic system to report and record incidents and near misses.

## **Learning from incidents and Improving safety standards**

Patients and staff told us incidents kept recurring. Staff expressed concerns about security stating that contraband items such as lighters and CDs were consistently found on the wards. This presented increased risks to both staff and patients. This practice meant that patients were not consistently safeguarded from potential harm caused by risks not being addressed. Security measures had been tightened and systems put in place on our return visit.

## **Reliable systems, processes and practices to keep people safe and safeguarded from abuse.**

Systems were in place for keeping people safe and safeguarded from abuse. We saw that staff had completed training in safeguarding vulnerable adults and children. Staff we spoke with were able to describe different types of abuse and knew how to raise any safeguarding concerns. We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

Patients told us that they felt safe on the ward most of the time. The occasions when they did not feel safe on the ward were due to the lack of visible staffing and staff being overloaded with paperwork. They did however praise the staff for managing some very difficult situations.

We observed staff managing some very complex situations whilst remaining calm and positive. The staff told us they were proud of how they manage complex conditions and how interesting but challenging that made their work. They spoke with pride about their skills in de-escalation of incidents and the very limited use of seclusion. All staff had been trained in the management of violence and aggression. Staff told us this training was really good and useful.

We were concerned about the very high ambient temperatures of the room where the medicines were stored and in the seclusion room. We found that the temperatures of the medicine room, medicines refrigerators and the seclusion room were not being monitored. On our return visit, this had been addressed.

Staff told us a common reason for people coming to the ward was their risk of suicide. Whilst in the medicine room, we noted some of the lifesaving equipment was missing or out of date. On our return, this had been addressed.

## **Assessing and monitoring safety and risk**

Lack of staffing was identified as a concern both by patients, staff and the manager. Some staff felt the ward was not safe at times when very busy, at night or when staff were off sick with no replacements. There were no staff toilet facilities on the ward meaning that staff had to leave the ward to use the facilities. At night, this left the ward understaffed. Staff told us they did not have enough time to complete paperwork, engage effectively with patients on a one to one basis or take detained patients on escorted leave. They also told us it was a regular occurrence that they did not get any breaks during the day. They said staff sickness was not always covered, leaving the ward unsafe and increasing the pressure on the remaining staff. Some staff told us they had reported these concerns to senior managers but did not feel they were listened to or their opinions valued. Senior managers were aware of these concerns and had begun addressing the issue when we returned.

There were comprehensive handover sessions between shifts where every person was discussed briefly and current risks were identified. Communication was good, the language respectful and the level of detail was sufficient to provide a basis for providing care.

# Are services safe?

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

## **Understanding and management of foreseeable risks**

We found that risk assessments were being reviewed after incidents. However, in some cases, changes were not in practice reducing the risks, for example, contraband items. Information was sometimes not recorded fully on the computerised record system leaving a potential for miscommunication and misunderstanding. This meant that staff were potentially not fully informed of the changes to care plans and risk assessments or recent events, leaving both patients and staff at increased risk of harm.

We witnessed staff completing incident forms and submitting them online for investigation by the unit manager. This information then went verbally into handover to be shared with the staff team. There was a backlog of reports waiting to be reviewed by management. On our return visit, a system was in place to ensure reports were reviewed in a timelier manner.

## **Southmead Hospital - Mason place of safety**

### **Track record on safety**

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an on-line electronic system to report and record incidents and near misses.

### **Learning from incidents and Improving safety standards**

Learning had taken place following an incident with a person under the age of 18 years. Operating procedures and staff practices had been reviewed with some changes made to reduce the likelihood of a similar incident. The trust had plans to change the environment of the unit to better protect the safety and privacy of any person under the age of 18 years held there.

### **Reliable systems, processes and practices to keep people safe and safeguarded from abuse.**

Systems were in place for keeping people safe and safeguarded from abuse. We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

We were able to speak with one person in the place of safety. They told us they felt safe in the unit.

We were concerned that the environment was not conducive to keeping people safe. The unit became

operational in February 2014 and there was some redesign and alteration from its previous use as a high dependency unit. There were four bedrooms. The bedroom window handles and ensuite door handles were not ligature safe and was load bearing. Radiators and bedrooms were cold. The seclusion room's electric blind which was used to manage natural light did not work. The ceiling in this room was stained with some substance. We raised these potential risks to patient safety with staff on the day of our visit.

### **Assessing and monitoring safety and risk**

Risk assessments were carried out. Staff worked with the police, approved mental health professionals (AMHP) and medical staff to ensure people were safeguarded from harm.

Staffing levels and skill mix had been set. There were four members of staff on the unit. There were always qualified nurses available to ensure that when people came into the place of safety, staff had the skills and knowledge to ensure that people were safeguarded from harm. Child and Adolescent Mental Health services undertook assessments for young people attending within the target of two hours after their detention in the day or out of hours. Staff told us the set staffing levels were adequate and were reviewed daily to take into account levels of acuity, and increased if needed.

We found that there had been no formal seclusion recording for two episodes of seclusion as set out in the trust's policy and procedure on seclusion.

## **Fountain Way - Place of safety**

### **Track record on safety**

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. Staff we spoke with were able to describe their role in the reporting process. We saw that staff had access to an on-line electronic system to report and record incidents and near misses.

### **Reliable systems, processes and practices to keep people safe and safeguarded from abuse.**

Systems were in place for keeping people safe and safeguarded from abuse. We noted that staff were able to access all policies and procedures on the trust's intranet system to ensure they had the appropriate guidance to care for people safely.

We were concerned that the environment was not conducive to keeping people safe. There was a potential

# Are services safe?

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

ligature point in the bathroom. A patient could also potentially barricade themselves into the “sitting room”. Neither the observation window nor the viewing mirror gave staff a full view of the whole room. This meant that the patient could isolate themselves and be out of sight of the staff leaving them at risk of harm to themselves. On our return visit, these concerns had been escalated to be discussed at the health and safety meeting.

