WM QRS West Midlands Quality Review Service

NHS

Review of Care of Vulnerable Adults in Acute Hospitals

Report Date: October 2012 Visit Dates: May 2011 to January 2012

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INTRODUCTION

West Midlands Quality Review Service (WMQRS) was set up as a collaborative venture by NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews - often through peer review visits, producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on the WMQRS website: http://www.wmqi.westmidlands.nhs.uk/wmqrs

Reviews of mental health services, health services for people with learning disabilities, dementia services and care of vulnerable adults in acute hospitals in the West Midlands were undertaken between May 2011 and January 2012. Full reports of each visit are available on the WMQRS website, including details of compliance with Quality Standards and membership of the visiting teams. This report contains the Care of Vulnerable Adults section from each of the 2011/12 visit reports. These should be read in the context of the full visit reports, including details of compliance with WMQRS Quality Standards for Care of Vulnerable Adults in Acute Hospitals, Version 1.1 (December 2010).

The dates for each visit are given in Appendix 1.

The reports reflect the situation at the time of the peer review visits. Services may have changed and developed since these visits.

ACKNOWLEDGMENTS

West Midlands Quality Review Service would like to thank the staff and patients of the West Midlands Vulnerable Adults Services for their hard work in preparing for the reviews and for their kindness and helpfulness during the course of the visits. Thanks are also due to the visiting teams and their employing organisations for the time and expertise they contributed to these reviews.

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DUDLEY & WALSALL HEALTH ECONOMY

DUDLEY GROUP NHS FOUNDATION TRUST

During this visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Emergency Department, Emergency Admissions Unit and three medical wards.

General Comments and Achievements

Reviewers were impressed by several aspects of the care of vulnerable adults at Dudley Group NHS Foundation Trust. Trust policies and procedures were generally clear and available, although a few were out of date. Non-executive Director and PALS involvement in monitoring and improving care of vulnerable adults was strong. White boards, through which patients needing additional care were identified, were robustly implemented and appeared to be in regular use. A team specialising in the care of people with acute confusion was in place. A nutritional support worker had recently been appointed on a pilot basis.

Good Practice

1 A 'Take the Time' campaign, produced by the Dudley and Walsall Mental Health Partnership NHS Trust (Trust-Wide) was being implemented with the aim of improving staff understanding of the needs and wishes of vulnerable adults.

2 The Emergency Department had a good checklist used with patients aged over 65s and other vulnerable adults to ensure staffed consider all relevant issues when caring for these patients.

3 The Trust had implemented a very good campaign on tissue viability and reducing hospital-acquired pressure sores. This campaign was embedding good care at all levels in the Trust, including training staff, providing information on wards, ensuring Board members were aware of progress and a process of 'ward to Board' assurance.

4 PALS was working with a group of people with learning disabilities to provide training to staff on care of people with learning disabilities with emphasis on the skills needed to negotiate care planning.

Immediate Risks: None

Concerns

1 **Mental health liaison**

No mental health support / liaison team was available at the time of the visit. A liaison team had been commissioned from June 2011. Several staff who met the reviewers were unclear about the starting date and scope of the new service and, in particular, whether it would include the care of patients with dementia.

2 **Mental Capacity Act and Deprivation of Liberty Safeguards Training**

A Board report on safeguarding stated that 45% staff had had training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Reviewers were concerned that this was too low and that, from the information provided, achievement of the expected training in safeguarding, Mental Capacity Act and Deprivation of Liberty Safeguards was not being robustly monitored.

3 Actions to mitigate the risk of pressure sores for patients on trolleys for long periods of time had been implemented following the WMQRS review in October 2010, which identified this as an immediate risk to clinical safety and clinical outcomes. Some of the actions, including 'Waterlow' scoring for patients waiting on trolleys in the Emergency Department, had been implemented only recently. It was not clear that mattresses were now easily available. The Trust Board should assure themselves that the action plan from the October 2010 review has been implemented in full in all relevant departments.

Further Consideration

1 Specialist clinical support for people with learning disabilities within the Trust was not available. A business case for a Learning Disabilities Support Worker had been prepared.

2 There was some inconsistency in the way care planning was undertaken by ward staff. Some were using set care plans and in some areas no care plans could be evidenced.

3 The Trust Board received several reports on vulnerability and safeguarding. The key performance indicators for these issues were not clear to reviewers. It may be helpful to review Board reporting of these issues.

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WALSALL HEALTHCARE NHS TRUST

During this visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: stroke rehabilitation ward, acute medicine ward, general medical ward and surgical ward.

General Comments and Achievements

Walsall Healthcare NHS Trust had excellent leadership for the development of adult safeguarding and care of vulnerable adults. Policies and procedures were evident in clinical areas. Non-executive Director, PALS and patient involvement in monitoring and improving care of vulnerable adults was strong. Reviewers were particularly impressed by the arrangements for governance of safeguarding and care of vulnerable adults.

Good Practice

1 The Trust had very good processes for identifying vulnerable adults which included a clear proforma for admissions and for patients attending out-patients and a 'trigger tool'. The 'trigger tool' ensured that information about patients with additional needs was sensitively communicated in order to avoid stigma.

2 The monthly safeguarding report was good, with clear key performance indicators. The report was in a standard format so that trends could be clearly seen.

Immediate Risks: None

Concerns

1 Assessments of need were taking place but, apart from the stroke rehabilitation ward, there was little evidence in patients' notes that these assessments were being followed through to care planning and clear actions.

2 Arrangements for monitoring locum and agency staff were not sufficiently robust to identify whether locum and agency staff had up to date safeguarding, MCA and DOLS training.

Further Consideration

1 The Trust was heavily dependent on one Adult Safeguarding Lead and arrangements for cover for unexpected absences were not robust. The Adult Safeguarding Lead also had significant operational and training responsibilities. When addressing this issue, reviewers suggest that the Trust consider a model whereby the undoubted expertise of the Adult Safeguarding Lead is 'rolled out' and others are encouraged to develop their expertise. This may help changes to become embedded and part of routine practice.

2 A mental health liaison service for younger adults was in place. Two mental health nurses in the discharge team specialised in the care of people with dementia and an acute liaison learning disabilities nurse was available. The arrangements for liaison on the care of older adults with mental health problems before discharge were not formalised and may benefit from review.

3 The Trust had plans to link the 'trigger tool' (see good practice) to the Fusion IT system. If possible, this would help communication about the care of vulnerable adults in the Trust.

4 The flow chart in the Trust safeguarding policy did not reflect what is happening in practice, especially about arrangements during absences of the Adult Safeguarding Lead. Reviewers suggested that the policy is amended to reflect current practice.

5 A new medical lead for adult safeguarding had been appointed but had no time allocated for this role. The need for time within the job plan should be kept under review.

6 It was not clear that all documents had been ratified through the expected Trust processes.

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COMMISSIONING

NHS DUDLEY

Concerns

1 Mental health liaison: See Dudley Group NHS Foundation Trust section of this report.

NHS WALSALL

Concerns

1 Adult Safeguarding Board: The Walsall Adult Safeguarding Board met in April 2011 but had not met for a year before this. Reviewers were concerned that this was not frequent enough to ensure that all safeguarding issues were being appropriately addressed. (A Safeguarding Board within Walsall Healthcare NHS Trust had continued to meet regularly with representation from the Adult Safeguarding Unit.)

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COVENTRY & WARWICKSHIRE HEALTH ECONOMY

ACUTE TRUST-WIDE & CLINICAL AREAS

GEORGE ELIOT HOSPITAL NHS TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Emergency Department, Emergency Medical Unit, Acute Surgical Ward, Orthopaedic Ward and Lydgate Ward.

General Comments and Achievements

The care of vulnerable adults was given a high priority by the Trust. A clinical lead had recently been appointed and regular meetings with the lead Non-Executive Director were in place. PALS and the Patient Forum were involved in 'snap shot' surveys of care on in-patient wards. A lot of work had taken place on improving patient safety and the Trust Board was actively using patient stories to inform the Board on care received. A range of other mechanisms for patient feedback were also in use, including immediate 'smiley face' feedback, patient forums, use of volunteer in the 'snap shot' surveys, and regular consideration of findings by Trust governance meetings.

