Inspection Report

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

Bowmere Hospital

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Tel: 01244364186

Date of Inspection: 17 January 2014

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We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Cooperating with other providers	✓ Met this standard
Safety and suitability of premises	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Cheshire and Wirral Partnership NHS Foundation Trust
Overview of the service	Bowmere Hospital is situated at the The Countess of Chester Health Park. The hospital provides a range of mental health services for adults,children and adolescents. These include psychiatric intensive care units and inpatient wards.
Type of services	Community based services for people with mental health needs Hospital services for people with mental health needs, learning disabilities and problems with substance misuse Rehabilitation services
Regulated activities	Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

This was an unannounced inspection.

How we carried out this inspection

We carried out a visit on 17 January 2014, checked how people were cared for at each stage of their treatment and care, spoke with one or more advocates for people who use services and talked with people who use the service. We talked with staff, reviewed information given to us by the provider and reviewed information sent to us by other regulators or the Department of Health.

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

What people told us and what we found

We carried out an unannounced responsive inspection to Bowmere Hospital and we spent time on Beech ward . This was due to concerns raised with regard to the safety and suitability of the premises and the level of monitoring undertaken in respect of patients mental health needs.

We spoke with five patients who told us they felt they were receiving a good standard of care and that staff were supportive and respectful towards them. Some comments made were:

"Staff treat me with respect and observe my dignity."

"I'm happy with the care I receive here and I'm able to speak with staff if I feel a little low."

Care and treatment plans and risk assessments were in place with information about patients care and medical needs and risks identified. Records showed patients were supported to understand their issues and learn coping mechanisms to help them when they were discharged from the ward.

Records showed the service worked with a range of professionals both within the organisation and external.

We toured the ward and found it to be well decorated bright and pleasantly furnished. We looked at a selection of patient risk assessments. We found that the ward did not routinely carry out an environmental risk assessment to ensure patients bedrooms were safe and could meet their specific needs.

Observations were documented using a variety of recording methods. However the level of observations carried out throughout a 24 hour period were not recorded in the electronic daily notes. This meant there was not a chronological overview of patient's presentation or behaviour nor the assessments made by staff to maintain their safety and to monitor their wellbeing.

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

What we have told the provider to do

We have asked the provider to send us a report by 12 March 2014, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

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

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

Our judgements for each standard inspected

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

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

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

We spoke with five patients who told us they felt they were receiving a good standard of care and that staff were supportive and respectful towards them. Some comments made were:

"Staff treat me with respect and observe my dignity."

"I'm happy with the care I receive here and I'm able to speak with staff if I feel a little low".

"I have no problems with the other service users and I feel safe on the ward".

We looked at six care records. Care and treatment plans and risk assessments were in place with information about patients care and medical needs and risks identified. Three of the six records viewed showed patients had been involved in the care planning, risk management and review processes. The provider may find it useful to note two patients spoken with told us they had not been involved in the care planning process and could not recall this being discussed with them.

Discussions/consultations between the Psychiatrist/Responsible Clinician and the patients were documented. Patient's care and treatment plans were monitored closely by members of the multidisciplinary team who met on the ward weekly. Records showed patients were supported to understand their issues and learn coping mechanisms to help them when they were discharged from the ward.

Overall the focus at admission was the point when patients would be discharged and there were systems in place to engage with external agencies prior to a patient being discharged. The provider may find it useful to note that two patients spoken with were not aware of any discharge plans. The ward manager advised us that discussions about discharge plans took place on an individual basis. The timing of such discussions was

dependent on how far along patients were on their recovery journey.

Records showed patients were supported by a range of healthcare professionals including dieticians, psychiatrists, registered mental nurses and occupational therapists. Minutes of multidisciplinary meetings showed patients benefited from a staff team who worked well together and shared information to support them in their recovery.

Records showed patients physical health care needs were monitored and where appropriate other medical healthcare professionals' input and advice was sought such as dietetic services.

Records showed and discussions with members of the staff team confirmed they had received appropriate training to meet the needs of the patients they supported.

