Leicester City Local Involvement Network
Enter and View Report
The Agnes Unit and Bradgate Unit
Leicestershire Partnership NHS Trust
7 January 2013
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The Agnes Unit Building
The Agnes Unit Therapy Unit Floor Plan
THE AGNES UNIT

Introduction

The Agnes Unit, which is based at Gorse Hill, was opened in 2008 and is a 20 bed inpatient service for adults with learning disabilities who require assessment, treatment or intensive support which cannot be provided in the community. This covers Leicester, Leicestershire and Rutland.

It is made up of five individual 'pods', each with four en-suite bedrooms, two bathrooms, lounge, dining room, kitchen and office, as well as a courtyard and access to a very large garden.

There are eight beds for patients who need longer term support and these individuals are either on a Forensic Care Pathway or have been repatriated to Leicester from out of county placements and the aim of the longer stay is to rehabilitate and support patients to be able to live safely in the community.

The other 8 are for patients who need shorter term admission for assessment and treatment. This is either planned or as an emergency, due to crisis situations that may arise in the community.

Enter and View

The Agnes Unit is built in a horseshoe shape with pods and courtyards on the side of the connecting corridors and the courtyards are accessible from the Pod units.

1. Entrance

We started at the entrance and went through two lots of locked doors. Nobody under the age of 18 is allowed to visit the units for their own safety. We went into the staff room with 6 comfortable chairs to talk to the two matrons Judith Pither and Jenny White. They answered all of our questions very thoroughly and did not mind our recording what they had to say. Finally, we were given a complete tour of the whole building. All of the building was painted in very soft colours with subtle furnishings and all door handles are very short so no damage can be caused.

2. Family Room and Visiting Rooms

These have soft chairs with plastic coverings and plenty of room. All visitors are given alarms, if visit is unaccompanied by staff, visitor has received induction and a risk assessment is completed. There are soft chairs are for both visitors’ and patients’ safety.

3. The Women’s Lounge

This is again subtly painted with soft chairs and a TV boxed into a unit. There are short door handles so they cannot be used for tying ligatures to. These are open at all times and accessible with a key fob.
4. **TV and Games Room**  
This room has a TV, a Wii and Xbox installed, soft chairs, short door handles and accessible for patients during the daytime.

5. **Faith Room**  
Once again this was subtly coloured with soft chairs, but there was also a font washing unit on one wall. This made it a multi faith room with everything well thought out for all faiths. This was locked at all times, except when being used.

6. **Leaf Chair Room**  
This is the room in which we sat with the matrons at the beginning of our visit. It had six petal-shaped chairs that were very heavy but normal chairs. This is mainly used for the staff and they could meet with people like us in private. This room was kept locked at all times with staff using their fobs to access the room.

7. **Nursing Office**  
An office that speaks for itself, again very subtly painted but private for the nursing staff’s use only, The staff all have a wrist fob which unlocks all the doors, otherwise the rooms are always locked.

8. **Arts and Crafts – Therapy Suite**  
This room is where all the arts and crafts take place. On the wall there was a drawing by Tom, one of the patients we spoke to, he allowed us to photograph it and it is a very good pencil sketch.
The patients also made two art designs which are hung on the wall in the corridor. These were made when someone from Voluntary Action Leicester came and did an art project with the patients – very interesting works of art.

9. Small Kitchen
Opposite the Arts and Crafts room was a small kitchen where we met three young patients, Tom, Sarah and Ruth and we were able to talk with them. They were sharing X-Box games and enjoying a coffee and a chat with some of the staff.

Tom said that he loved art, drawing, poetry and reading. He was very clever at art and liked using the computer and was allowed to laminate his drawings, acting, but he also liked looking at pictures and all forms of art.

Sarah said she liked dancing, Zumba and street dancing. She also helps set up the shop and sells snacks and toiletries along with a staff members to the other patients. She says she also enjoyed cooking and went to college one day a week to do English.

Ruth liked acting, enjoyed stroking the Golden Retriever when it came in with the “Pat the Dog” scheme they run. She also liked playing X-Box games and was very good at Scrabble.

