Good

Greater Manchester West Mental Health NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXV13	Recovery First	Ash Ward, Cedar Ward, Dove Ward, Beech Ward (Beech Ward not open yet)	WA8 0GT
RXVA9	Bramley Street	Bramley Street	M7 1YE
RXV17	Meadowbrook Unit	Copeland Ward	M6 8HG
RXV00	Greater Manchester West Mental Health NHS Foundation Trust Headquarters	John Denmark Unit	M25 3BL

This report describes our judgement of the quality of care provided within this core service by Greater Manchester West Mental Health NHS Foundation Trust. Where relevant we provide detail of each location or area of service visited.

Summary of findings

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Greater Manchester West Mental Health NHS Foundation Trust and these are brought together to inform our overall judgement of Greater Manchester West Mental Health NHS Foundation Trust.

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Summary of findings

Overall summary

We rated long stay/rehabilitation mental health wards for working age adults as GOOD because:

- The wards provided a safe environment. The layout across the service allowed for monitoring of patients, with good use of mirrors for blind spots on Ash and Dove wards. All wards complied with the requirements of same sex accommodation guidance.There were sufficient staff deployed to meet the needs of the patients, with on-going recruitment in place to meet shortfalls in staffing numbers. There was access to personal alarms and call buttons in rooms across the service. Risk assessments were completed and up to date.
- Thirty nine care records were reviewed across the service, all of a high standard, patient focussed, and comprehensive.Physical examinations were undertaken and effectively monitored. Multi disciplinary team meetings were well attended with the patient being central to all discussion. Mental Health Act records were in place and in order.
- We saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional. We attended a care programme approach meeting in which a patient had a list of considerations for approval to allow acceptance of a job offer, and the team gave full consideration and agreement to the request. There was evidence of family and carer involvement in the care of patients. Patients stated they were happy with the service.
- In the six months prior to inspection there had been no delayed discharges, referral to assessment / referral to treatment delays or readmissions for this core service. Facilities such as specific telephone rooms were available for private telephone calls. There was access to well-maintained outside areas. Patients were actively encouraged to find voluntary or paid work. Activities were available across the service, including weekend activities. There was access to information about services, with consideration for culture and language. Complaints were dealt with and results fed back to both patients and staff.
- Staff knew the values of the trust. Senior management visited the service regularly. Key performance indicators were used across the service to monitor and improve the service. Staff could raise issues confidently and could give input into service development. The service had actively embraced duty of candour, with the use of staff questionnaires to enhance understanding.

However:

- mandatory training for the service was not being monitored or audited effectively, leading to confusion over figures. The mandatory training figures for Recovery First were well monitored and showed a compliance rate of 83%, with the other service locations averaging compliance at 78%.
- Mental Health Act and Mental Capacity Act training access was not very effective, but the trust had identified this and was working towards a solution.
- Immediate Life Support training was not given enough prominence in training schedules, and needed to be addressed.

Summary of findings

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

Are services safe?

Good

We rated safe as GOOD because:

- the ward layout across the service allowed for monitoring of patients, with good use of mirrors for blind spots on Ash and Dove wards.
- ligature points were noted in environmental risk plans and mitigated to good effect for patient safety.
- Copeland Ward and the John Denmark Unit both complied with guidance on the provision of same-sex accommodation, with segregated sleeping areas and separate lounges for men and women. Toilet arrangements also met the required standard.
- nursing rotas indicated that the minimum number of nurses required was met, and that was amended dependent upon the needs of the ward.
- blanket restrictions were only used when justified. On the John Denmark Unit, consideration was given to aspects of character deemed particular to deaf people: it was believed that access to a particular item must be open to all, or not at all - this was an aspect of deaf society that was given consideration.
- staff had access to personal alarms and were wearing them. Across the service, there was good access to call buttons in rooms. At Bramley Street, staff were noted not to carry personal alarms, but the rooms in which they interviewed patients had call buttons.

However,

- mandatory training for the service was not being audited effectively, leading to confusion over figures. The mandatory training figures for Recovery First were well monitored and showed a compliance rate of 83%, with the other service locations averaging compliance at 78%.

Are services effective?