The Accident and Emergency Department had a good system of identifying people who were particularly vulnerable and 'flags' were carried throughout their stay in hospital. There was also a system of identifying repeat attendances of people who were particularly vulnerable. The Trust was piloting a new system for totalling fluid charts at lunchtime.

Good Practice

1 The Trust had implemented 'Back to Basics' Matrons. The Nurse Director, Matrons and Senior Sisters met once a week specifically to look at governance issues, in particular trends of serious incidents, root cause analysis and any 'lessons learnt' from incidents. This information was then cascaded to service areas.

2 The rapid tranquilisation protocol policy was good and had been developed with an acute trust focus. This policy included an aggression risk assessment tool (Walter Brennan tool) to assess potential violence and aggression. The implementation of the policy had been audited and reported to the Trust Board. The audit showed a low level of sedation episodes.

3 A wide range of information was available for patients with learning disabilities. The information in easy read was very good and explicit.

4 Specialist advice was readily accessible during normal working hours for queries about the care of people with dementia, learning disabilities and mental health problems. Staff were very positive about the support received. The staff who met the visiting team were clear about the roles of the specialist advisers and when to access them.

Immediate Risks

1 **Mental health liaison services in acute Trusts**

At the time of the visit there was no mental health liaison service within South Warwickshire NHS Foundation Trust and, in practice, no formal service for people with mental health problems aged 65 and over outside normal working hours across Coventry and Warwickshire. As a result, access to an urgent mental health assessment could be significantly delayed and patients were admitted to the acute Trusts while waiting an assessment. As well as the impact on these individuals and their families, this placed particular pressure on acute Trust staff and could affect other patients. Mental health liaison services were available during normal working hours at George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust. Crisis teams were available outside working hours but were not commissioned to care for people aged 65 and over. The 2011/12 service specification for Community Mental Health Teams for older people identified arrangements for urgent assessment but this was not yet reflected in practice. Reviewers were told that the crisis teams would sometimes see someone over 65 on a 'grace and favour' basis. This issue was identified as a concern in all 2010 Coventry and Warwickshire urgent care review visits. Since then the 'in hours' service at South Warwickshire NHS Foundation Trust has reduced and attempts to resolve the issue have not been successful.

Concerns

1 **Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DOLS) – Awareness**

Several staff who met the visiting team were unclear about MCA and DOLS and how to access assessments. Some staff were also unsure about the relationship with the Mental Health Act. Some training was available but this did not adequately explain these areas and the action staff should take if they had concerns.

Further Consideration

1 Work was taking place on the development of a consistent, concise system of handover at all levels (ISOBAR). Reviewers commended this work and encouraged evaluation and dissemination if the pilot achieved the aim of making ward handovers shorter and of better quality.

2 The Trust policy on missing patients may benefit from specific consideration of those people who lack mental capacity.

3 A review of care planning was taking place with the aim of making sure care plans were addressing patients' individual needs.

4 Information for staff and patients on raising concerns may benefit from review. It was not clear which information was intended for patients and carers and which for staff (or whether information was intended for both). Some posters had different information on who to contact out of hours. The NHS Warwickshire leaflet was very good but had an external telephone number.

5 A 'Safeguarding Care Bundle' was being introduced which included the introduction of sticky labels and duplicated form filling. Reviewers suggested that implementation should be carefully monitored to ensure that the care bundle is achieving the expected outcomes.

SOUTH WARWICKSHIRE NHS FOUNDATION TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Acute Medical Admissions, Squire, Respiratory, Acute Medicine and Stroke Wards.

General Comments and Achievements

The Trust was aware of issues which needed to be addressed and had plans for further education and awareness of care of people with dementia and those with learning disabilities. Work undertaken to raise awareness of DOLS had led to an increase in the number and timeliness of referrals (17 in the last year). One nurse with both general and mental health training had made a good contribution to the training and awareness programme. The Trust had recently taken on the provision of community services for Warwickshire and several Trust-wide policies were, as a result, being revised.

Good Practice

1 The Observation Unit had one double bed space with facilities for relatives to stay during the initial phase of admission. Staff had a positive attitude to encouraging carers to stay to support people who were particularly vulnerable.

2 A visual, real time display board 'Heartbeat' showing triggers and markers of vulnerability was being rolled out across all departments. The information on the board stayed with the patient which helped transfers between different areas. Reviewers noted, however, this was completed better in some wards than others.

3 Patients were routinely part of staff education programmes which ensured that the patient perspective was given a high priority.

4 The discharge team was actively involved in clinical capacity management. The team visited wards daily and identified clinical issues which may be delaying the patient pathway as well as working with patients with more complex needs.

Immediate Risks:

1 **Mental health liaison services in acute Trusts**

At the time of the visit there was no mental health liaison service within South Warwickshire NHS Foundation Trust and, in practice, no formal service for people with mental health problems aged 65 and over outside normal working hours across Coventry and Warwickshire. As a result, access to an urgent mental health assessment could be significantly delayed and patients were admitted to the acute Trusts while waiting an assessment. As well as the impact on these individuals and their families, this placed particular pressure on acute Trust staff and could affect other patients. Mental health liaison services were

available during normal working hours at George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust. Crisis teams were available outside working hours but were not commissioned to care for people aged 65 and over. The 2011/12 service specification for Community Mental Health Teams for older people identified arrangements for urgent assessment but this was not yet reflected in practice. Reviewers were told that the crisis teams would sometimes see someone over 65 on a 'grace and favour' basis. This issue was identified as a concern in all 2010 Coventry and Warwickshire urgent care review visits. Since then the 'in hours' service at South Warwickshire NHS Foundation Trust has reduced and attempts to resolve the issue have not been successful.

Concerns

1 No policy on restraint was available at the time of the review and implementation could not, therefore, be audited.

2 The Trust had no Mental Capacity Act policy. (There was a policy on DOLS but this did not cover MCA.)

Further Consideration

1 Reviewers observed an example on the respiratory ward where nursing staff did not respond appropriately to the needs of a distressed patient. This particular example was of concern. As this was the only example seen by reviewers this issue has not been included in the concerns section of this report. Reviewers recommended, however, that the Trust undertake further work to assure itself that these problems are not happening routinely. On the same ward, bowel action charts had not been completed as expected.

2 Reviewers were told that PALS would investigate issues of concern rather than reporting these or referring for advice, and the level of investigation undertaken may not always be appropriate, especially for safeguarding issues.

3 Management arrangements for safeguarding and the care of vulnerable adults were under review following the integration with community services. Reviewers agreed that this review was needed and encouraged the Trust to ensure revised arrangements are clarified as soon as possible with consideration of a defined role for a safeguarding lead.

4 A competence framework for MCA, DOLS and safeguarding training had not yet been developed. Staff received 45 minutes training covering all three areas as part of mandatory training. Consideration should be given to some more in depth training, especially for some staff with 'front line' responsibility.

5 Several staff who met the visiting team were not aware of the missing patient flow chart. The flow chart covered patients who had been identified as vulnerable or where there were concerns about mental capacity. Appropriate action to find patients not previously identified as vulnerable was not clear in the flow chart.

6 Information for patients and carers on raising concerns about safeguarding was not easily visible. (An NMC poster targeted at staff was available.)

7 The future role of nursing staff with both general and mental health training may benefit from review to ensure best use is being made of these skills.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Trauma and Orthopaedic Ward, Stroke Ward, Clinical Decisions Unit, Elderly Care Ward and Short Stay Medical Ward.

General Comments and Achievements

Patient feedback gathered during visit was positive about the attitude and care given by staff. A good working relationship with partner agencies was evident, in particular, a proactive Partnership Board for the Coventry area.

Good Practice

1 A Dementia Lead in the acute Trust was working to increase the profile of care of people with dementia as well as providing good support and training and development for front line staff. Staff who met the visiting team clearly valued this role. Link workers for wards had also been trained.