10. The Dining Room
The Dining Room was a lovely light room and used for the meals that patients heat up in the small kitchen in the Therapy Suite.
11. The Sensory Room
This was again furnished with soft seats and a soft bed. In one corner was a tube light that looked like a fish tank design that kept changing colours and was very relaxing. There were some small lights switched on near the bed that twinkled and sparkled, these were like Christmas tree lights. The curtains were closed, but it was a very calming room for the patients to use should they get upset and need to calm themselves down.

12. The Gym
This was a lovely large room with a wooden floor and a basketball ring at one end of the room – the views of the entire garden were amazing.

There was also a tennis court outside for patients to use, picnic tables for in the Summer and all was very safely fenced in for the patients’ own protection. They were always accompanied by staff when outside. They also use the gym for parties at Diwali and Christmas and at other times.

13. The Kitchen
This was quite a large kitchen and one end had lower work surfaces for people in wheelchairs to use. The patients learnt how to do cooking here. They could also re-heat chilled meals in the microwave, which they could buy and bring in.

Cooked food from home was not allowed to be brought in because of health and safety and infection control. Patients could buy ready meals and bring these in to heat in the microwave. There were no metal utensils or cutlery, everything was plastic.

14. The Laundry
Patients can use the laundry if they wish to and it is very well equipped. As usual though, they will mostly be accompanied by at all times if they are youngsters.

15. Computer and Quiet Room
This is where patients can use the computer, or if they want a quiet space to be on their own, or wish to talk to a friend. They can also use the X-Box to play games.

16. Meeting Rooms
This is where patients, families and medics and staff meet to discuss a patient’s discharge and treatment plan. Patients are consulted about their treatment and what is happening with them at all times and they can either choose to have their family present or not.
17. **Courtyards**
These are lovely areas that patients can access at times of the day. They are enclosed by the buildings, so patients can be seen at all times whilst using the courtyards.

18. **The Pods**
These are locked areas where the patients’ bedrooms are. They all have their own swipe card to access their room. They are single rooms with en-suite bathrooms or wet room. They are subtly painted, consist of a bed a wardrobe and a shelving unit, a TV and a dressing table.

Each Pod consists of either 4 bedrooms and there are also separate toilets. There are always two members of staff working in the Pods, sometimes three or 4 and at night time two staff on duty in each Pod.

Each Pod’s bedroom area can be separated by single sex areas and can be locked off at any time with male and female areas kept separate. The middle bit has a nurses’ room where medication is locked away.

In each bedroom the doors can be locked, open or shut as the patient would like. Small handles to stop patients tying things on to them. The nurses’ room does have ligature cutters if necessary to be used.

There is access from each Pod to the courtyard and all bedrooms have a garden view.

19. **Clinical Room**
This room contains oxygen and a defibrillator machine.
20. **Extra Care Suite**
Again, all soft furnishings, a window and a very small courtyard for this room. Attached to this room is the Seclusion Room.

21. **Seclusion Room**
This is a smallish room with a soft sponge bed, a window, a clock on the wall, CCTV to watch the patients, a small mirror on the ceiling and a small glass petition in the door where patients can be observed and can also talk to the member of staff who is always on duty when this room is occupied.

Patients will spend time in the room whilst they calm down. A doctor had to check the patient after two hours to see they are alright. Most patients calm down in less than two hours, or just over two hours. They will then be let out into the Extra Care Suite until they are ready to go back to their room.

The room used to be used 3 or 4 times a day three years ago, but now with more staff on duty, has only been used 3 or 4 times in the last five months. They also have soft clothing should they need the patient to stop self-harming.

The unit is totally equipped for disabled patients and wheelchair patients with the size of the doors, dropped work surfaces and larger bedroom and bathrooms for disabled patients.

22. **Record System**
Following the most recent CQC Report on the Agnes Unit and points relating to their record keeping, the LINk were keen to understand what remedial work had been taken and there appears to have been a massive overhaul:

- Both paper and electronic records are kept
- The Trust document was changed and improved
- The Service document also has to be used
- Electronic forms now available
- Admission Packs are available and given to patients on arrival. We were given copies of all the documents and leaflets given to patients
- All notes now have numbers and kept updated
- When a patient is discharged, their notes are transferred to storage
- If they are re-admitted they have a new set of notes that upon discharges will be put with all the previous notes.
- When patients are discharged they are still supported at home or in a safe house

As they have a protected meal time, we were unable to see any more of the unit. We were told that they eat with plastic cutlery, so that no one can harm themselves or others.
We carried out a Question and Answer session with two staff members, Judith Pither and Jenny White and asked them how old the building was. They said it was built about 4 years ago and both had been there for at least 2 years. We then asked them the following questions?