Good

- **We rated effective as GOOD because:**
- thirty nine care records were reviewed across the service. They were of a high standard and comprehensive
- physical examinations were undertaken and monitored using the physical health information technology system
- pharmacy procedures were reviewed and found to be operating within NICE guidance and using best practice; medication cards were checked and found to be in order

Summary of findings

- the trust undertook a variety of local/national audits, and the staff of the service were involved in a prescription card audit, infection prevention annual audit, hand washing techniques audit, and a safe staffing audit
- psychologist input was available and utilised across the service. John Denmark Unit used a broad scope of psychological therapies relating to the treatment of deaf patients with mental health problems, including speech and language therapies and family therapies
- during MDT meetings we saw effective working relationships with care coordinators that reflected a holistic working approach
- we attended two multi-disciplinary team meetings; both displayed a high standard of interaction both with staff and service users
- Mental Health Act administrators were employed across the service, ensuring a central contact point for information, advice, and the audit of paperwork relating to the Mental Health Act. Mental health administration was good across the service
- a full Mental Health Act review was conducted on Ash ward at Recovery First as part of the inspection process. The review noted only minor areas for improvement.
- staff showed a good working knowledge of the Mental Capacity Act (MCA) and capacity principles. Care records across the service indicated the MCA was considered and used appropriately
- Deprivation of Liberty Safeguards (DOLs) were applied when appropriate. In the six months prior to inspection, the John Denmark Unit had successfully applied for three DOLs.

However

- Mental Health Act and Mental Capacity Act training access was not very effective, but the trust had identified this and was working towards a solution.

Are services caring?

Good

We rated caring as GOOD because:

- across the service, we spoke with 22 patients. These patients had diagnoses complicated by hearing impairment and other physical ailments
- we saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional. On

Summary of findings

Ash ward, we saw a person with autism who was clearly unhappy about something, and staff immediately and calmly dealt with the situation in a manner that allowed the patient to de-escalate and continue safely with his activity

- the 39 care records reviewed across the service showed that the individual needs of patients were clearly considered and included in care plans
- the process to welcome and orient patients to the service was thoughtful and thorough. At Ash ward, a pre-assessment was given to each patient, with a risk formulation meeting, and a visit to the ward prior to admission. A 20-page brochure was also given to the patient, fully explaining the expectations of the patient and the ward
- we attended one care programmed approach (CPA) meeting in which the patient entered with a list of considerations. The team discussed the merits of each consideration with the patient, and an agreement was reached that suited all
- the advocacy service at Bramley Street was very complimentary about the manner in which their service was promoted to patients
- on John Denmark Unit, 'all about me' files were maintained and we saw copies of advanced statements within those files
- Staff involved familes in in the care of patients. On John Denmark Unit, video conference facilities were in place so that patients from Scotland could communicate with family, and involve them in their care.

Are services responsive to people's needs?

Good

We rated responsive as GOOD because:

- there were no out of area placements attributed to the service in the six months prior to the inspection
- at Recovery First site, no leave beds were filled; they remained open for the return of the patient
- movement between wards was usually due to a step-down process: patients on Ash ward were moved to Dove ward as their presentation and mental health status improved. Movement from a step-down ward to the original ward due to relapse was seen to be unusual
- in the six months prior to inspection there had been no delayed discharges, referral to assessment / referral to treatment or readmissions for this core service
- the service was well equipped with therapy rooms and activity rooms for patients. The clinic rooms were generally well equipped; the clinic room on John Denmark Unit was very well equipped, including an electro cardiogram machine

- there were facilities to make private telephone calls; at the Recovery First site, each ward had a small telephone room, which had a seat and contact numbers for various services
- there was access to outside space across the service. Gardens were well maintained, some wards had vegetable gardens maintained as an activity by patients. Cedar ward had access to bicycles, that patients and staff could use on the cycle path around the hospital
- all wards on Recovery First site had kitchenettes that could be used by service users at any time during the day. On other wards there were kitchen facilities that allowed service users to get either their own drinks or access cooking facilities
- activities were available across the service over a seven-day period. Wards had activity coordinators who worked weekends
- patients were actively encouraged to find voluntary or paid work. On Ash ward, we attended a CPA meeting in which the patient had requested more leave due to securing a job. After consultation with the team, it was agreed that the psychiatrist would prepare a reference for the patient, and he also agreed to more unescorted leave
- John Denmark Unit trained its staff to level two of the British Sign Language format. We saw cleaning staff as well as nurses communicating with patients using sign language
- all wards visited had noticeboards full of information relating to patient rights, how to complain and mental health services available within the community. We saw minutes of patient community meetings at Recovery First that raised issues of access and they were seen to have been acted upon
- at Bramley Street, information leaflets were also available in Somalian, Ethiopian, Czechoslovakian and Hindu. We were told that if required leaflets could be produced from the computer system in almost any language.