Cooperating with other providers ✓ Met this standard

People should get safe and coordinated care when they move between different services

Our judgement

The provider was meeting this standard.

People's health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different services. This was because the provider worked in co-operation with others.

Reasons for our judgement

Records showed the ward worked with a range of professionals both within the organisation and external agencies. There were information sharing protocols in place particularly with regard to child protection and safeguarding vulnerable adults concerns.

We looked at how information was shared within the organisation when patients were moved between wards and other hospital sites. For patients transferred from psychiatric intensive care units a detailed summary was documented on the electronic care notes system. This enabled the new staff team to quickly identify patients' needs, current and recent risks. The provider may find it useful to note that Beech ward did not provide this summary when patients were transferred to other wards within Bowmere Hospital or to other units within the organisation. This left patients at risk of not receiving appropriate support and observations. The ward manager stated that when a patient was transferred a member of staff would accompany them and provide a verbal handover. They acknowledged this verbal handover was not recorded as given or received within the patients electronic care notes system.

Senior managers involved in the inspection visited reported that the current clinical observation and recording policy and procedure was being reviewed. This was to ensure there was clear guidance for the staff team to follow and to promote consistent practice with regard to observations undertaken and information recorded. This information was confirmed in an e-mail dated 21 January 2014.

Members of the staff team spoken with said working with professionals from different agencies worked well and that they had built positive working relationships with partner organisations to better support the patients in their care.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

We toured the ward and found it to be well decorated, bright and pleasantly furnished.

The majority of fixtures, fittings and furnishings provided had been assessed as being either a low or no ligature risk to patients who presented with self harming behaviours. However the en-suite doors in bedrooms had, following an incident been identified as a ligature point risk. The provider carried out a detailed risk assessment and produced an action plan to carry out work to reduce or eliminate the risk. Information provided by the provider indicated that work to remove the risk of the en-suite doors being used as a ligature point would start in February and be completed by August 2014.

The provider may find it useful to note that the activity room and small lounge areas were situated in areas of the ward that would not allow in line of site observations to be carried out. This may pose a risk to the wellbeing of more vulnerable patients. We were informed following the inspection that if a patient required an increased level of observation due to risk, then a member of staff allocated to the patient would move to a position where they were able to see the patient. Also that the location of all rooms was taken into account as part of the annual environmental risk assessment.

Records showed that the provider had systems in place to ensure facilities, furnishings and equipment were maintained. We spoke with five patients who raised no concerns about the ward environment.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were not maintained.

We have judged that this has a minor impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We looked at a selection of patient risk assessments. We found that the ward did not routinely carry out environmental risk assessments to ensure patients bedrooms were safe and could meet their specific needs. For example if a patient to be admitted to the ward had active thoughts of self harm and a history of such behaviours. There were no specific assessment or record in place to demonstrate that the provider had taken reasonable steps to identify possible risks and take action to prevent or reduce them.

We looked at the observation records for four patients. We found the information was recorded using a variety of recording methods such as paper documents, on a white board in the nurses' office and on patient's electronic daily notes. Observation risk assessments were carried out to determine the level of observation patient's needed. This information was then recorded on the white board. The level of observation required could change throughout the day as this was determined by the patients behaviours and presentation. We found the electronic daily notes did not reflect any changes through a 24 hour period. This meant there was no system in place to record chronologically an overview of patient's presentation and behaviour and to demonstrate the actions taken to maintain patients safety and wellbeing.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

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 activities	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: Observation records and risk assessments did not always accurately reflect the risks identified and the level of support and monitoring required to maintain patients safety and wellbeing.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 12 March 2014.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

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

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

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

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

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

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

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

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

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

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

How we define our judgements

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

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

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

How we define our judgements (continued)

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

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

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

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

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

Glossary of terms we use in this report

Essential standard

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

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

Regulated activity

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

Glossary of terms we use in this report (continued)

(Registered) Provider

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

Regulations

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

Responsive inspection

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

Routine inspection

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

Themed inspection

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

Contact us

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