Q1. **Do you have an Admission Pack?**
Everyone who is admitted receives an Admission Pack and also a brochure and these are given to them on arrival, together with all the relevant paperwork. Everyone is over 18 years old and at this point they also talk about how they might be discharged and what package might be put into place.

Q2. **What facilities do you have in the way of secured beds?**
It was confirmed that there are 8 locked beds for rehab which cater for offenders from the courts that are sent by the courts for treatment under Section 31-41 for medium to low secure. If they have received a custodial sentence they are expected to be here for a period of time (12-18 months) particularly where drugs or alcohol are involved and sent here for treatment through which they have to achieve something.

They were asked if they were in some ways a “Halfway House” and they said yes they were and worked with social workers to offer support and get the patients back into the community.

Q3. **Do you have facilities for people with disabilities?**
They confirmed that they don’t have that many patients who actually come with disabilities, but all the facilities in the building had been designed to meet the needs of people with disabilities. All bedrooms were en-suite with bathrooms and toilets some of which are specifically designed so they can be used by individuals with disabilities and also sensory disabilities.

Q4. **What Assessment and Treatment Beds do you have?**
We were told there were 12 beds in total but only 8 were currently in use and take people in from Leicester, Leicestershire and Rutland who can’t live in the community and come here for assessment and treatment. Some have greater mental problems which mean they cannot live in the community and some go into residential care. Everyone is assessed and individual packages designed to suit each patient.

For people with sensory disabilities there is a therapist on site with information signage. There is an occupation therapist who will assess people’s needs. There are lots of activities for patients with Sensory Room, Activity Suite, a gym, gardening and all facilities you can imagine.
Q5. **Do you have local involvement with Voluntary Groups?**
In the past Voluntary Action Leicestershire (VAL) comes in to work on Art projects and there is also an Art group.

Q6. **How do you support a person who is discharged back into the Community?**
When a person is discharged into the community they look at what the patients needs are in that community and this involves patients and other services. They continually work to ensure everything is in place and both patients and their families are involved in meetings with medical staff.
When they leave some live alone without support, some live with support and some have to have 24/7 support.

Q7. **If the person is not happy to go, what do you do next?**
We were told that none of their patients have this problem as there are reviews and discussions with the patients and they consider every aspect of a patient’s lifestyle which is very important.

Q8. **What are your Constraints—Financial or other?**
We were told that there were more constraints mainly because of money and a large turnover of staff and found it difficult to keep staff. The biggest problem is making services available in the community which causes difficulties and local authorities put money in place for care, but this could cause further difficulties.

Q9. **Record keeping**
We were informed that this has been massively overhauled and a new index has been developed that is both paper and electronic. This was done using the Trust document and Service document. Electronic forms are also available and also Admission Packs. They confirmed that record-keeping is regularly audited.

Q10. **Have you anything in place for African patients that have just come over?**
We were advised that it is more likely that Asian patients come here and are not allowed to bring their food, but can use the prayer room.

Q11. **Are there a large number of visitors?**
They do limit the number of visitors which all have to be aged 18 or over and no staff member is under 18 either. They said that people are honest about things and the medics and community teams outside in the community are all involved alongside the families who are open and honest about the patients and youngsters who visit the unit are also involved.
Q12. **Question about Food**  
All the food is chilled food and there is a menu which is fixed one week ahead. They cater for diets for all races including Halal, Gluton-free, diabetes, etc.

Q13. **RestRAINT methods used and how often?**  
The confirmed that restraints are not used so often and have an alarm system. Restraints used to be used 3 to 4 times a day 3 years ago and the alarm system may go off 2 or 3 times a week rather than every day.  
There is also much less use of the Seclusion Room which had been used regularly but has only been used 3-4 times in the last 5 months. It is used less because there are more staff who are also better trained.

Q14. **How do you use the Seclusion or Extra Care Suite?**  
The Seclusion suite has soft coloured walls and soft furniture and used for distressed patients and is designed to they cannot hurt themselves. The Seclusion Policy is to make sure of the patient’s safety and they have to come out as soon as possible?  