2 The PALS service was developing innovative ways of gathering information on patients' experiences, especially those of different cultural groups. In particular, volunteers supported the in-patient surveys and there was an on-line feedback system. There was evidence that the Trust had made changes as a result of patient feedback, for example, wheelchair parks and improvements to the physical environment.

Immediate Risks: None

Concerns: None

Further Consideration

1 In addition to the patient feedback mechanisms already developed, it may be helpful to consider other specialised mechanisms to gather views from 'difficult to reach' groups (for example, frail elderly people and victims of domestic violence).

2 Staff were not always clear about out of hours arrangements for access to specialist advice on the care of people with dementia or learning disabilities. The crisis team was contacted for advice on the care of people with mental health problems. A list summarising the link workers/ champions within the Trust and out of hours arrangements may help to address this.

3 Several policies and procedures were either not in place or in draft form and, if implemented, would have been of concern:

   a. The restraint policy included a mental health section which only covered mental capacity. Reviewers suggested that the information in the draft policy could be misleading. The number of DOLS referrals in the last year appeared low (8).

b. The missing patients flow chart was insufficient as a standalone policy.

c. There were no guidelines on the care of people with challenging behaviour.

4 Support for feeding was triggered by verbal communication between staff. Reviewers suggested that consideration should be given to a systematic process (for example, red trays or marking on whiteboards or the bed head) to ensure that feeding support was consistently provided when needed.

5 The training strategy was in draft form and did not cover care of people with challenging behaviour. However some areas of practice were utilising the 'abc' system as advised by the Dementia Lead.

6 The bedside folder may benefit from being updated to include information on staff and information on reporting safeguarding concerns.

7 Representation on the Adult Safeguarding Board may benefit from review to ensure consistent, appropriate representation from the Trust. The named Director did not attend and the lead Consultant had not yet been included.

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COMMISSIONING

NHS COVENTRY and NHS WARWICKSHIRE VULNERABLE ADULTS IN ACUTE HOSPITALS COMMISSIONING

Immediate Risk:

1 **Mental health liaison services in acute Trusts**

At the time of the visit there was no mental health liaison service within South Warwickshire NHS Foundation Trust and, in practice, no formal service for people with mental health problems aged 65 and over outside normal working hours across Coventry and Warwickshire. As a result, access to an urgent mental health assessment could be significantly delayed and patients were admitted to the acute Trusts while waiting an assessment. As well as the impact on these individuals and their families, this placed particular pressure on acute Trust staff and could affect other patients. Mental health liaison services were available during normal working hours at George Eliot Hospital NHS Trust and University Hospitals Coventry and Warwickshire NHS Trust. Crisis teams were available outside working hours but were not commissioned to care for people aged 65 and over. The 2011/12 service specification for Community Mental Health Teams for older people identified arrangements for urgent assessment but this was not yet reflected in practice. Reviewers were told that the crisis teams would sometimes see someone over 65 on a 'grace and favour' basis. This issue was identified as a concern in all 2010 Coventry and Warwickshire urgent care review visits. Since then the 'in hours' service at South Warwickshire NHS Foundation Trust has reduced and attempts to resolve the issue have not been successful.

No other specific commissioning issues were identified.

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BIRMINGHAM & SOLIHULL HEALTH ECONOMY

ACUTE TRUST-WIDE AND CLINICAL AREAS

HEART OF ENGLAND NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

Good Hope Hosptial: Trauma and Orthopaedics (Ward 14) Stroke & Elderly Care (Ward 24) Acute Medical Unit, Respiratory (Ward 8), Elderly Care Wards (10 & 12).

Solihull Hospital: Acute Medical Unit, Acute Medical Unit Short Stay (20a), Stroke (Ward 8) Cardiac (Ward 17), Respiratory (Ward 19), Acute Medicine/ Elderly Care, Diabetes and Gastroenterology (Ward 18), Orthopaedics (Ward 15 – Elective Patients only).

Birmingham Heartlands Hospital: Emergency Department, Renal Medicine (Ward 3), Surgical Assessment Unit (Ward 11), Trauma and Orthopaedics (Beech Ward), Elderly Care (Ward 21), Haematology/oncology (Ward 19) Elderly care short stay (Ward 30) .

General Comments and Achievements

Much work has been undertaken across the Trust in the last year. A newly appointed safeguarding adults matron and site lead nurses were in place. The adult safeguarding steering board membership and terms of reference had been revised and greater links with other agencies were being developed. A 'challenging behaviour' work-stream sub-group was looking at polices and practice around restraint, sedation and challenging behaviour. A range of nursing metrics were reported and audits had shown improvements in the delivery of some aspects of care across all hospital sites. The lead for safeguarding was very proactive and was delivering training.

Immediate Risks: None

Good Practice

1 The Acute Medical Short Stay ward was pioneering several initiatives to improve fluid and food intakes for certain groups of patients. These included

   a. Increasing the number of formal hot drink rounds during the day. In particular, patients were asked if they wished to be offered an early morning hot drink.

   b. Availability of snack boxes, which included a range of finger foods

   c. Use of coloured tableware (blue gingham table covers and blue and green crockery) to help those with dementia.

2 A Safeguarding SharePoint on the intranet had been developed and contained a wealth of information including contact numbers, publications, research and audit, policies, training and other useful information. It was an easy to access site and staff in the clinical areas found it very helpful.

3 Leadership on safeguarding and care of vulnerable adults was visible at all levels (from Board to Ward). All staff who met the visiting team were clear about who they should ask if they had queries.

4 Nursing metrics were being reported and were empowering staff to make changes and improve care. This was creating staff engagement and competition between wards.

5 A Care of the Elderly consultant worked in the Emergency Department during normal working hours in order to improve the care of older people. This initiative had avoided several admissions.

6 The first edition of a Safeguarding Newsletter had been produced in June 2011.

7 Ward 21 at Birmingham Heartlands Hospital had made several improvements to the environment, including electronic openers to help people with disabilities to access the toilets.

Concerns

1 **Care Planning**

There was evidence of inconsistency and a lack of quality control in the way care planning was undertaken on the wards visited. The approach to care planning did not optimise personalised care. The Trust was aware of this and was reviewing the documentation. On some wards, progress against care plans was documented in either the electronic ward handover or the patient's notes or duplicated in both. It was therefore not clear that the most up to date information was being communicated to staff. In one set of records reviewed the electronic handover record had not been updated for two days and the patient notes were not accessible to check whether any entries had been made (Good Hope). The use of the 're-positioning chart' was not clear: Some staff reported that a once daily record was acceptable if the patient was on an 'air bed' as they do not need re-positioning whereas care records reviewed at Solihull showed that regular re-positioning was undertaken and documented. Individualising of care plans was limited and related mainly to the risk assessment document. This would therefore cover those areas deemed at greater risk and would not include other care that may be required. An 'activity of daily living' check list was in use at Solihull but it was not clear if this document was used elsewhere in the Trust. Reviewers were told that the Trust was aware of these issues and work was underway to address them through the development and implementation of an electronic system to standardise and improve nursing assessment and care planning.

Further Consideration

1 Some staff did not appear to understand the importance of independent access to interpreters in the best interests of the patient. Examples included a lack of clarity about use of family members for interpretation and staff who were unsure whether they could be used to translate.

2 A medical lead with responsibility for safeguarding and improving the care of vulnerable adults within the Trust may help to support the lead for safeguarding and raise awareness and training among medical staff.

3 The areas visited used different ways of highlighting patients with specific needs, for example, those at risk of falls or pressure sores or those requiring help with nutrition. The Trust was in the process of

implementing an electronic 'patient at a glance' screen which will enable triggers to be documented and grouped (safety bundle) and this will help communication about the care of vulnerable adults in the Trust.

4 Staff understood what to do if they had safeguarding concerns but did not appear to appreciate that their actions, and the actions of other staff, could comprise neglect. Staff responsibilities in this area were also not well understood.