Are services well-led?

Good

We rated well-led as GOOD because:

- staff knew the values and objectives of the trust
- staff could identify senior managers in the organisation. Staff at Recovery First stated that senior management visited on a regular basis
- staffing was covered adequately, using a staffing ladder process that allowed staff to be brought in to cover casemix
- nursing staff were seen to be carrying out clinical audit
- we saw evidence of complaints being dealt with and feedback being given to staff

Summary of findings

- safeguarding, Mental Capacity Act and Mental Health Act procedures were all being followed
- key performance indicators (KPIs) were used across the service to monitor and improve performance. The Recovery First quality performance indicator report for January 2016 showed medicine issues, agency usage, complaints and incident reporting levels amongst the indicators. Minutes from meetings showed that these details were reported back to staff
- the staff sickness rate across the service averaged at 5.4%
- staff told us they felt able to raise concerns without fear or victimisation or reprisal
- minutes of meetings at both staff and management level showed staff being allowed to give input into service development. Staff at John Denmark reported they felt confident that their feedback was considered
- the trust had a duty of candour policy, ratified in January 2015.Staff were able to show knowledge of the need to inform patients and carers if and when something went wrong. In staff minutes from November 2015, Copeland ward staff completed two questionnaires in relation to the policy, Duty of Candour and Lessons Learned, with good results

Summary of findings

Information about the service

The long stay/rehabilitation mental health wards for working age adults provided by the Greater Manchester West Mental Health NHS Foundation Trust covered a wide geographical area (the John Denmark Unit was a national centre for treatment of deaf people with mental health diagnoses, with patients from as far as Scotland). Services were based in Prestwich, Salford, and Widnes. Each unit comprised of a multidisciplinary team of health professionals who worked with patients and their carers to provide effective treatment designed to help prepare patients for discharge back into the community.

Bramley Street service provided a 12-bed rehabilitation service for adult males aged 18 years and over, aimed at treatment, education about diagnosis, and the patient recovery journey. The John Denmark Unit was an 18-bed service for deaf male and female adults with mental health diagnoses; it had inpatient and community services supporting deaf, deafened and deaf/blind adults to improve and help them to recover. Recovery First was a 72-bed locked rehabilitation facility in Widnes providing care to both male and female adults with specialist mental health needs. The service was a joint approach with a leading independent provider; their aim was to provide care for people with serious and complex mental health problems, including autistic spectrum conditions and personality disorder. Copeland ward at the Meadowbrook Unit was a 15-bed rehabilitation ward for males and females offering long-term recovery focused care in a ward environment.

There had been 18 inspections across the trust: these included Meadowbrook Unit, Bramley Street and Recovery First. There were no compliance actions associated with this service.

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Nicholas Smith, Head of Inspection, Care Quality Commission

Team Leaders: Sarah Dunnett, Inspection Manager Care Quality Commission

The team inspecting the long stay/rehabilitation mental health wards for working age adults consisted of one CQC inspector, three specialist advisers, one expert by experience, two British Sign Language experts and a Mental Health Act reviewer.

Why we carried out this inspection

We inspected this core service as part of our on-going comprehensive mental health inspection programme.

How we carried out this inspection

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

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

Summary of findings

Prior to the inspection, we reviewed information that was held about these services, contacted a range of other organisations for information and sought feedback from patients and staff at four focus groups attended by staff and patients of the service.

During the inspection visit, the inspection team:

- visited all seven of the wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 22 patients who were using the service, as well as two carers, and collected feedback from 17 patients using comment cards
- spoke with the managers or acting managers for each of the wards
- spoke with 29 other staff members; including doctors, nurses and social workers
- attended and observed two multi-disciplinary meetings and one care programme approach review.
- arranged four focus groups for staff from the service
- looked at 39 treatment records of patients
- carried out a specific check of the medication management on four wards
- examined policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We conducted four focus groups relating to this service in the week before the inspection. We also collected 17 comment cards specific to the service completed prior to the inspection.

Focus group feedback showed positive and negative comments about the service. It was clear that staff involvement and the environment for the service was deemed effective. However, it was also commented on that people felt more staff are needed; people were aware that a recruitment drive was on going.

Comment cards again showed positive and negative feedback for the service. Staff and the service environment were praised, although one comment for Dove ward said that the patients would like a cold-water drinks machine. Other negative comments included staff not being available, and that staff were not getting their breaks. One comment card said that the food was not very good.