## **Assessing and monitoring safety and risk**

When in use, the suite is staffed by the acute ward. There is an allocated member of staff 24 hours a day. We saw policies and procedures to guide staff in managing the suite effectively. From the paperwork we looked at, these policies appeared to have been followed correctly.

Staff worked with the police, approved mental health professional and medical staff to ensure the person was safeguarded from harm.

There were always qualified nurses available to ensure that when people came into the place of safety staff had the skills and knowledge to ensure that people were safeguarded from harm.

The place of safety had a designated member of staff based on the acute admissions ward on site. Staff on the acute ward told us that they were proud of the care they provided but that it did on occasion increase the risk to patients on the acute ward when someone was in the place of safety and the staff member had to leave. The modern matron told us that they have not yet recruited the additional staff for the place of safety despite the funding being available.

In the event of a physical health emergency, the lifesaving equipment would be used from the intensive care unit. We noted the emergency equipment on that ward was incomplete and training of staff in the use of medical devices was not completely up to date. This meant that a patient may be at risk of not being cared for effectively in the event of a physical health emergency. On our return visit, this had been resolved.

## **Sandalwood - Place of Safety**

### **Track record on safety**

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. We saw that staff had access to an on-line electronic system to report and record incidents and near misses.

### **Reliable systems, processes and practices to keep people safe and safeguarded from abuse.**

Systems were in place for keeping people safe and safeguarded from abuse. We noted that staff were able to access all policies and procedures on the trust’s intranet system to ensure they had the appropriate guidance to care for people safely.

Staff at Applewood said they always felt safe. They carried personal alarms and had good access to back up help if required from the nearby ward. There was a good outside space where patients could go to de-escalate and stay calm. There was no CCTV in the place of safety maintaining patients’ dignity at all times.

## **Green Lane - Place of safety**

### **Track record on safety**

Arrangements for reporting safety incidents and allegations of or actual abuse were in place. We saw that staff had access to an on-line electronic system to report and record incidents and near misses.

### **Reliable systems, processes and practices to keep people safe and safeguarded from abuse.**

Systems were in place for keeping people safe and safeguarded from abuse. We noted that staff were able to access all policies and procedures on the trust’s intranet system to ensure they had the appropriate guidance to care for people safely.

Green lane had integrated electronic notes which were easy to manoeuvre and covered safety and child protection issues.

Outside space was available for people detained in the unit but this was not contained therefore people could only stand by an open door and were not able to walk around.

# Are services effective?

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.

## Summary of findings

People's needs, including their physical health needs, were assessed and care and treatment was planned to meet them. Overall, we saw good multi-disciplinary working. People's knowledge and involvement in their care plans varied across the sites and some care plans were not completed at Ashdown. Patients and staff told us that there was a lack of appropriate activities on Elizabeth Casson House and Ashdown but there was a good range of activities on Hazel.

Some performance information, such as patient readmissions, was used to help improve the quality of the service.

Most staff had received their mandatory training but had been unable to access more specialist training. Overall, most staff had received regular supervision but there were some gaps.

Systems were in place to ensure compliance with the Mental Health Act (MHA). However Mental Health Act assessments following a section 136 were often delayed out of hours and we noted that two different section 136 protocols were being used in the different places of safety. We also found occasions where seclusion was not recognised and managed within the safeguards set out in the Mental Health Act Code of Practice.

patients weekly. Any abnormal readings were reported to medical staff for further investigation. Staff told us, and we saw from records, that specialist healthcare was being accessed for patients when needed.

We noted that admission paperwork was fully completed in care records we looked at. We saw that close observation records were being kept for some patients and the ones we sampled were completed fully.

### Outcomes for people using services

Some performance information, such as patient readmissions, was used to help improve the quality of the service. Staff had access to the trust's electronic IQ system that allowed them to look at their performance as a ward and compare that to other areas of the trust's facilities.

All staff received an induction programme when beginning employment with the trust. We saw that all staff had received their mandatory training. However some staff told us that they found this difficult due to the demands on wards and so completed some online courses in their own time. Staff had been unable to access more specialist training.

We saw that most staff had received regular supervision but there were some gaps. For example 13 out of 29 members of staff had not received supervision within one month before our visit. Staff told us that it was difficult to make times for supervision due to the demands on staff time from the PICUs. Staff told us they found the supervision sessions helpful when available.

Reflective practice sessions were offered to staff by the clinical psychologist but we heard that these were often cancelled on Elizabeth Casson House due to staff shortages on the ward. Staff told us they highly valued these sessions feeling they improved their practice and care of patients and also reduced their own stress.

The trust had recognised that the ward environment on Elizabeth Casson House lacked sufficient space for the women, particularly now that their number of beds has increased from eight to ten with all beds ordinarily full. Plans were in place to increase the amount of space for the women. The plans had included input from the women themselves. Both PICUs were clean when we visited.

Patients and staff told us about the lack of appropriate activities on the Elizabeth Casson House. Staff said they often didn't have time to engage as much as they wanted

## Our findings

### Callington Road Hospital - Elizabeth Casson House and Hazel PICUs

#### Assessment and delivery of care and treatment

People's needs were assessed and care and treatment was planned to meet identified needs. People we spoke with were aware of their care plans and some said they had contributed to them. Care plans considered all aspects of the person's circumstances and were centred on them as an individual. They were regularly reviewed and updated to reflect changing needs.

We saw that people's physical health needs were assessed regularly. Physical health examinations and assessments were documented by medical staff following the patient's admission to the ward. Nurses and health care assistants were completing baseline physical health checks on

# Are services effective?

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with patients. Patients told us there was not much to do. Plans were in place to increase the amount and range of activities for patients. We found a good range of activities with positive patient feedback on these on Hazel ward.