5 Patient and carer information about how to raise safeguarding concerns was not easily visible. The Trust had been told that public information would be available from the Solihull and Birmingham Safeguarding Boards but little progress had been made for 18 months. The Trust was addressing this gap in information for patients and carers by developing an in-house safeguarding leaflet.

6 The number of staff who had received training in safeguarding and care of vulnerable adults was low at the time of the visit but the Trust had plans for all registered nurses to complete this training by September 2011. At the time of the visit only 23% of non-clinical staff and 31% of clinical staff had undertaken training to level 2.

7 Not all patients had easy access to a television on Ward 30. Patient bedside televisions had been removed by *Patient Line* because of lack of use.

8 Reviewers were impressed that several improvements had been developed fairly recently or were being planned and It will be important to ensure that these are followed through to full implementation. Examples included a support worker for safeguarding, implementation of new policies, implementation of the Trust dementia strategy, Safeguarding Champions, closer working with social workers, and implementing patient information and discharge planning booklets.

BIRMINGHAM WOMEN'S NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: antenatal clinic, ward 8 (gynaecology), ward 1 (antenatal inpatients), ward 4 (postnatal care).

General Comments and Achievements

The Trust provided a good environment for women and newborn children. All staff who the reviewers met were very focussed on identifying vulnerable adults and ensuring their needs were met. Multi-disciplinary working was well developed and there were good links to child protection arrangements. Work to develop female genital mutilation service was in progress and a consultant had been appointed. The Trust had done much work on 'Listening into Action' and improving feedback from patients, including implementing real-time feedback pads. Information was available in other formats for people with visual or hearing difficulties and in other languages (CDs). The Trust intranet had lots of information with easy links to safeguarding information and national policies.

Immediate Risks: None

Good Practice

1 There was a good process for communicating the learning from incidents, including the Trust 'Risky Business' newsletter and several examples of changes of organisational policy and practice.

2 A good range of specialist roles supported the care of people with mental health problems, substance misuse, teenage pregnancies and safeguarding.

3 The resources available to support safeguarding and improving care of vulnerable adults were good with one whole-time-equivalent lead plus additional support and a medical lead with time allocated for this work.

4 The Patient Adviser and Information Service were able to produce bespoke information for patients with specific needs.

5 An attractive 'Values' logo gave a clear message about the Trust's values.

Concerns

1 The safeguarding leaflet which is taken from appendix D of the Trust Safeguarding Policy conflicts with the multi-agency policy leaflet in relation to referring suspected abuse of vulnerable adults. The flow chart implies that staff may need to confirm that abuse has taken place whereas the multi agency policy suggested escalating all concerns with no judgement required. Reviewers were told that the leaflet was not due for review until 2012.

Further Consideration

1 The safeguarding training concentrated on the care of the unborn child. It may be helpful to review whether the training programme gives sufficient emphasis to safeguarding of adults.

2 Post-induction training on safeguarding and care of vulnerable adults relied on a leaflet every three years. The Trust may wish to review whether this is sufficient, especially for senior staff in clinical areas.

3 The key performance indicators relating to safeguarding and care of vulnerable adults had not yet been defined. Complaints and incident analysis did not yet separately identify vulnerable adults.

4 A great deal of work was taking place on improving care of people with learning disabilities. A draft pathway was available and a resource folder was being developed. Reviewers encouraged continuation of this work.

5 Several guidelines and policies were in draft form, including those relating to missing people, people with learning disabilities, domestic abuse and consent. (The 2009 consent policy was being revised.) It will be important that these are finalised and fully implemented.

6 The approach to staff feedback about complaints and incidents may benefit from review. Reviewers were given examples where staff had not been told about complaints and incidents in order to save them from distress.

7 *Lorenzo* had a trigger mechanism for identifying vulnerable adults but this was not working on the day of the visit. The Trust should monitor that this does function effectively.

ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Wards 1, 2, pre-operative assessment clinic and out-patients department.

General Comments and Achievements

Key personnel within the Trust were enthusiastic and committed to improving the care of vulnerable adults. These staff were aware of the areas that needed to be addressed and had good plans for taking these forward. Reviewers were confident that appropriate action would be taken on safeguarding issues identified to the senior team. The Trust intranet had lots of information with easy links to safeguarding information and national policies.

Immediate Risks: None

Good Practice

1 A good multi agency safeguarding referral form was in use.

2 Posters about domestic violence were displayed in ladies toilets.

Concerns

1 **Staff training**

Most staff in clinical areas had not yet had appropriate training on safeguarding and care of vulnerable adults. Although staff would probably react appropriately to significant abuse, reviewers were not confident that more subtle clues would be noticed and appropriate action taken, including consideration of issues which may have occurred before admission or after discharge. Staff were also not clear about their responsibilities in relation to those of other agencies.

Further Consideration

1 The management of safeguarding issues was heavily dependent on two people who had limited time for this work. Because of the lack of staff training (see above) the team was dealing with issues which may more appropriately have been managed by clinical staff. Consideration should be given to greater empowerment of clinical staff and /or increasing the time available to the safeguarding team.

2 An easily accessible 'quick reference' guide for staff may be helpful as part of building their confidence in handling safeguarding issues. This could be produced quickly and its implementation supported by the staff training programme.

3 Medical staff did not appear to be involved with work to improve the care of vulnerable adults, including improving safeguarding. Greater involvement of the Medical Lead in this work may be a helpful way to achieve engagement of other medical staff.

4 Several staff commented that the Trust was a 'low risk' organisation for safeguarding and improving the care of vulnerable adults, because the organisation did not manage an Emergency Department. There was a gap in the realisation that adults might be admitted from environments where abuse had occurred or may be being transferred on to unsafe environments. There was limited appreciation of the Trust's responsibility in these potentially unsafe situations; it seemed to be the view that either the professionals involved in care prior to admission or professionals involved in the care following discharge would pick this up. Raising awareness of the orthopaedic aspects of safeguarding and the contribution of the Trust to the care of vulnerable adults may be helpful. As part of this work, continuing to build links with the discharge planning team and with voluntary groups may be beneficial.

SANDWELL & WEST BIRMINGHAM HOSPITALS NHS TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Priory 4, Priory 3, Lyndon 4 and Priory 2 at Sandwell and D21, D24, D16, D18-MAU and A&E at City Hospital.

General Comments and Achievements

Reviewers were impressed by the approach taken by Sandwell and West Birmingham Hospitals NHS Trust to improving the care of vulnerable adults in hospital. In particular, reviewers commended the caring culture of the organisation, the scope of the work undertaken and the way in which changes had been firmly embedded into practice. Medical as well as nursing staff were engaged and committed to the changes. The "You said – we did" posters provided feedback to patients, carers and staff about changes made. Excellent minutes from the Sandwell Learning Disability Board were available in easy read format. Dementia care advice across both sites was comprehensive and staff had a good understanding of how to care for patients. At City Hospital arrangements for access to specialist advice for people with learning disabilities were robust. Staff had a good understanding of advanced care planning and reasonable adjustments.

Immediate Risks: None

Good Practice

1 Board members regularly undertook 'walk-rounds' focussing on patient experience, including safeguarding.

2 The RAID service at City Hospital provided excellent support for patients with mental health problems.

3 Involvement of relatives and carers was firmly embedded into all aspects of the organisation of services as well as in the care of individual patients.

4 An excellent Trust therapeutic observation / 'specialing' policy clearly identified the level of care required.

5 A well-publicised 'Promises' logo gave a clear message about the Trust's commitment to its patients.

Concerns

1 At the time of the visit Sandwell Hospital did not have easy access to mental health assessment or to specialist clinical advice for people with learning disabilities. A band 7 liaison psychiatric nurse had just been appointed and an advert had been placed for a band 6 nurse. Interviews were planned for the day after the visit for a lead nurse for clinical advice for people with learning disabilities.

Further Consideration

1 Many audits were being undertaken. It may be helpful to review these to ensure the most efficient approach to auditing was being undertaken.