The Seclusion Room is now used for shorter times to calm the patient down and talk to the staff. A doctor has to attend every 2 hours by law.

Q15. **How do you prevent self harming?**  
The whole building is ligature safe. People are assessed and they check on patients every 15 minutes, but this is done more often if observation levels are higher.. On some occasions patients have had to be dressed in special garments to maintain dignity. There are stop and search policy and procedures in place. All cutlery used is mainly plastic and the staff are always very aware of what is going on and if anyone is likely to try and harm themselves.

Q16. **How much monitoring is done?**  
All risk assessments and care plans are discussed at every handover and Observation levels are also discussed. There are alert cards available. Staff safety is taken very seriously and constantly assessed with staff now having a safety alarm.

Q17. **Do you employ any disabled staff?**  
Staffs with various disabilities are employed and staff with certain disabilities are assessed by Occupational Health in relation to their ability to work in certain areas and also employ people in administrative roles.
Summary

Our reason for the visit was to check the Patient Pathway through the whole of the unit.

The building was purpose-built for patients with learning disabilities only four years ago so everything has been built to a very high specification and included all the latest aids to treatment and so patients are unable to cause harm to themselves or other patients or staff using the facility.

We were asked to check the way treatments were recorded, as this had been somewhat confusing and not done electronically before.

A great deal has been done to improve this with an Admission Pack, a leaflet explaining why the NHS needs to collect information about patients, an information leaflet about Advocate now being provided to each patient on admission.

They also plan for the patient’s discharge starting on the day that they admitted, working alongside and with the patients and their families to help them settle back into the community with plenty of support when they are discharged.

If it is found that this facility is not suitable for a patient’s need, another unit will be found to accommodate the patient’s needs. Everything can be done will be done to help the patient recover and resume their place in the community.

These documents were given to us:-

1. Brochures
2. Complaints
3. Healthcare
4. Advocate leaflet – everyone referred to an Advocate
5. Safeguarding
6. Food and drink
LANES TEST

The decision to admit will be made on an individual patient basis and will be a clinical decision based on patient need, taking into account service implications.

During working hours
The LANES Test should be completed by Inpatient Consultant Psychiatrist and the Lead Nurse of the Agnes Unit.

Outside working hours
The LANES Test should be completed by the Consultant Psychiatrist on-call in discussion with the Shift Co-ordinator of the Agnes Unit.

L Legal Test
Consider the legal implications when admitting (Mental Health Act and Mental Capacity Act legislation).

A Availability Test
Consider the availability of a bed on the Agnes Unit and in other divisions of LPT including Adult Mental Health / Short Breaks.

N Necessity
Consider if it is necessary to admit (Risks, best interests of the patient)

E Eligibility
Does the patient have moderate to severe LD?
Are they 18 years old or over?
Do they have issues / problems / needs relating to Mental Health, ASD, Dementia, Behaviour or Forensic history?

S Suitability
Consider patient mix on Pods, risks, staffing, environmental factors and gender when deciding to admit patient.
## ADMISSION

<table>
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<th>RESPONSIBLE PROFESSIONAL</th>
<th>FORMS</th>
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| 1 Admission clerking to include  
  a. Psychiatric history.  
  b. Physical examination including screening for VTE, Q-Risks, Diabetic foot.  
  c. Investigations and  
  d. Management plan.  
  2 E-prescribe (check MARR sheet and double check with qualified nurse) case notes, discuss with GP if necessary  
  3 Check the risk screening done by nurse and agree the level of observation and admission to appropriate Pod.  
  4 Review Admission legal status – Informal / MHA Section / DoLs.  
  5 Complete medical section of Admission Checklist  
  If admitted out of working hours, written handover of incomplete tasks to the Agnes Unit Doctor the next working day.  
  6 Admission clerking (see admission checklist).  
  7 Consider and discuss the suitable Pod / Room with shift leader and admitting psychiatrist.  
  8 Collect background information (CPA interagency assessment & Morgan risk assessment).  
  9 Check if nearest relative informed.  
  10 Agree level of observation with doctor. | Psychiatrist | Admission clerking  
  VTE screening  
  Diabetic foot screening  
  Q-Risks screening  
  Metabolic screening  
  Admission Checklist |
| 11 Welcome the patient and orientate to the Pod.  
  12 Provide and explain Agnes Unit brochure.  
  13 Check the prescription (check it against MARR sheet) and double check.  
  14 Check if they have had a recent annual health check.  
  15 Complete the GP registration process.  
  16 Collect patients particulars e.g. height, weight, eye colour etc (police ID form)  
  17 Obtain consent to patient having photograph taken.  
  18 Update MARACIS information.  
  19 If admitted out of working hours, to inform CLDT professionals of admission.  
  20 To create medical, nursing and allied professional notes and patient stickers.  
  21 To gather relevant information from Secure and Share.  
  22 To send invites for further meetings to relevant parties after discussion with Pathway Co-ordinator. | Admin | Admission Checklist  
  CPA Interagency assessment with Morgan  
  CPA Multi Agency Assessment  
  Agnes Unit Brochure  
  Agnes Unit Brochure  
  GP registration  
  Police ID info  
  Patient particulars ID  
  Consent form |  
  3D Consent Form  
  Admission Checklist  
  Admission notification Letter  
  Admission Letter |
The Bradgate Unit