## **Multi-disciplinary working**

We saw good multi-disciplinary working on the wards, including weekly multi-disciplinary meetings to discuss patient care and treatment. This was limited by the reduced medical cover. We noted that social workers were now working within the local authority and not based in the trust. We saw staff from the trust were covering traditional social work tasks in order to provide personalised comprehensive care for their patients.

There was proactive engagement with other health bodies to co-ordinate care and meet people's needs. Examples include close work with oncology and the local acute healthcare provider.

## **Mental Health Act (MHA)**

Systems were in place to ensure compliance with the Mental Health Act (MHA). Legal documentation was routinely scrutinised within the trust. We reviewed a sample of records for patients who were detained under the MHA. All documents were in place. All treatment appeared to have been given under an appropriate legal authority.

We saw that staff had regularly explained their rights to detained patients. People we spoke with were aware of their rights under the MHA. A standardised system was in place for authorising and recording section 17 leave of absence.

We found incidents of patients being nursed on a one to one or two to one basis in the de-escalation areas in the PICUs and being prevented from leaving that area. These incidents were not recorded as episodes of seclusion and as a result the legal safeguards in place for seclusion were not met. We saw that this had been addressed on our return visit to Elizabeth Casson House.

## **Fountain Way - Ashdown PICU**

### **Assessment and delivery of care and treatment**

The manager told us patients were not involved in the initial care planning but were aware of the care plans and reviews once completed. They told us this was due to the increased volatility of the patients on admission and they felt it wasn't appropriate to include them. This appeared to

be a "blanket policy" applied to all patients. This was being addressed on our return visit. An assessment was in place to evidence whether the patient was able to be involved at that stage.

Patients told us staff listened to them and had one to one time often on a daily basis. The care records we looked at showed that some care plans had not been completed and a patient told us that they had not been asked to contribute to or sign a care plan. Action had been taken on our return visit.

We noted that admission paperwork was fully completed in care records we looked at. Staff expressed frustration about how long paperwork took to complete saying they should spend that time with the patients.

Patients were reviewed regularly by the consultant psychiatrist and we saw documentation of this. We saw that close observation records were being kept for some patients and the ones we sampled were completed fully.

## **Outcomes for people using services**

Some performance information, such as patient readmissions, was used to help improve the quality of the service. Staff had access to the trust's electronic IQ system that allowed them to look at their performance as a ward and compare that to other areas of the trust.

## **Staff, equipment and facilities**

Every staff member we spoke with on the ward said they really enjoyed their work. Staff told us about the pressure they were under due to poor staffing and how this impacted on receiving supervision. They told us they felt overwhelmed at times and the current managerial supervision arrangements were poor and ineffective as meetings were reliant on being able to "leave the floor". Some staff expressed they felt that this was the cause of sickness levels continuing to rise.

Staff told us that supervision was provided in two forms, individual and group. However they described the group supervision as not being about individual supervision support. It took the form of a team meeting where specific topics were discussed. There was no opportunity for staff to discuss personal issues in this format, in accordance with their understanding of supervision. They pointed out that this was recorded in the same way as individual

# Are services effective?

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supervision. This meant that staff could have a complete supervision record and have only attended these meetings, and not received individual support to manage personal stress levels.

The staff described a weekly meeting with the psychologist during which they felt was very supportive and valuable to them in managing the stress levels.

Patients told us that staff were well trained and knowledgeable. Staff told us they wanted to access more training in addition to their mandatory training. Issues of travel and time were cited as barriers to accessing some training as face to face training occurred on other sites in the trust which were difficult to access. We were informed by one member of staff that they had to get training done before January each year as after that courses would get cancelled due to lack of trust funds.

Both patients and staff told us of the lack of appropriate activities on the ward. Staff said they often didn't have time to engage as much as they wanted with patients. A patient told us "it's boring. There's nothing to talk about except meals and medication". Staff told us they believed that the activities offered were not of interest to the demographic of the patients. As a result, they felt patients got bored and irritable.

We did not see a timetable of activities on the ward and during the inspection we saw limited activities happening. Patients told us that lack of staff prevented them from accessing activities off the ward such as the gym as they required escorting. On our return visit, we saw a timetable of activities had been put in place and activities were happening during the day with the occupational therapist.

## **Multi-disciplinary working**

The consultant and medical staff were a regular presence on the ward and patients told us they were excellent. We observed good interaction between the ward staff and staff on the acute ward where most patients were transferred on discharge.

There were regular team meetings on the ward to discuss issues arising and monitor care provision. Ward rounds happened weekly and involved all relevant professionals.

Staff told us the 24hour crisis team were very supportive and would come to the ward if they needed extra assistance out of hours.

We noted the mental health advocacy service visited the ward regularly and information about the service was available in the reception area. We noted in addition a concern of the advocacy service around the alleged potential obstruction of their role by medical staff.

## **Mental Health Act (MHA)**

Systems were in place to ensure compliance with the Mental Health Act (MHA). Legal documentation was routinely scrutinised within the trust. We reviewed a sample of records for patients who were detained under the MHA and all required documentation was in place. All treatment appeared to have been given under an appropriate legal authority.

We saw that staff had regularly explained their rights to detained patients. People we spoke with were aware of their rights under the MHA.

A standardised system was in place for authorising and recording section 17 leave of absence. Patients and staff told us that on occasion detained patients were unable to take their escorted leave or had to wait a long time. Staff said this was because on occasion they did not have enough staff to escort the person.

The mental health advocate we spoke with expressed concern and felt that some medical staff had been obstructive to them in their role. Meeting times had been changed and ward reviews cancelled at the last minute without informing them despite the patient specifically requesting their attendance. This was raised with staff during our visit.