2 Some nursing documentation may benefit from being consolidated.

3 A few policies had not yet been ratified and some did not yet reflect the latest guidance.

4 The workload and approach used by the safeguarding team should be kept under review to ensure the team does not become a 'victim of its own success' and to ensure that, wherever appropriate, responsibility is taken by operational staff in clinical areas.

5 Reviewers were impressed by the work taking place on caring for people with dementia and those with challenging behaviour, including staff training, and encouraged continuation of this approach.

UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Trauma-410, Multi-speciality Medicine 513, 514, 515 and 516.

General Comments and Achievements

Reviewers were impressed with the new hospital and the space and privacy available on the wards. The wards that were visited had a calm and quiet ambience. Visibility in the rooms and bays were very good with plenty of natural daylight. Some wards were a bit cluttered. Patients were seen being helped with feeding and patients were observed resting in the afternoon. A range of nursing metrics was available via the ward-level 'dashboard'. The Trust dignity team included an activities coordinator and a mental health facilitator. There was good evidence of governance arrangements for safeguarding and care of the vulnerable patient. The Trust was actively working with 'hard to reach' vulnerable groups in the local community.

Immediate Risks: None

Good Practice

1 There was a strong ethos on dignity across the organisation. Examples included:

   a. The Trust ran an annual conference on dignity which was well supported and attended by a wide range of voluntary and statutory organisations.

b. Work of the dignity team across the elderly care wards was impressive and included:

i. 'Specialing' bags with activities for use by staff for those patients. The bags also included the Trust policy for reference and the 'about me' documentation to ensure that individual needs could be documented.

ii. Communication boxes were in place across 10 wards, these included external hearing aids for use by patients who were hard of hearing, spare batteries for hearing aids, a spectacle repair box, information on interpreters and laminated sign language sheets.

iii. The activity coordinator was very visible and was highly valued by staff and patients.

iv. The team undertook 'Dignity' visits to check completion of appropriate care plans and risk assessments and make sure that the communication boxes and 'let's respect' boxes were in place. An action plan from each visit was sent to the wards (often triggered by a complaint or comment).

c. One hundred and sixty six dignity champions were in place across the Trust.

2 Reviewers were impressed that daily real-time patient surveys were undertaken by volunteers or members of the patient information team.

3 The presentation of the nursing dashboard was clear and accessible. Ward and Directorate Reports were easily accessible.

Concerns

1 Data on the proportion of staff who had undertaken expected training in safeguarding and care of vulnerable adults were not available.

Further Consideration

1 The DoLS flow chart used a limited definition for when to refer at the beginning of the flow chart. A wider definition may help to ensure that patients are appropriately referred.

2 Several projects on safeguarding and improving the care of vulnerable adults were in progress. Arrangements for evaluation and, if applicable, roll-out of these projects were not clear. In some cases several projects were taking place at the same time and it may be difficult to determine the impact of each.

3 The Trust was working to improve accountability of nursing staff and reviewers considered that this should continue to full implementation.

4 The workload and approach used by the safeguarding team should be kept under review to ensure the team does not become a 'victim of its own success' and to ensure that, wherever appropriate, responsibility is taken by operational staff in clinical areas.

5 Reviewers identified opportunities for improving patient pathways through improved collaboration with other services, for example, services for people with learning disabilities. Mechanisms for achieving effective collaboration did not appear well-developed.

6 Information on how to raise safeguarding concerns was available on televisions only and it may be helpful to raise awareness through use of other communication routes. Mechanisms for sharing best practice and feedback on learning from incidents also appeared variable and may benefit from review.

7 Nursing dashboard information was no longer available to patients and carers in the clinical areas. Reviewers felt that wider availability of this information would be helpful.

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COMMISSIONING

BIRMINGHAM and SOLIHULL CLUSTER

No specific commissioning issues were identified.

HEREFORDSHIRE HEALTH ECONOMY

WYE VALLEY NHS TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Wye Ward, Frome Ward, Accident & Emergency Department, Admissions Ward and Monnow Ward.

General Comments and Achievements

The Trust was in the process of significant organisational change. This was bringing several benefits, including a greater emphasis on prevention and pro-active interventions. The Trust had a good vision for developing its care of vulnerable adults and had a good strategy for this. Wards were well organised and the environment in the new building was particularly good.

Good Practice

1 Excellent support for nutrition was available. It was noticeable that at meal times all available staff stopped other activities and helped with nutrition without delay.

2 The safeguarding process was very well documented. Charts were clear about the actions to be taken in or out of hours and where information packs were available. Self-addressed envelopes were available to ensure that any concerns were communicated correctly and without delay. Staff who met the visiting team were all aware of the arrangements. An internal "case de-briefing" form had been introduced and this ensured feedback to ward areas.

Immediate Risks: None

Concerns

1 Staff were not accessing training in the Mental Capacity Act and Deprivation of Liberty Safeguards. This was being addressed and would have been of more serious a concern if the screening documentation had not included good prompts with advice on action to be taken.

2 The 'Multi-Agency Adult Safeguarding Policy' and 'Safeguarding Adults Framework' both provided guidance on adhering to the Mental Capacity Act and the Deprivation of Liberty. The' Multi-Agency Adult Safeguarding Policy' and competency framework had not yet been operationalised and did not cover challenging behaviour. The framework covered registered professionals but was not clear about the different disciplines which needed Mental Capacity Act training and the level or frequency with which this should occur. A training strategy included medical staff but there was no evidence of training or updates having taken place.

3 No guidelines on restraint and sedation were in use in the Trust.

Further Consideration

1 Reviewers were impressed with the good work on the implementation of the 'Multi-Agency Adult Safeguarding Policy' and 'Safeguarding Adults Framework'. It will be important to ensure that these are followed through to full implementation.

2 In addition to the patient feedback mechanisms already developed, it may be helpful to consider other mechanisms to gather views from 'difficult to reach' groups (for example, frail elderly people and victims of domestic violence).

3 The Trust Medical Director had lead responsibility for safeguarding and improving the care of vulnerable adults. It may be helpful to identify an additional medical 'champion' within the Trust to support the lead in raising awareness and ensuring training among medical staff.

4 A missing patient's policy covering the new organisation was not yet in place. The Trust was aware of this and was in process of reviewing its guidance.

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COMMISSIONING

No specific commissioning issues were identified.

WORCESTERSHIRE HEALTH ECONOMY

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

During this visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

Alexandra Hospital, Redditch: Emergency Department, Ward 9 Gynaecology, Ward 10 Surgery

Worcestershire Royal Hospital: Emergency Department, Falls Out-patient Department, Respiratory HDU and General Medicine

General Comments and Achievements

Much work had been undertaken across the Trust in raising awareness of caring for vulnerable adults. A range of nursing metrics was reported and audits had shown improvements in the delivery of some aspects of care across all hospital sites. Ten patients were spoken to by reviewers and all were appreciative of the care they had received. Staff were committed and knowledgeable. 'Comfort and Care' rounds had been implemented. A good range of information was available for patients and carers. An integrated discharge team provided support for people who were particularly vulnerable.

Good Practice

1 Acute hospital liaison services for people with learning disabilities worked very well.

2 A Carers Development Officer was developing work with carers on all wards and departments.

3 A dementia care mapping exercise had focussed on the patient experience as well as carers' experiences.

4 An alert in the hospital electronic record (Oasis) flagged admissions of people who may be vulnerable and ensured that the liaison teams were notified if the person was admitted.

5 Safeguarding posters were in available in four languages.

Immediate Risks: None

Concerns: None

Further Consideration

1 Cover for the Safeguarding Lead was through Matrons. It was not clear to reviewers that this arrangement would ensure robust cover, consistent understanding and implementation of policies, and effective follow-up of issues identified.

2 Additional training for PALS about safeguarding may be helpful in order to develop understanding of safeguarding issues and processes.

3 Reviewers were impressed that several improvements had been developed recently or were being planned. It will be important to ensure that these are followed through to full implementation. Examples included a

support worker for safeguarding, implementation of new policies, implementation of the Trust dementia strategy, Safeguarding Champions, closer working with social workers, patient information and discharge planning booklets.