Good practice

The care plans at Bramley Street were of a very high standard with evidence of carer involvement. All patients stated that they had been involved in the care plans and contributed to the content, reflecting their needs and wishes.

Areas for improvement

Action the provider SHOULD take to improve

- The trust should take steps to improve monitoring of mandatory training.
- The trust should improve access to Mental Health Act and Mental Capacity Act training.
- The trust should ensure that Immediate Life Support training is not cancelled.

Greater Manchester West Mental Health NHS Foundation Trust

Long stay/rehabilitation mental health wards for working age adults

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Ash Ward, Cedar Ward, Dove Ward, Beech Ward (Beech ward not open yet)	Recovery First
Bramley Street	Bramley Street
Copeland Ward	Meadowbrook Unit
John Denmark Unit	Greater Manchester West Mental Health NHS Foundation Trust Headquarters

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act (MHA) 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

The MHA was not part of the mandatory training programme for the trust. Interviews with staff and reviews of Mental Health Act administration showed that there was evidence of good knowledge and good practice in relation to the MHA. However, the recording and auditing of staff participation in training of the MHA was poor.

The Recovery First service showed 81% compliance with mandatory training of the MHA, driven by foundations for growth training; this was monitored and audited within the joint venture. A full mental health act review of Ash ward was undertaken as part of the inspection, and no concerns were identified.

Detailed findings

Reviews of medication and adherence to the MHA across the service showed that the MHA was being applied. Advocacy was available to patients who required assistance; a new advocacy service relationship had been arranged.

Between November 2014 and November 2015 a Mental Health Act review had been carried out at all the service locations, the results were all positive for the service.

Mental Capacity Act and Deprivation of Liberty Safeguards

The Mental Capacity Act was not part of the mandatory training programme for the trust. Interviews with staff and reviews of 39 care records within the service showed that the Mental Capacity Act was being applied correctly.

Minutes from a Mental Health Act and Mental Capacity Act Compliance Committee in August 2015 showed that 65% of staff were aware of the process of implementing and applying the Mental Capacity Act, but there were anomalies around the training figures. This anomaly was still apparent on inspection, with poor recording and auditing of staff participation in training of the Mental Capacity Act.

However, an e-learning package for Mental Capacity Act had been introduced in January 2016, and the trust were confident that this would improve their training figures in due course.

The Recovery First service showed 80% compliance with mandatory training of the Mental Capacity Act, driven by foundations for growth (FFG) training; this was monitored and audited within the joint venture.

The John Denmark Unit had successfully applied three Deprivation of Liberty safeguards in the period December 2014 to September 2015.

Good

Are services safe?

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

* People are protected from physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse

Our findings

Safe and clean environment

The ward layout across the service allowed for monitoring of patients, with good use of mirrors for blind spots on Ash and Dove wards. Copeland ward and John Denmark Unit had nursing stations in each segregated unit, to allow for patient monitoring and safety. Ligature points were noted in environmental risk plans and mitigated to good effect for patient safety. Copeland ward and the John Denmark Unit both complied with same-sex regulations, with segregated sleeping areas and separate lounges for men and women. Toilet arrangements also met the required standard. All wards met guidance for same-sex accommodation across the service.

Clinic rooms were very clean and well equipped, with verified up-to-date equipment and calibrated monitoring equipment. The clinic room on John Denmark Unit was very well equipped, well lit, and had an electro cardiogram monitor present. Seclusion rooms met required standards, with privacy and dignity clearly considered. Ash ward utilised “soothe boxes”, a transparent individualised box containing precious items of patients, used to de-escalate a patient in times of being upset, in crisis, or relapse.

Ward areas across the service were very clean, well maintained, and had appropriate and safe furnishings in place. The John Denmark unit utilised round and hexagonal tables to facilitate good peripheral vision, due to the use of signing to communicate. Staff were seen to regularly use hand washing gel dispensers available on the wards. Patient-Led Assessments of the Care Environment 2015 figures for cleanliness showed 100% across the trust on all sites. Cleaning rosters were checked and were up to date, showing regular times for cleaning the wards. Environmental risk and assessment plans were checked and were up to date.

Staff had access to personal alarms and were wearing them. Across the service, there was good access to call buttons in rooms. At Bramley Street, staff were noted not to carry personal alarms, but the rooms in which they interviewed patients had call buttons.