## **Southmead Hospital - Mason Place of Safety Assessment and delivery of care and treatment**

Staff told us that a person's physical state was assessed in the community and paramedic assistance sought by the police before coming to the place of safety.

## **Staff, equipment and facilities**

The environment was clean and well maintained. Staff told us that building work would soon start to redesign the unit to reduce the number of bedrooms from four to three for patients over the age of 18 years old and to provide a dedicated bedroom and separate lounge for patients under 16 years old.

# Are services effective?

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.

## **Multi-disciplinary working**

We saw that staff worked together with social workers, the emergency duty team, medical staff and the police to ensure that patients had the assessment they needed and could be referred onto appropriate services.

## **Mental Health Act (MHA)**

Good systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. Legal documentation was routinely scrutinised within the trust. Staff demonstrated a good understanding of the Mental Health Act and Code of Practice and were aware of the rights of people to refuse medication where applicable. We saw there had been one episode of rapid tranquilisation administered under the Mental Capacity Act in the four weeks before our visit. Case records clearly confirmed all appropriate capacity assessments had taken place prior to administration. We also saw staff had carried out medication reconciliation with, for example, the person's general practitioner.

The policy on the use of section 136 used in this location did contain a set target time for people to be assessed as required by the Code of Practice.

## **Fountain Way - Place of Safety**

### **Assessment and delivery of care and treatment**

Staff told us that a person's physical state was assessed in the community and paramedic assistance sought by the police before coming to the place of safety.

We looked at records relating to care given in the place of safety which detailed personal information and events leading to the admission. This included times of arrival and the professionals involved. We noted lengthy delays in patients being assessed by the emergency duty team. The main reason cited in the records was the lack of staff on the duty team or their reluctance to assess if there was a shortage of available beds.

### **Staff, equipment and facilities**

Staff had identified that the environment was not conducive for someone in great distress. The unit was very dark, hot and with no access to fresh air. Staff had escalated concerns to the trust board but no action had yet been taken. On our return visit, we saw evidence that the concerns had again been escalated with more urgency and were due to be discussed at a forthcoming meeting.

There were always qualified nurses available to ensure that when people came into the place of safety staff had the skills and knowledge to ensure that people were safeguarded from harm.

The place of safety had a designated member of staff based on the acute admissions ward on site. Staff on the acute ward told us that they were proud of the care they provided but that it did on occasion increase the risk to patients on the acute ward when someone was in the place of safety and the staff member had to leave. The modern matron told us that despite attempts to recruit they have not yet recruited the additional staff for the place of safety despite the funding being available.

## **Multi-disciplinary working**

We saw that staff worked together with social workers, the emergency duty team, medical staff and the police to ensure that patients had the assessment they needed and could be referred onto appropriate services.

Patients were often subject to lengthy delays before assessment. We noted from the records that there were significant issues accessing out of hours assessments by the emergency duty team. Staff had identified this as a concern and documented the reasons each time this happened. The main reasons cited were the lack of staff in the emergency team, records stated "unable to attend due to lack of staffing" or their reluctance to attend if a bed was not available. Once the assessment had begun, the process appeared to progress without delay.

## **Mental Health Act (MHA)**

Systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. The paperwork we looked at appeared to be completed accurately and fully.

The policy on the use of section 136 used in this location did not contain a set target time for people to be assessed as required by the MHA Code of Practice.

## **Applewood - Place of Safety**

### **Assessment and delivery of care and treatment**

Staff told us that a person's physical state was assessed on arrival at the place of safety.

Staff told us that they had difficulties getting police personnel to stay to help manage aggressive or intoxicated patients. As a result a joint protocol had been devised

# Are services effective?

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.

between the trust and police which provided clear guidelines and was now operating. We noted that time scales differed on obtaining a Mental Health Act assessment.

## **Mental Health Act (MHA)**

Systems were in place to ensure compliance with the Mental Health Act (MHA). The paperwork we looked at appeared to be completed accurately and fully.

## **Green Lane - Place of safety**

### **Assessment and delivery of care and treatment**

A clear protocol and contract with multidisciplinary agencies and disciplines was in place for the care of people under the age of 18 in the place of safety.

We noted that there were some long waits between detention and the Mental Health Act assessment being performed, the longest being 31 hours. Reasons given were that the Approved Mental Health Professional refused to attend if no onward bed could be identified.

## **Staff, equipment and facilities**

Staff told us that staffing for the place of safety was covered by the ward at night and weekends and daytime by the intensive team. This could lead to staff shortages on the ward when cover was required which they felt was unacceptable.

The environment was well maintained and clean.

## **Mental Health Act (MHA)**

Systems were in place to ensure compliance with the Mental Health Act (MHA) and adherence to the guiding principles of the MHA Code of Practice. The paperwork we looked at appeared to be completed accurately and fully. Information about patients' rights under Section 136 were given and explained to them.

# Are services caring?

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

## Summary of findings

Staff appeared kind and compassionate. We observed staff treating patients with respect and communicating effectively with them. They showed their desire to provide high quality care despite the challenges of staffing levels and the needs of the patients on the ward, which was associated with volatility of behaviour.

People we spoke with were positive about the staff and felt they made a positive impact on their experience on the ward. However, some people were concerned at the lack of time staff had to spend with them.

Patients' cultural needs were being met in the PICUs in Bristol but we found some concerns about patients' religious needs being met and incidents where their privacy had not been respected in Ashdown. The environment at Green Lane did not promote people's treatment or dignity.

We saw that patients' families were able to visit and that, where necessary, visiting times were arranged at a time to suit them.