4 Governance of the diagnostic process within Worcestershire Acute Hospitals NHS Trust may benefit from review. Reviewers were told that the acute hospital liaison service was undertaking assessments, discussing these with psychiatrists and then telling people their diagnosis while they were in hospital. It was not clear that patients following this pathway, especially those with a first presentation, had access to an appropriate range of assessment and diagnostic tests, and access to the support that was available in other settings.

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COMMISSIONING

NHS WORCESTERSHIRE

No specific commissioning issues were identified.

SOUTH STAFFORDSHIRE & SHROPSHIRE HEALTH ECONOMY

BURTON HOSPITALS NHS FOUNDATION TRUST

During this visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Emergency Department, Emergency Admissions Unit, Ward 7 Haematology / Oncology, Ward 12 Frail Elderly, Ward 20 Orthopaedics and Gynaecology.

General Comments and Achievements

Over the last year a lot of work had taken place to raise awareness of the care of vulnerable adults and to ensure that appropriate policies and procedures were in place. A comprehensive 'strategic direction' document had been developed. A range of nursing metrics had been piloted and were being implemented across general wards, with the aim of later implementation in more specialist areas such as the Emergency Department and Emergency Admissions Unit. A new lead for safeguarding and care of vulnerable adults had been appointed and a programme of training and awareness was beginning. The staff who met the reviewing team were pleased with the progress achieved and aware of the actions that were still needed. In the clinical areas visited patient care seemed well organised and staff were responding appropriately to the privacy and dignity needs of patients. The electronic care planning system enabled individual care planning and provided the opportunity for appropriate prompts for staff.

Work had been undertaken to improve the care of people with dementia including a pilot of dementia ward metrics, a 'This is Me' pilot on two wards and awareness training. The Trust had a Dementia Working Group which involved the Alzheimer's Society and had developed a Dementia Strategy.

Good Practice

1 Case studies were used extensively in safeguarding training. This helped staff to understand exactly what they had to do in particular circumstances.

2 Good links with PALS were in place and there was a shared understanding of who should be alerted about different issues and good information was available.

3 In the orthopaedic ward the nursing station had been moved into the bays which made patients more visible to the nursing staff. There was a good individualised, falls prevention risk-assessment chart. The number of falls had reduced since these changes had been made.

Immediate Risks: None

Concerns

1 **MCA and DoLS Training**

The number of staff who had received training in Deprivation of Liberty Safeguards was not clear but it appeared that most staff had not yet received this training. The time allocated to Mental Capacity Act and DoLS training was short and the clinical staff on the wards visited by reviewers had limited knowledge of these areas.

2 **Guidelines and Policies**

There were no guidelines on the action to take if patients went missing. The Safeguarding policy had limited information about MCA and DoLS. It referred to the MCA code of practice but this was not available on all the wards. The restraint policy was available but did not cover challenging behaviour or de-escalation of incidents. The rapid tranquillisation policy was in draft form and did not yet include the latest national recommendations on rapid tranquillisation.

Further Consideration

1 Safeguarding training was allocated 90 minutes in mandatory training. It may be helpful to review whether this is sufficient for staff with ward management responsibility.

2 FEAT (Frail Elderly Access Team) had recently started work with the aim of reducing admissions. Reviewers suggested that data collection on the impact of the team, including re-admissions, was needed to ensure the team having the expected impact and no unexpected consequences.

3 Some aspects of the Trust IT system may benefit from further consideration, including use of the 'person with learning disability trigger' (staff who met the reviewers thought this was available but could not find it when asked), access for agency staff, advanced care plans and the Liverpool care pathway.

4 Several improvements had been developed fairly recently or were being planned. It will be important to ensure that these are all followed through to full implementation. Examples included the FEAT, nursing metrics dashboard, Safeguarding Lead and Dementia Specialist Adviser and safeguarding.

5 The number of DoLS referrals appeared low and understanding of the reasons may be helpful in order to prioritise work in this area. It may be because staff do not yet have appropriate training and awareness (see above).

6 Reviewers did not meet any staff with specific responsibility for the care of people with learning disabilities. They were told that there had been a specific post in the past. The need for additional support in this area may benefit from further consideration although community support was available.

SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

During this visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

Princess Royal Hospital: Ward 10, Ward 14, MAU and Ward 15

Royal Shrewsbury Hospital: Ward 24, A/E Department, Ward 27 and Ward 28

General Comments and Achievements

Shrewsbury and Telford Hospital NHS Trust had been going though significant organisational change and several staff were still uncertain about their roles. Some senior management and senior nursing staff had left the Trust or had changed roles and there were still some gaps in the nursing management structure at the time of the visit.

Reviewers noted an increased focus on improving quality and there were lots of plans to improve the care of vulnerable adults. Progress included the development of nursing metrics and the introduction of a dementia working group. Weekly 'patient triangulation meetings' had started where complaints were reviewed and trends identified. There were plans to implement a patient experience group. Recruitment of an Associate Director for Patient Safety to take the lead for safeguarding and care of vulnerable adults across the Trust was taking place. Meanwhile, a safeguarding nurse was in post and temporarily supported by another senior nurse. Reviewers recognised the pressure placed on these two individuals by the large agenda of improving the care of vulnerable adults.

Good Practice

1 A joint appointment of a 'Dignity Professor' had been made with Staffordshire University. This post illustrated the Trust's commitment to linking the educational needs of staff and the care of patients across the Trust.

2 A joint approach to the delivery of MCA and DoLS training had been agreed with local authorities in Shropshire and Telford & Wrekin.

3 The in-patient unit for people with learning disabilities based on the Royal Shrewsbury Hospital site provided easy access to advice on the care of people with learning disabilities and their carers for staff at Royal Shrewsbury Hospital and for PALS. Relationships with this service were good.

Immediate Risks: None

Concerns

1 **Care of Vulnerable Adults**

Care of vulnerable adults within Shrewsbury and Telford Hospital NHS Trust was of serious concern for a combination of reasons:

a. **Care Planning**

Assessment of vulnerable adults was taking place but care planning following an assessment was not consistent or individualised, and the actions required were not robustly documented. 'Care rounds' had been implemented but recording and evaluation of these was variable. Reviewers saw several examples where it had been documented consistently that the patient was asleep during the day. It was not clear that alternative monitoring of patient comfort took place for these patients. Reviewers also observed one particularly vulnerable patient with no care plan addressing his specific needs and

two instances where the care being offered was sub-optimal - the comfort round recording had been completed but the patients were obviously distressed.

b. **MCA and DoLS Training**

The safeguarding training strategy and competence framework were not consistent as to whether training was included in the Trust induction or local induction. Reviewers met staff who were unclear what was included in the induction framework and who reported difficulty in accessing places on the integrated MCA and DoLS training.

c. **Nominated Lead**

There was no nominated lead for the care of vulnerable adults across the Trust. The Trust was aware of this and was considering appointing to a post within the new structure.

d. **Review and Learning**

Clinical areas did not have systems in place for review and learning from incidents, complaints and other feedback. There was a Trust-wide system but this did not link effectively with systems in individual clinical areas.

e. **Guidelines and Policies**

The Trust did not have a Restraint and Sedation Policy. The draft policy available to reviewers did not appear to comply with the latest guidance on chemical restraint for older people or second line drug management. There was no 'missing patients' policy and the safeguarding policy was due for review in 2009.

Further Consideration

1 Work with the Local Authority to ensure that there are sufficient training places for Trust staff training in MCA and DoLS may be helpful.

2 Little relevant patient information was available in the clinical areas reviewed. The Trust may wish to work with the newly formed Patient Involvement Group on ways of ensuring that those patients who are particularly vulnerable have timely access to appropriate information.

3 A medical lead with responsibility for safeguarding and improving the care of vulnerable adults within the Trust may help to support the Safeguarding Lead (when appointed) and raise awareness and training among medical staff.

4 It may be helpful to review the role of the Dignity Professor, especially in relation to dementia care, to ensure best use is being made of his skills.