Introduction

The Enter and View carried out on 7 December 2013 was a return visit to look at Ashby Ward and the Beaumont Ward and were met by two senior members of staff.

Ashby Ward

We were first taken to Ashby Ward which is one of the older wards and holds 20 patients. On our way we passed a garden area with a greenhouse and potting sheds that we were told patients could use and also, a Linnaeus Nursery where patients can go to grow plants that then take to market to sell.

Ashby Ward – Acute Ward

We were introduced to the Matron who answered all of our questions.

Q1. Have you had any language problems in the ward?
We were told that they do sometimes have problems, but they are able to call on a Translation Service. The main problems are with some of the Polish Community but they have not had many Somali patients on the ward.

Q2. What activities do you provide?
The patients seem to like coffee mornings, competitions, Wii Games, films, photography, Arts and Crafts, walks and shopping. Their main activity was coffee mornings where they could all sit together and chat with each other.

As with all the wards, the staff work with the patients from admission, preparing them for when they are discharged back into the community. They find out what is available in the area around where the patient normally lives and try to get as much information for the patients as they can on what is available for them to get involved with when they are discharged.

Q3. Do you cater for patients’ spiritual and cultural needs?
There is a multi-faith chaplaincy team available and multi-faith services held for patients to attend. They carried out a survey to establish people’s experiences of using the chaplaincy. The survey was live at the time, but did say they would let LINk have a copy if one was required.
Q4. **Do you tell patients about Advocacy?**
All patients are made aware of all the main Advocacy options.

Q5. **Do you have any voluntary groups who come to the ward?**
They said they do have volunteers who come to the wards to offer massages and to pamper the patients which act as relaxation.

They are setting up a Recovery College, starting in April. Nicky Mawer is doing it and helps supporting the patients in local areas make better use of it. They are advertising for someone to do therapeutic treatments and interviewing on 23 and 24 January to get someone who will give the patients dedicated support.

With so many different catchment areas they have patients come to the Bradgate Unit from all over the country. There needs to be good communications with groups such as Care Action and Labelled who work with and help people who have become new carers for a member of their family and also help patients to find activities in the areas they come from, so that they can become involved in their local community when discharged..

Q6. **How has the use of restraints changed?**
The unit has changed a great deal as the level of patients’ illness is a lot higher now in the wards. They do tend to use seclusion more, but this depends on the behaviour of the patient.

Q7. **What improvements have been made to stop people absconding?**
Patients, who are there on a voluntary basis, are checked up on by Matron every half hour. There are boards with patients’ names on, so they can check where the patients should be and what they should be doing.

Communications are very important; who what, when and where. Training and education is offered and they work more closely with the Police. The main aim is to keep people happy. There is a handover protocol and spot checks by the Head of Access for Mental Health.

Q8. **If any members of staff think something is wrong, is there somewhere they can go to ‘air their concerns’?**
They do have complaints from the staff but don’t want to stop them being able to express their concerns. The formal procedure is to look into complaints and a Disciplinary Policy has been improved.