## Our findings

### Callington Road Hospital - Elizabeth Casson House and Hazel PICUs

#### Kindness, dignity and respect

Staff appeared kind with a caring compassionate attitude. We observed staff treating patients with respect and communicating effectively with them. They showed the desire to provide high quality care despite the challenges of staffing levels and acuity of the ward with associated volatility of behaviour.

People we spoke with were positive about the staff. One person said, "They are really good here and have helped me". However some people were concerned at the lack of time staff had to spend with them. One person said "They are so busy and have to respond to alarms all the time and don't have time to sit down with me."

#### People using services involvement

People we spoke with told us they were involved in their care and treatment. Most were aware of their care plans and those that were not were still acutely unwell and unable to comprehend this.

People we spoke with were able to discuss their medication and its use. Patient information leaflets about the range of medications were available.

All patients had a comprehensive personal file containing information such as their most recent care plan, information on their rights under the Mental Health Act and contact details for specialist solicitors. These files were kept in the office due to risks associated with their unsupervised use but patients could access this when they wanted. They were also used in one to one sessions with key workers.

Patients had access to advocacy including an independent mental health advocate (IMHA) and there was information on the notice boards on how to access this service.

#### Emotional support for care and treatment

Visitors to the ward were encouraged and information on visiting times was displayed. Where necessary visiting times were arranged at a time to suit them. There was a private space for visits outside the main ward area. Some toys were available for children who visited as were changing facilities for babies.

### Fountain Way - Ashdown PICU

#### Kindness, dignity and respect

Staff we spoke with showed they were genuinely caring towards patients and demonstrated their knowledge that decisions made during admission could have a significant impact on the patient's experience of the ward. They showed the desire to provide high quality care despite the challenges of staffing levels and acuity of the ward with associated volatility of behaviour.

Patients told us the staff always tried to be helpful. We observed staff behaving in a supportive manner towards patients during our inspection.

An area of concern was raised about staff not respecting the privacy of people's rooms. The patient acknowledged that on occasion when they were not well, it was necessary for staff to enter their bedroom and have the door open. The patient told us that staff routinely entered bedrooms

# Are services caring?

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

without knocking and left doors open even when there was no clinical need. We raised this with staff on the day of our visit. On our return visit, we noted staff knocking on bedroom doors.

There is a chaplain who visits the ward regularly however a patient told us they had requested an imam to come to the ward. This had been some time previous to our inspection and staff had not acted on the request. The patient asked to use the multi-faith room on site and was told by members of staff that the room did not exist. The patient was not on the ward when we returned and the manager told us they were addressing this with all staff in supervision.

## **People using services involvement**

Patients told us staff listened to them and had one to one time often on a daily basis. The care records we looked at showed that some care plans had not been completed and a patient told us that they had not been asked to contribute to or sign a care plan. Patients told us they were not always involved in the initial care planning but were involved in care plans reviews. We raised this with staff and action was being taken to address this on our return visit. An assessment was in place to evidence whether the patient was able to be involved at that stage.

## **Emotional support for care and treatment**

We saw that patients' families were able to visit. We noted a comment that it often took a long time to gain access to the ward. We experienced this during our inspections.

Patients told us that staff do listen to them in one to one sessions and generally around the ward. The patients we spoke with felt supported by their named nurse and the carers. They did say that they felt that the staff appeared stressed and needed to be supported more by the senior management.

## **Southmead Hospital - Mason Place of Safety**

### **Kindness, dignity and respect**

Two people were detained under section 135 and section 136 respectively on the day of our inspection. One person told us this was their first experience of the service and arrest and described both police and ward staff as friendly and sensitive. They were offered access to communication with family and treated with dignity and respect.

Staff appeared kind with a caring compassionate attitude. They put a significant effort into treating patients with dignity. We observed staff treating patients with respect

and communicating effectively with them. Staff told us they believed that effective de-escalation techniques were minimising potential outbreaks of verbal and physical violence and aggression.

## **People using services involvement**

Records we looked at showed that people were involved wherever possible in their care and treatment.

## **Fountain Way - Place of Safety**

### **Kindness, dignity and respect**

There was no person in the place of safety during our inspection. We spoke with staff on the acute wards that cover the place of safety when it is in use. They showed they were genuinely caring towards patients and demonstrated their knowledge that decisions made during admission could have a significant impact on the patient's experience.

Staff on the acute ward that has responsibility for the place of safety appeared kind with a caring compassionate attitude. They put a significant effort into treating patients with dignity. We observed staff treating patients with respect and communicating effectively with them. Staff were using the environment to try and afford the patients some privacy, using the extra room as a "lounge" area for them to have some space with a little privacy. Due to the safety concerns about the environment detailed earlier in this report, the door to the sitting room and bathroom had to remain open.

## **People using services involvement**

There was no one in the place of safety during our inspection. Records we looked at showed us that people were involved wherever possible in their care and treatment.

## **Applewood - Place of Safety**

### **Kindness, dignity and respect**

Applewood ward staff who are responsible for the place of safety appeared knowledgeable, compassionate and caring. They were also aware and responsive to gender and cultural needs.

The place of safety was a therapeutic environment with outside space that was enclosed with planting and a bench. Smoking was permitted.

# Are services caring?

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

## **People using services involvement**

There was no one in the place of safety during our inspection. Records we looked at showed us that people were involved wherever possible in their care and treatment.

## **Green Lane - Place of safety**

### **Kindness, dignity and respect**

The environment was not therapeutic or respecting of dignity. There was no bed or curtains at the window. There was a sofa in one room that patients could lay on. One

room was completely bare. Staff told us that they strive to make patients experience in the unit as pleasant as possible. They keep patients up to date and give reassurance where required.

## **People using services involvement**

There was no one in the place of safety during our inspection. Records we looked at showed us that people were involved wherever possible in their care and treatment.