5 The Trust was pursuing a range of initiatives to improve safeguarding and care of vulnerable adults. Reviewers suggested that further consideration should be given to the ways in which the Trust will assure itself that these have all been fully implemented and how their use and effectiveness will be evaluated.

ROBERT JONES AND AGNES HUNT HOSPITAL NHS FOUNDATION TRUST

During this visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in four clinical areas.

General Comments and Achievements

Staff at Robert Jones and Agnes Hunt NHS Foundation Trust had made significant efforts to improve the care of vulnerable people. Staff were welcoming and clinical areas appeared well-organised. Pathways for major and minor surgery were in place. There were good working relationships across the Trust and the Nursing Director and Deputy Director undertook regular clinical work. Standards of record-keeping were good and an IPAD 'information tracker' was planned which would give 'real time' patient experience feedback.

Good Practice

1 The Deprivation of Liberty Poster on the wards was very clear and easy to read.

2 In collaboration with service users the Trust had produced an easy read information booklet for people with learning disabilities who attended the Trust.

3 The Falls Assessment Intervention Tool was very good and had been extended to cover two hourly interactions with the patients and 'intentional rounds'. Since implementation there had been a 12% reduction in falls.

Immediate Risks: None

Concerns

1 **Safeguarding Training**

Although 40% of Trust staff had received safeguarding training during 2011 the staff who met reviewers were not clear about their role in relation to safeguarding. Reviewers considered that they would react appropriately to significant abuse but the Trust should assure itself that the expected safeguarding competences are being achieved through the training.

2 **Guidelines and Policies**

Several guidelines and polices were in draft form or not in place, including 'missing patients', restraint and sedation, and identification of vulnerable adults policies. The multi-agency Safeguarding Policy for Shropshire and Telford and Wrekin did not include Robert Jones and Agnes Hunt NHS Foundation Trust in its list of agreed organisations. This had been raised by the Trust but had not yet been amended. The policy was dated 2009 and, although subject to regular review, there was no indication of a formal review date.

Further Consideration

1 Several staff commented that the Trust was a 'low risk' organisation for safeguarding and improving the care of vulnerable adults because the organisation undertook mainly elective and rehabilitation work.

Raising awareness of the orthopaedic and rehabilitation aspects of safeguarding and the contribution of the Trust to the care of vulnerable adults may be helpful.

2 A medical lead with responsibility for safeguarding and improving the care of vulnerable adults within the Trust may help to support the Safeguarding Lead and raise awareness and training among medical staff.

3 The 'Violence and Aggression' Policy may benefit from review to include the management of behaviours that challenge.

4 Staff were clear about access to interpretation services for Welsh speakers but some staff were not clear about interpretation services for people speaking other languages and access to sign language interpreters for people with hearing problems.

5 Criteria for access to rehabilitation may benefit from review. It appeared that, due to the current screening process for surgery, people with dementia may be deemed ineligible for rehabilitation when, in practice, they may benefit.

6 Telephone advice was available from the Mytton Oak Learning Disabilities Team but this team was not able to visit patients within the Trust to advise on their care. Further consideration of the support needed by Trust patients with learning disabilities may be helpful.

MID STAFFORDSHIRE NHS FOUNDATION TRUST

During this visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas: Trauma and Orthopaedics, Acute Medical Unit, Surgical Assessment Unit, Outpatients and Ward 10 (Care of the elderly).

General Comments and Achievements

Mid Staffordshire NHS Foundation Trust had good awareness of the issues which needed to be addressed in relation to the care of vulnerable adults had had started addressing them. A lot of work was in progress and there was good commitment at all levels to seeing this through to full implementation. Discharge coordinators were working well to access potential delays and problems relating to discharges.

Several very good initiatives had started, including a pilot in two areas of 'I want great care' which involved 'real time' feedback for doctors about patient interactions. There were plans to extend this initiative to other areas of the Trust. 'In your shoes' events were bringing staff and patients together to discuss experiences of care. This provided staff with direct feedback on patient experiences. Reviewers were impressed by the amount of good practice which was being developed and by the determination to ensure that this was fully implemented at all levels.

Good Practice

1 The Dementia Team regularly visited wards to identify patients who may be suffering from dementia. A 'breakfast club' had been started on the care of the elderly ward by the dementia team to encourage social

interaction and improve nutrition and hydration for those with dementia**.** The dementia team also worked with allied health professionals to ensure the specific needs of people with dementia were addressed. They had been instrumental in achieving implementation across the Trust of 'About Me' which gave information on the individual and their likes and wishes.

2 A social worker attended the care of the elderly ward twice a day and was proactive in meeting the needs of those people who were particularly vulnerable.

3 Wards were visited regularly by PALS (three times a week) and by a Trust Executive Director (at least weekly). Executive Directors were informed daily of all incidents which occurred the previous day.

4 The Dewey 'wandering patient' risk assessment provided a comprehensive assessment of vulnerable adults Several policies, including the discharge policy and 'missing patients' policy were very clear and included robust checklists for staff to use.

5 Good guidance on one to one nursing observation was in use. This included a clear assessment process and outcomes.

Immediate Risks: None

Concerns

1 **MCA and DoLS Training**

Levels of staff training in MCA and DoLS were low (21 and 20 staff respectively had been training in 2010/11). As a result, staff in clinical areas were not clear about MCA and DoLS and their responsibilities in these two areas. The Trust was aware of this and had plans to implement additional training.

2 **Restraint and Sedation Policy**

The Trust did not have a Restraint and Sedation Policy.

Further Consideration

1 Links between the (external) Safeguarding Board and the (internal) Safeguarding Group may benefit from being formalised. The lead Director attended the external group and the Associate Director the internal group. Informal links were in place.

2 Some of the progress was not yet fully embedded in all the clinical areas visited and it will be important to ensure that full implementation is achieved. For example, patient information that had been developed was not always available, there was relatively little information available about safeguarding, and the discharge form was not always being used. It may also be helpful to check that the safeguarding training is achieving the expected training outcomes.

3 It may be possible to use existing staff and expertise to support the further development of the care of vulnerable adults. For example, reviewers met one staff nurse who had particular expertise in the care of people with learning disabilities. Similarly, the dementia team may be helpful in supporting MCA and DoLS

training. It may also be helpful to identify a consultant who would raise awareness among medical staff and ensure appropriate training is in place.

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COMMISSIONING

SHROPSHIRE COUNTY PCT and NHS TELFORD AND WREKIN

No specific commissioning issues were identified.

NHS SOUTH STAFFORDSHIRE

No specific commissioning issues were identified.

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NORTH STAFFORDSHIRE HEALTH ECONOMY

UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST

During the visit, reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

City General: Ward 122 (Frail Elderly Assessment Unit), Ward 123, Ward 108 and Ward 105(day case surgery)

Royal Infirmary: Accident and Emergency and Short Stay Unit Ward 19 (Fracture Neck of Femur Ward, Ward 1 (Neurology)

General Comments and Achievements

Staff were welcoming and passionate about what they were doing, and had pride in their work. Patients appeared well cared for in all the areas visited. The Trust was working well with community groups. For example, the Tissue Viability group was working with local community groups to help raise awareness. The Trust had held several health economy-wide user focus groups 'Big Conversations'. The Safeguarding Nurse had been in place for 12 months and was well known across all sites. Social Workers were based in the Trust which helped with the management of complex discharges. 'Clinical Champions' for vulnerable people had been implemented. A Quarterly safeguarding newsletter was produced. Discharge facilitators were present on the Frail Elderly Admissions Unit and were being introduced into wards. Good use was being made of volunteers. Matrons were giving good leadership. The Trust was going through an organisational change exercise and reviewers recognised that improving achievement of quality indicators was not easy in this climate.

Good Practice

1 The Frail Elderly Assessment Unit was an excellent concept and the unit was working well. Impressive data were available showing that patients were being actively moved out of the acute hospital. The ward environment was designed to focus on rehabilitation and recovery.