Safe staffing

There were 218 staff employed across the service. The Recovery First site had 141 staff, with 77 staff across the other locations. There were staff vacancies at Bramley Street, Copeland ward and the John Denmark Unit. Copeland ward had a staff vacancy rate of 40% managed by use of bank staff, however a strong recruitment campaign was under way and the trust was confident of a marked decrease in this rate.

Copeland ward had the highest sickness rate at 7%, with an overall service sickness rate of 5%. Bank staff who were experienced and familiar with the service were used to cover shifts. There were only 17 shifts not filled by bank staff in a 12-month period to December 2015. Regular bank staff use was a feature across the service, with familiar staff being called and utilised before a general request for staff coverage. The Recovery First site used a ‘staffing ladder’ to estimate the number of staff needed on any given shift; this related to the number of patients as well as observation levels.

There was a core number of staff per shift (on Cedar Ward it was a minimum of two qualified and three non-qualified on a day shift, and one qualified and three non-qualified on a night shift). Nursing rotas indicated that the minimum number of nurses required was met, and that was amended dependent upon the needs of the ward. Ward and unit managers were able to request staff and adjust staffing as the casemix required.

During the inspection, we saw qualified staff in patient areas of the wards. On Cedar ward, staffing on a Sunday was increased to have an extra nurse on duty, to ensure activities would not be cancelled or missed. Care records showed that regular one to one time with patients was being provided across the service.

Escorted leave could be delayed due to problems on the wards, but it was very rarely cancelled. We saw evidence of explanations to patients for escorted leave being delayed, and rearranged within a short time frame. On Cedar ward, a log was kept of cancellations, with reasons appended and explained to the patient. On Copeland ward occupational therapists (OTs) and assistant OTs would assist if escorted

Good

Are services safe?

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

leave was due for a patient. On Dove ward a weekly meeting was held each Friday and a planner completed to ensure that escorted leave was granted and prevented conflict over who had what leave and when.

There were enough staff to carry out physical interventions. A physical health improvement tool (PHIT) was used to monitor and ensure that physical health monitoring was effective and regular.

Each of the wards had access to medical cover day and night; should emergency treatment be warranted patients would be taken to designated accident and emergency units. On Copeland ward there was an on-call doctor, and its location meant rapid access to medical emergency services.

The average mandatory training rate for staff was 78%. Up to date immediate life support training figures were low: 45% for Copeland ward, 55% for Bramley Street and 50% for the John Denmark Unit. However, we saw evidence that the trust had recently cancelled immediate life support training for service staff as only two staff members attended. Staff were confident in their skills to deal with an emergency.

Fire safety (74%), infection control level three (56%), and prevention and management of violence and aggression (68% at Copeland ward and 54% at the John Denmark Unit) were all below 75%. At Recovery First, only fire safety (71%) and infection control (67%) mandatory training were below 75%. The overall mandatory training rate for Recovery First stood at 83%.

However, the mandatory training figures provided by the trust were not accurate when compared with service figures. Evidence was seen to show that staff in the service were booked in for updates and training.

Assessing and managing risk to patients and staff

There was one patient being nursed in long term segregation. The patient was visited on the ward during the inspection, and treatment and seclusion records were well documented and in order, and in keeping with good practice for patients living with autism. The trust was actively seeking an alternative placement for the patient in a medium secure unit as they felt they could not meet his needs. The carer of the patient stated she was very happy with his care on Beech ward. She stated she was involved in his care plans.

Care records of 39 patients were reviewed and found to have completed and up to date risk assessments. The STAR (version 2) risk assessment tool was used by the trust. Cedar ward was a ward for people with autism, and risk assessments were regularly reviewed.

Blanket restrictions were only used when justified, in relation to such items as weapons or illicit drugs. On the John Denmark Unit, consideration was given to aspects of character deemed particular to deaf people: it was believed that access to a particular item must be open to all, or not at all. This was an aspect of deaf society that was actively considered.

Signs were apparent across the service informing informal patients of their right to leave the ward when they wanted. Due to the mix of detained and informal patients, informal patients had to request staff to open the door to leave the ward.

Observations levels followed a standard format. Level three observations was for general observations each hour; level two observations could be used at five, ten, fifteen or thirty minute periods each hour; and level one observations meant one to one nursing, either within line of sight or within arms-reach.