# Are services responsive to people's needs?

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

## Summary of findings

Bed availability appeared to be a trust-wide issue with intensive care beds always in demand. The lack of available beds meant that there were delays in transferring a patient who was ready to move from a PICU to an acute psychiatric bed. Staff also reported that patients were transferred from PICUs to acute beds too early due to the pressure on beds.

Mental Health Act assessments following a section 136 were often delayed out of hours, on bank holidays and at weekends. We also saw some significant delays in people moving on to the appropriate service once their assessment had been completed.

Both staff and patients knew how to make a complaint. Some patients and staff felt managers did not always take their concerns seriously and actions were not always taken or seen to be taken as a result.

## Our findings

### Callington Road Hospital - Elizabeth Casson House and Hazel PICUs

#### Planning and delivering services

As the only female PICU at the trust, Elizabeth Casson House took admissions from all geographical areas of the trust. Two of its beds were commissioned for patients from other areas of the South West.

Hazel ward was commissioned to take admissions from Bristol, South Gloucester, North Somerset and B&NES. The ward also took patients from other geographical areas covered by the trust when a bed was not available in the trust's other PICU in Salisbury. This meant that some patients were a long distance from their home area and not all patients on the ward were as close to home as possible.

#### Right care at the right time

Bed availability appeared to be a trust-wide issue with intensive care beds always in demand. We observed during our visits several urgent requests for a PICU bed. As the wards were full this meant that patients were either transferred to an acute psychiatric bed, sometimes as a

'swap' for a patient needing a PICU, admitted to the other PICU in Salisbury, or admitted to a private provider PICU bed. One such patient was admitted to a PICU in Bradford during our visit.

#### Care Pathway

Staff worked with other services in the trust to make arrangements to transfer or discharge patients. However staff told us that bed availability meant that there had been delays on occasion in transferring a patient who was ready to move to an acute psychiatric bed and no longer needed the security and intensive nursing from a PICU. We observed that one patient was transferred from Elizabeth Casson House to an acute psychiatric bed following recommendation from the First Tier Tribunal. Another patient was discharged from section by the Tribunal who commented that they had heard in evidence that there were huge pressures on beds in the acute wards and it might be weeks until the patient could be transferred. Staff also reported that patients were transferred too early in their care pathway to acute beds due to the pressure on PICU beds and the need to make room for a new admission.

#### Learning from concerns and complaints

Information about the complaints process was clearly displayed with leaflets available for patients or visitors to take away and read privately. People we spoke with knew how to make a complaint and said that they felt able to talk to staff if they had a concern. Staff we spoke with were aware of the trust's complaint policy.

### Fountain Way - Ashdown PICU

#### Planning and delivering services

Staff told us the average length of stay on the ward was four to six weeks. Staff and patients told us the ward was always busy. Patients did not express any concerns about this affecting the quality of their care but did express concern for the staff with such high stress levels.

The ward had a very positive working relationship with the other wards onsite and the crisis team. Patients told us they felt the ward worked well with the acute ward to help during the transfer process.

#### Right care at the right time

Bed availability appears to be a trust-wide issue with intensive care beds always in demand.

During our inspection, several senior staff spoke about the challenges posed by the geographical area of the trust.

# Are services responsive to people's needs?

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

They told us that patients are often long distances away from their home area due to bed availability and this impacted on the care provided and the potential for families to visit. It is worth noting that repatriating people to the home area was stressed as a high priority.

## Care Pathway

The ward worked with other services to provide all aspects of care. These included social services, psychological therapies, physiotherapy and occupational therapy and the crisis team. Together they worked with the patient towards stabilising their mental health and looking to move them into acute services as soon as possible and safe. Patients told us it was good they only stayed there as long as necessary.

Ward rounds happened regularly to review care and medical staff were available daily to assist staff to overcome any challenges that arose.

## Learning from concerns and complaints

Patients told us they knew to speak to the staff if they were not happy with anything. The morning meeting was a means of expressing their views, although some patients did not feel comfortable speaking out. Staff told us they know how to support patients and their relatives to make complaints. We found staff and patients to be very open with their views throughout the inspection.

Some patients and staff voiced their concern that the managers did not always take their concerns seriously and actions were not always taken or seen to be taken as a result. We raised these issues with senior managers. They were aware of this and recognised that communication of feedback was important to ensure staff and patients felt involved and listened to.

## Mason – Place of Safety

### Planning and delivering services

We saw comprehensive policies and procedures relating to the care of people in the place of safety.

### Right care at the right time

Access to the service appeared to be effective. Medical and approved mental health professional cover was provided through a rota and on call system. We saw that 30 out of the 77 people detained at the place of safety in April 2014 were admitted to a psychiatric bed following assessment. Staff told us police had improved their assessment and

decision making process when considering to detain under section 135 or 136. They reported that the monthly liaison meetings held between the trust and police on the use of sections 135 or 136 were positive.

Bed availability appeared to be a trust-wide issue with acute psychiatric beds always in demand. Staff reported delays in people moving on the appropriate service once their assessment had been completed. This meant people were at risk of not receiving the right care at the right time.

There was a two hour target to complete assessments of children and adolescents which were being met both in the day and out of hours. Young people under the age of 18 years old were nursed automatically on 1:1 observations and had a separate part of the unit to access if required. Delays in arranging follow up care or sourcing appropriate placements meant that young people could remain on the unit for up to 48 hours following assessment. Plans to address this were being made by the trust at the time of the inspection. A national children's charity and a service user's experience had been sought to contribute to this service review.

## Fountain Way - Place of Safety

### Planning and delivering services

We saw comprehensive policies and procedures relating to the care of people in the place of safety.