2 The 'Missing Patients' policy had clear flow charts covering different types of absences and actions required. The policy covered all patients within the Trust (i.e. not just in-patients).

3 The 'pressure area care' leaflet for patients was very good. It gave clear visible information about what to look out for and who to contact for further advice.

Immediate Risks: None

Concerns

1 Mental health liaison services were limited and, as a result, patients were often admitted while awaiting a mental health assessment. The response for adults aged less than 65 relied on the crisis team attending the acute hospital. Consideration was being given to the development of a mental health liaison service within the acute Trust.

Further Consideration

1 The discharge policy was under review and was not yet explicit about arrangements for discharging people who are particularly vulnerable.

2 Patient information was not easily accessible in the clinical areas visited and it was not clear how those who were not mobile would be able to access the information that was available.

3 A 'Wander guard' was in use but this was not reflected in appropriate Trust policies.

4 There were some examples of good learning and development at an individual service level but this was not evident in all of the clinical areas visited. Further development of local review and learning mechanisms may be helpful, including increasing feedback to staff from root cause analyses.

5 Several different working groups were looking at various care groups. It was not clear that membership and attendance was always appropriate for the work being undertaken and, as a result, expectations may not be achieved.

6 The key performance indicators that were being used were not all consistent and up to date in the areas viewed. It was not clear that staff understood which indicators were relevant to their work.

7 'Comfort rounds' were in place in four areas visited and appeared to be improving care. Evaluation and, if appropriate, implementation across other areas should be considered.

8 Policies were generally quite wordy and may benefit from review to ensure that staff are able to access the information quickly. Policies also often included cross-references to other policies (for example, the section about DoLS in nursing and medical guidelines referred staff to the consent policy) which may make it difficult for staff to understand what was required.

9 Based on the evidence available, medical staff training in safeguarding, MCA and DoLS did not appear to be being robustly implemented and monitored.

10 Competences were available for band 5 staff but not for all other staff. Further work on competences for all staff and mechanisms for ensuring these are achieved may be helpful.

11 Staff were not always clear how to access interpreters outside of normal working hours.

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COMMISSIONING

NHS Stoke and NHS North Staffordshire

No specific commissioning issues were identified.

SANDWELL & WOLVERHAMPTON HEALTH ECONOMY

THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

During the visit reviewers looked at Trust-wide guidelines and policies and tested their implementation in the following clinical areas:

Accident and Emergency Department, Emergency Admissions Unit, Ward D19 (Respiratory) and Ward D22 (Acute Care for People with Dementia)

General Comments and Achievements

Staff who met the reviewers were enthusiastic and committed to improving care of vulnerable adults. The Information Centre was a good resource and the Trust was actively working with PALS to improve the care provided. The Trust screen saver reminded staff of the importance of Deprivation of Liberty Safeguards and infection prevention. Technology was well-used, for example, '*Vital Pac'* was in place and linked to the Critical Care Outreach Team. Patients with dementia were 'flagged' on the Trust Patient Administration System, although this information was not linked to the A&E system. Work had taken place on improving the safety and effectiveness of discharge and preventing pressure ulcers. Further work on the discharge pathway was being piloted on one of the 'best practice' wards. Reporting arrangements through Key Performance Indicators were robust. The Trust also promoted 'Always Events' which encouraged staff understanding and awareness of the principles of good care. Implementation was driven through strong accountability arrangements. Further work was taking place looking at accessing GP registers of people with learning disabilities. Awareness of the needs of vulnerable adults was included on the Trust induction programme.

Good Practice

1 A dementia training programme provided basic awareness for appropriate staff about the dementia pathway.

2 A specific ward provided acute care for people with dementia. This ward was staffed to a higher level than other wards and staff had greater awareness of the needs of people with dementia and their carers. The environment on the ward was particularly designed around the needs of people with dementia. The Dementia Outreach Team actively supported the Emergency Admissions Unit and West Park Rehabilitation Hospital and advised community staff concerned about acute care for people with dementia.

3 'Safe Hands' technology was in use. Staff and patients were tagged and data will be analysed to look at the time spent with patients and to improve the care offered.

4 Good easy read information was available about PALS, spiritual support and making a complaint.

5 Good use was made of the 'skin bundle' for the prevention of hospital-acquired pressure ulcers. The system for monitoring and managing pressure ulcers included an initial root cause analysis within 48 hours, full root

cause analysis if required and a meeting with the Chief Nursing Officer within one week. As a result lessons and learning were implemented quickly.

6 Three 'best practice' wards were used to pilot rapid improvements which were then evaluated and, if effective, rolled out to other wards. This had led to demonstrable reductions in falls and pressure ulcers.

Immediate Risks: None

Concerns

1 **Mental Capacity Act and Deprivation of Liberty Safeguards Awareness**

The Mental Capacity Act was mentioned in the Trust Safeguarding Policy and covered in staff induction but several staff in clinical areas were not clear about the Mental Capacity Act and their responsibilities in relation to it. Nearly all staff had completed induction but few staff were trained to a higher level in relation to the Mental Capacity Act. Some staff were also unclear about Deprivation of Liberty Safeguards.

2 **Care Planning**

Care planning for adults who were particularly vulnerable was not consistently implemented and care plans were incomplete in many of the records reviewed on the visit.

3 **Liaison Service**

The only mental health liaison service available for adults aged under 65 was the Crisis Team. This team did respond to crises, especially in the Accident and Emergency Department, but was not able to support other patients with mental health needs in the acute Trust. More effective mental health liaison may help to reduce length of stay as well as improving the care for patients. See also Commissioning section of the report.

Further Consideration

1 Reviewers were told that staffing levels were higher on Ward D22 because of the complexity of the patients there but that patients with dementia who were elsewhere in the hospital generally caused more problems for staff. These patients could not be admitted to Ward D22 because a bed was not available. The outreach team assess 'outlying' patients and prioritise those needing admission to Ward D22 but patients in need of higher staffing levels and specialist expertise may still not be able to access this care quickly.

2 The care plan in use on the Ward D22 used 'care standards' which may not result in the most holistic, individualised plan for meeting the patients' needs. The 'About Me' document was in use but in its current format did not translate into an individual care plan. This may be addressed by the planned implementation of a dementia pathway.

3 It may be helpful to raise staff awareness about access to interpreter services. Some staff were unaware of the availability of and guidelines on use of these services. Staff awareness of the Restraint Policy could also be improved as some staff were unclear about restraint.

4 The Trust had several initiatives covering care planning, dignity, reducing risk, care of carers and prevention of harm. Some of these applied to community as well as hospital staff. It may be helpful to combine these into an overall strategy. This may help staff to understand the relationship of the different initiatives and their contribution to the welfare of patients.

5 Further work with PALS was being considered to improve the identification and engagement with vulnerable adults, with the aim of ensuring their voice was heard and that the needs of carers were addressed.

6 The 'best practice' wards were trying a new approach to discharge of vulnerable adults. Reviewers encouraged continuation of this work and, if appropriate, roll-out and inclusion in the Trust Discharge Policy.

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COMMISSIONING

Concern

1 The only mental health liaison service for adults aged under 65 available at the Royal Wolverhampton Hospitals NHS Trust was the Crisis Team. This team did respond to crises, especially in the Accident and Emergency Department, but was not able to support other patients with mental health needs in the Trust. More effective mental health liaison may help to reduce length of stay as well as improving the care for patients.

Further Consideration

1 Reviewers were told that delays in discharge from Ward D22 meant that appropriate patients could not always be transferred to the facility. Further joint work on discharge for this patient group may be helpful.

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APPENDIX 1 VISIT DATES

Health Economy	Visit dates
Dudley & Walsall	9th - 13th May 2011
Coventry & Warwickshire	14th - 24th June 2011
Birmingham & Solihull	5th - 14th July 2011
Herefordshire	13th - 15th September 2011
Worcestershire	20th - 23rd September 2011
South Staffordshire & Shropshire	4th - 13th October 2011
North Staffordshire	18th - 20th October 2011
Sandwell & Wolverhampton	16th - 20th January 2012