Nine workshops have taken place which all staff have been to. It proved to be really successful and they were able to say what they thought about what was happening on the ward.
A Professional Practice Plan is in place telling the staff about clinical risks, ward environment and to whom staff will be able to complain about without feeling they will be picked on for airing their concerns.

Q9. **A Doctor says that a patient can be discharged but the patients do not feel ready. How do you deal with this?**

They employ a Discharge Facilitator who has just started working on the wards. They start working with patients when they are admitted, on their discharge and find out what the patients need and what their concerns about being discharged are. There is also a Crisis Team that helps explain what will happen when they leave.

Patients normally stay 3-4 weeks and a process is put in place within 3 days ready for discharge. There is a dedicated consultant for each ward, which means the majority of patients on the ward will have the same consultant. This enables a good relationship to build up between the Matron and the Consultant and the Consultant is totally focused on his/her own patients on the ward. 17 patients out of 20 belong to one consultant.

There is no limit for the length of time a patient may stay on the ward and depends on the patient’s needs. Sometimes it is no longer the right place as patients can become institutionalised within 2 weeks. Some patients with no homes feel safer in the ward environment, but they are told this cannot be the answer.

The ward has an Employment Clinic every week and social services come in to discuss Personal Budgets. There is follow-up when they go home and they have support workers helping them all the way.

Q10. **What facilities are there for patients with disabilities?**

Every patient has a separate bedroom, but some wards are better equipped for patients with disabilities. An example was given around Sensory Disability where a patient who was blind had to have nursing support all the time on the ward because they do not have railing to hold onto that would be a ligature danger for other patients.

If they had a deaf patient, they would look for different accommodation and also arrange for someone to do sign language.

Patients with depression can become institutionalised very quickly, but alcohol and drugs, which can generate bad behaviour, are not acceptable on the ward.
Summary

Once we had asked our questions we thought we would be allowed to look around the ward as we had done at the Agnes Unit but at no time was this suggested to us, or were we asked if we would like to look around, so when we had finished our questions we left the ward and were taken to the newer Beaumont Ward where we were given a conducted tour around the ward by the Matron El.

All wards served chilled food that is reheated, snacks, fruit, sandwiches and tea and coffee are available to all patients.

The questions we asked related to Ashby Ward, but may apply to all the other wards in the unit and the booklet provided on Ashby Ward is similar to those provided on other wards.

Beaumont Ward - Acute Ward

This ward has only been open for a year, so the bedrooms were very like the bedrooms at the Agnes Unit. They are building a new ward and are taking the features of all the new wards and putting them into the new ward.

Beaumont is a mixed sex ward with one male corridor and one female. Four rooms at the bottom are larger, 2 rooms being for disabled patients and the other two being larger so that could be male or female accommodation. Meals are chilled and re-heated on all wards with snack, fruits sandwiches, coffee and tea available on all the wards.

Matron Rachael El met us and showed us around. All the bedrooms are en-suite and single patient rooms. As you enter the ward there is a family room decorated in subtle colours, a meeting room is next door, an interview room (which was being used when we were there) a clinical room for patients to see the nurse and separate toilets available. There is also a TV lounge.

All patients have a swipe card to get into their rooms, but also a kitchen is available for patients to make drinks, but they have to use their swipe card to use the kitchen. This helps the staff to assess patients and how they are coping, without the patient being aware that they are being assessed. There is also a stimulus room with a large bean bag in it.

Patients can start looking at their food needs and there is a Regan kitchen for the staff and large dining areas. There is a large area in the middle of the ward for men
only and there is a disabled toilet as well as separate toilets. Patients are allowed to go to the shops and buy things if they choose to.

All patients have their own en-suite rooms decorated in soft coloured paintwork. Privacy and dignity are preserved at all times and observations take place every hour on this ward. There are two large disabled rooms and very large en-suite bathrooms with wet rooms. An electric wheelchair can swing around very easily. All bedrooms have a bed, dressing table, chair and shelved area like those in the Agnes Unit and all of the men’s rooms are painted in soft blue colours.

The four large rooms at the bottom of the ward can be either male or female. The female bedroom corridor is the same as the male corridor and there is a large lounge area for the women, as well as the men’s area. The bedrooms are painted pink in the women’s corridor.

There is a large fenced in garden available to everyone and patients can work in the garden if they wish but they are looking to have a gardener to tidy it up.