### Right care at the right time

Access to the service appeared to be effective. However we found there had been significant delays in people moving on to the appropriate service once their assessment had been completed. This meant people were at risk of not receiving the right care at the right time. Causes of delays in transfer to other services were recorded as lack of bed availability, particularly in children's services, and the reluctance of children's services to become involved. Psychiatric beds for young people were provided by a different organisation and were located in Oxford. Staff told us a young person who had come into the place of safety over a bank holiday spent four days on the adult's acute psychiatric ward before being transferred to more appropriate services.

We saw minutes of trust-wide meetings which showed that such delays were discussed regularly. However action had not yet been taken to address this issue. Staff had followed this up again on our return inspection.

# Are services responsive to people's needs?

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

## **Applewood - Place of Safety**

### **Planning and delivering services**

We saw comprehensive policies and procedures relating to the care of people in the place of safety.

### **Right care at the right time**

We found that Mental Health Act assessments were often delayed out of hours, bank holidays and weekends due to lack of approved mental health professionals. For example, one patient had to wait until 12 pm the following day to have a Mental Health Act assessment.

## **Green Lane - Place of safety**

### **Planning and delivering services**

We saw comprehensive policies and procedures relating to the care of people in the place of safety.

### **Right care at the right time**

We found that there were some delays in Approved Mental Health Professionals (AMHPs) completing Mental Health Act assessments out of hours but good liaison during the day. The intensive team supervises bed management but again they indicated that some AMHPs would not attend for a Mental Health Act assessment if no bed had been identified. Staff told us this led to patient anxiety and frustration.

# Are services well-led?

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.

## Summary of findings

Staff members' knowledge of the vision and values of the trust varied, and they told us they did not feel they had had any input into them.

Staff generally felt supported by the managers at ward level but felt isolated within the trust and did not feel that their views were encouraged. Staff, including some consultant psychiatrists, did not feel their concerns had been listened to or that appropriate action had been taken. Consultant psychiatrists in Bristol told us they did not feel supported in their role by the trust.

Several meetings were held by the trust focusing on current provision and identifying concerns, but little if any action was taken to address some concerns.

The trust-wide governance and information system measures compliance with key issues such as records and supervision. Staff have access and can compare performance across wards.

### Leadership and culture

Staff we spoke with felt supported by the managers at ward level. Staff also valued the support of the team who worked well together and were committed to 'going the extra mile' to provide the service.

Leadership from above the ward level was not visible to staff. Staff did not understand the triumvirate leadership arrangements and had limited knowledge of who senior staff in Bristol and the wider trust were.

### Engagement

Staff we spoke with felt isolated as a service within the trust and did not feel that their views were encouraged. They had raised concerns about staffing levels to senior managers both verbally and in writing but did not feel listened to or that appropriate action had been taken.

We were told in the consultant psychiatrists' focus group for Bristol that senior managers were not responsive to the consultants' concerns about the service. One person said, "We raise patient safety issues and do not get any reply. Emails are not responded to." They told us they did not feel supported in their role by the trust. There was no forum for the consultant psychiatrists to meet with the triumvirate leadership team in Bristol or medical director and no medical staff committee for the trust where they could share and discuss their views and concerns.

### Fountain Way - Ashdown PICU

#### Vision and strategy

Staff we spoke with had varying levels of awareness about the vision of the trust. It appeared that the medics, consultants and managers had a much clearer vision of the trust purpose than the ward staff. Staff received information about the trust via email and intranet. They told us they didn't often have time to read emails and there were issues about being able to access a computer at work to read emails.

Staff told us they knew the onsite management well and most felt they had a good working relationship with them. Staff told us they would probably not recognise the senior trust management if they came on the ward.

#### Responsible governance

There is a trust-wide governance and information system called IQ. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

## Our findings

### Callington Road Hospital - Elizabeth Casson House and Hazel PICUs

#### Vision and strategy

Staff we spoke with had varying levels of awareness about the vision and values of the trust and told us they did not feel they had had any input into them. Staff received a weekly newsletter with information about the trust via the intranet. Staff told us they would probably not recognise the senior trust management if they came on the ward.

#### Responsible governance

There is a trust-wide governance and information system called IQ. This measures compliance with key issues such as records and supervision. Managers and staff have access to the system and are able to compare the performance of individual wards.

Staff we spoke with were aware of their roles and responsibilities on the ward. They knew where to go if they were not sure of anything. They demonstrated a depth of understanding of the challenges faced by the trust but also a frustration that concerns they had raised, such as staffing levels, were not appearing to be addressed.

# Are services well-led?

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.

Staff we spoke with were aware of their roles and responsibilities on the ward. They knew where to go if they were not sure of anything. They demonstrated a depth of understanding of the challenges faced by the trust but also a frustration that trust-wide issues were not appearing to be addressed with any urgency such as training provision and staffing levels.

## **Leadership and culture**

We received varying reports about the support staff received. Some staff reported they felt very supported and valued whilst others said they felt they were not supported. Issues were expressed around addressing concerns through email rather than directly with the person and allegations of bullying and unfair allocation of shifts and annual leave. We raised this with managers and were told they felt the issue had been settled.

Some staff expressed their feelings for the need for stronger, more visible leadership and direction. In a focus group, one person told us "I know managing wards is very demanding but sometimes they should be there dealing with situations with us, leading us and demonstrating to us that they care and are prepared to stand in and help, not just disappear to their office". On our return visit, we heard about plans to move the managers back onto the ward.

## **Engagement**

Patients told us that staff engaged with them as much as they were able to under the high demands of the ward. They said they saw the professional team regularly and most felt included in their care on a daily basis. However we did find that patients were not always involved in care reviews and some did not have copies of their care plans.

Staff told us they felt they worked closely as a team on ward level but felt isolated within the trust. Communication came to them via email or on the intranet. This was not easily accessible due to lack of computers and time to be able to sit a read correspondence.

## **Performance Improvement**

We saw evidence from several meetings focusing on current provision and identifying concerns. These meetings were well attended and showed that some issues were being addressed. However it was clear that some issues, in particular training, staffing and ward improvements, were spoken about each time with little if any action being taken

to remedy the situation. It appeared that trust-wide issues and concerns were not being highlighted or escalated assertively enough to trust level management for attention. On our return visit, these issues had been escalated again.

## **Southmead Hospital - Mason Place of Safety Engagement**

We were told in the consultant psychiatrists' focus group for Bristol that senior managers were not responsive to the consultants' concerns about the service. One person said, "We raise patient safety issues and do not get any reply. Emails are not responded to." They told us they did not feel supported in their role by the trust. There was no forum for the consultant psychiatrists to meet with the triumvirate leadership team in Bristol or medical director and no medical staff committee for the trust where they could share and discuss their views and concerns.

## **Performance Improvement**

We saw managers met regularly with the local police force to discuss the service and identify areas for improvements. Use of the place of safety was monitored and trends identified and discussed within the local and trust-wide place of safety meetings.

## **Fountain Way - Place of Safety Performance Improvement**

We saw managers met regularly with the local police force to discuss the service and identify areas for improvements. The police had a dedicated lead on the service. Use of the place of safety was monitored and trends identified and discussed within the local and trust-wide place of safety meetings. We looked at minutes of these meetings and issues were discussed each month but did not appear to lead to situations being rectified.

On our return visit, the concerns we raised had been escalated again with more urgency and a specific meeting to discuss and plan to address these was arranged for the day after our return visit.

## **Applewood - Place of Safety Leadership and culture**

Staff told us that they had received good supervision, appraisals and staff training. The doctors who we spoke with said the ward was well led.

# Are services well-led?

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.

## **Performance Improvement**

We saw managers met regularly with the local police force to discuss the service and identify areas for improvements. Use of the place of safety was monitored and trends identified and discussed within the local and trust-wide place of safety meetings.

## **Green Lane - Place of Safety Leadership and culture**

Staff told us that staffing for the place of safety was covered by the ward at night and weekends and daytime by the intensive team currently. This could lead to staff shortages on the ward when cover was required which they felt was unacceptable.

Staff including medical staff confirmed that they have good access to supervision, appraisals and staff training and thought the unit was well led.

## **Performance Improvement**

We saw managers met regularly with the local police force to discuss the service and identify areas for improvements. Use of the place of safety was monitored and trends identified and discussed within the local and trust-wide place of safety meetings.

# Compliance actions

## Action we have told the provider to take

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

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises

How the Regulation was not being met:

- In Hazel PICU we found potential ligature risks that had not been effectively mitigated or managed

Regulation 15(1)

### Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

### Regulation

The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care.

How the Regulation was not being met:

- We found delays in transferring patients where an alternative service is required. We found occasions when a patient may have been transferred earlier than their presentation had indicated.
- Individual patient risk assessments had not always been reviewed and updated following incidents of potential or actual harm
- We found that seclusion was not always recognised and managed within the safeguards set out in the MHA Code of Practice
- We found that physical health observations were not always carried out when people were secluded
- There was inadequate provision of structured activities on some units as required by the MHA Code of Practice meaning some patients complained of boredom

Regulation 9 (1) (b) (ii)(iii)

### Regulated activity

### Regulation

# Compliance actions

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

The registered person did not have suitable arrangements to protect patients from the risk of unsafe or unsuitable equipment:

How the Regulation was not being met:

- At Fountain Way emergency life support equipment was missing, not properly maintained and suitable for its purpose.

Regulation 16 (1) (b)

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person had not safeguarded the health, safety and welfare of service users by taking appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity:

How the Regulation was not being met:

- Elizabeth Casson House and Ashdown ward were experiencing significant staff shortages which may have impacted on patient care and safety.
- Arrangements for medical cover were not always sufficient at Callington Road.

Regulation 22

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person had not protected service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines:

How the Regulation was not being met:

- On some units we found that temperature checks necessary for ensuring the integrity of medications had not been made or remedial action undertaken where temperatures were unsafe

Regulation 13

# Compliance actions

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person had not ensured that as far as reasonably practicable there were suitable arrangements to ensure the dignity, privacy and independence of service users and that service users are enabled to make, or participate in making, decisions relating to their care or treatment.

How the Regulation was not being met:

- Not all patients were involved in the planning of their care and treatment

Regulation 17—(1)

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person did not protect service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment by regularly assessing and monitoring the quality of the services provided and identifying, assessing and managing risks relating to the health, welfare and safety of service users and others:

How the Regulation was not being met:

- We found occasions where the trust had not taken prompt and appropriate action to manage risks identified by serious incidents and concerns

Regulation 10

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person had not ensured that suitable arrangements were in place in order to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities by receiving appropriate training, professional development, supervision and appraisal;

- Staff told us that they do not always have access to effective supervision

# Compliance actions

- Not all staff at Fountain Way had received life support training.

Regulation 23

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person had not ensured that service users and others having access to premises where a regulated activity is carried on are protected against the risks associated with unsafe or unsuitable premises

How the Regulation was not being met:

- In two section 136 places of safety we found potential ligature risks that had not been effectively mitigated or managed
- The environment in the place of safety suites at Fountain Way and Green Lane were not conducive for someone in great distress

Regulation 15(1)

## Regulated activity

Assessment or medical treatment for persons detained under the Mental Health Act 1983

Treatment of disease, disorder or injury

## Regulation

The registered person had not taken proper steps to ensure that people were protected against the risk of receiving inappropriate or unsafe care.

How the Regulation was not being met:

- We found some significant delays in people moving on to the appropriate service once their assessment had been completed
- There were two policies governing the procedures for section 136 causing confusion. One of these did not meet the guidance set within the MHA Code of practice.

Regulation 9 (1) (b) (ii)(iii)