There is a board with all the religious staff named on it. There is also a board with all the nursing staff and consultants on. There is also a board advertising Advocacy.

All the wards will soon be together when the new ward opens at the end of March. In all there are 7 wards plus one psychiatric ward. The numbers of patients on each ward are as follows:

<table>
<thead>
<tr>
<th>Ward</th>
<th>Number of Patients</th>
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<tr>
<td>Ashby Ward</td>
<td>20 patients</td>
</tr>
<tr>
<td>Heather Ward</td>
<td>18 patients</td>
</tr>
<tr>
<td>Kirby Ward</td>
<td>23 patients</td>
</tr>
<tr>
<td>Bosworth Ward</td>
<td>20 patients + 1 extra</td>
</tr>
<tr>
<td>Thornton Ward</td>
<td>24 patients</td>
</tr>
<tr>
<td>Beaumont Ward</td>
<td>22 patients</td>
</tr>
<tr>
<td>Aston Ward</td>
<td>3 mother and baby rooms</td>
</tr>
<tr>
<td></td>
<td>7 detox rooms</td>
</tr>
<tr>
<td></td>
<td>13 general rooms</td>
</tr>
<tr>
<td>Belvoir Ward</td>
<td>10 Patients (Psychiatric Ward)</td>
</tr>
</tbody>
</table>

Total number of patients at the Bradgate Unit = 158

All the wards are Acute Wards but the patients are allowed to go to the shops and by things if they choose to.
Conclusions and Recommendations

We were not allowed to go further than the Sister’s office and certainly were not asked if we would like to speak to any of the patients, as we were on the other wards. It was a very stand-offish affair. Michael Gilhooley had his chair, but I had to stand 8 feet inside the ward outside the Sister’s office to do the notes. At no time were we allowed to look around the ward or allowed to speak to any of the patients.

On neither of the Bradgate Unit wards were we shown the Seclusion Room, for whatever reason we don’t know. They did say they used the Seclusion Room every day and sometimes several times a day, but as we were not shown it, we don’t know what or whether it conformed to the same standard as the Agnes Unit. We were allowed to speak to two patients on the second of the Bradgate Unit wards, but only as we looked at their rooms and not to really ask them any questions, apart from if they were happy with the rooms. It was a very quick tour around they seemed as if they wanted us to leave, but they did say as we were leaving, “if we had any questions we could write and ask them”, but that was when we were about to leave.

One recommendation we would make is that on all the wards they need to have more activities arranged to occupy patients both at the Bradgate Unit and Agnes Unit. The patients can do many activities if there is someone employed to help arrange these.

At the Agnes Unit more drawing facilities and art projects would allow the youngsters to get more involved and that can be born out by the pictures of the art project that we saw. They also like to listen to poetry and enjoy English classes. They are in this unit for 18 months to 2 years, so need much more stimulation, although they can play their computer games, but doing things in a group would mean that they could communicate amongst themselves a great deal more. We know the patients at the Bradgate Unit only stay for a short time, but they still need to be occupied more than just having coffee mornings, it is too easy.

They tend to rely on volunteers from Voluntary Action Leicestershire (VA) to do the art work and then they only come for two weeks at a time, once a year.

It is also difficult for them to keep staff in the Agnes Unit, as being a locked unit is not always an environment in which people want to work, so the staff turnover is constant, but the matrons seem to stay longer.
References to documents

Agnes Unit Brochure
http://www.leicspart.nhs.uk/Library/AgnesUnitBrochureOctober2011.pdf

Ashby Ward Information
http://www.leicspart.nhs.uk/Library/YourIntroductiontoAshbyWard.pdf

Beaumont Ward Information

Bradgate Unit Catering – the leaflet also applies to Agnes Unit Catering
http://www.leicspart.nhs.uk/UserPage.aspx?PageId=9420850e2db34cd3b061c3cf826b7f97

Mental Health Care Pathways
http://www.leicspart.nhs.uk/_InformationLibrary-Pathwaysofcare-MentalHealthPathways.aspx

Your Healthcare Record (Easy Read version)
http://www.leicspart.nhs.uk/Library/212EasyreadYourHealthcareRecord.pdf

Further information is available on the Leicestershire Partnership NHS Trust Website
http://www.leicspart.nhs.uk/