Verbal and other de-escalation techniques were preferred to restraint, and the figures provided by the trust showed generally restraint levels were not high. There were two incidents of prone restraints, both of which occurred on Dove Ward. In the six month period between 1 April 2015 and 18 October 2015 there had been 21 incidents of restraint on the John Denmark Unit, 47 incidents on Dove ward, 12 incidents on Copeland ward, and 35 incidents on Beech ward. However, Ash ward had 260 incidents of restraint, the ward populated by female patients with complex needs including a diagnosis of personality disorder. The ward manager on Ash Ward stated that due to self-harm, prevention of banging heads on the wall, and physical contact between patients, incident reporting was high and necessary.

Rapid tranquilisation was only used twice in six months across the service, and monitoring notes showed that National Institute for health and Care Excellence (NICE) guidance on short-term management in mental health settings (NG10, published March 2015) and best practice were followed.

Good

Are services safe?

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

Seclusion had been used 25 times across the wards in the Recovery First service in a six-month period. However, the patient detained on Beech ward had led to an unusually high number of seclusion incidents for one patient, 13 in total. On Dove ward, staff had recently de-commissioned the seclusion room, to be used as a therapy room. Seclusion records were noted to be in keeping with best practice. A full Mental Health Act review of Ash ward conducted during the inspection monitored and checked records.

Across the service, 94% of staff had received training in safeguarding of vulnerable adults and staff clearly understood safeguarding procedures. There had only been one safeguarding concern raised in the service in a 12-month period prior to the inspection.

Medicine management in the service was reviewed by pharmacists during the inspection and was found to follow NICE guidelines and best practice. Pharmacists found Rapid Tranquilisation policy had been updated to take into account NICE Guidance (NG10, violence and aggression: short term management in mental health, health and community settings, published May 2015). Medication reviews on Cedar ward for people with autism were regularly reviewed by multi-disciplinary teams.

There were family visiting rooms either on the wards or on site that could be accessed, and policy relating to visiting children was being followed.

Track record on safety

There were two serious incidents reported in the 12 months prior to inspection, both were unexpected inpatient deaths, one death on Ash ward and one death on Copeland ward.

On Copeland ward staff found evidence of illicit drug use on the ward, patients testing positive after section 17 leave. Previous practice was to stop leave entirely. However, it was decided that, in view of the likelihood that a patient was unlikely to stop their drug use, nor wished to stop their drug use, individualised plans would be used. Each patient found to have used drugs on leave would have leave stopped for 24 hours to observe and monitor any effects of their drug use. After this period, leave was re-initiated but monitored to ensure that no side effects were occurring, nor were illicit substances being taken onto the ward itself. This helped to stop blanket restrictions as well as ensuring leave was utilised leading to rehabilitation.

The most recent safeguarding incident occurred in September 2015 when a service user was subject to inappropriate behaviour from a staff member. This was under investigation by the police. Management plans were put in place to reduce the risk of repeat events.

Reporting incidents and learning from when things go wrong

Staff were interviewed and found to know what incidents they were required to report, and how to report. From 1 January 2015 to 3 December 2015, the trust reported 1801 incidents for the service. Of the incidents, 614 were self-harm, with 418 incidents of violence/aggression/abuse/harassment to staff. There were 85 medication incidents also reported.

Ash ward recorded the highest number of incidents with 620; Copeland ward followed this with 330. Of the 85 incidents reported for 'Medication', Ash ward and John Denmark Unit reported 20 incidents each. There were also 75 incidents of a 'Missing Patient' – 33 of them occurring at Bramley Street, followed by Copeland Ward with 28.

We saw evidence of explanation to patients if anything went wrong. On John Denmark Unit, we saw documented evidence of a minor medication error that had been fully explained to the patient. Minutes from staff meetings showed that feedback was given in relation to incidents within and outside of the trust. There were regular staff and team meetings across the service where minutes showed feedback was discussed.

We were told that staff were debriefed and offered support after serious incidents, but saw no documented evidence of this.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

Thirty nine care records were reviewed across the service. They were of a high standard and comprehensive. Physical examinations were undertaken and monitored using the physical health improvement tool system. Care records were up to date, holistic and person centred. There was clear evidence that patient and carer involvement was included in the compilation of care plans. Care plans at Bramley Street were found to be of a very high standard, with well-documented aspects of carer and patient involvement.

The trust used the PARIS computer system, introduced in September 2015. The system was continually being upgraded as faults were identified. The system was secure, and allowed for the scanning of paper documents to be carried out to ensure continuity of records. We saw evidence that scanning of information into the computer system was done in an efficient period.

Best practice in treatment and care

Pharmacy procedures were reviewed by pharmacists and found to be operating within NICE guidance and using best practice. Regular visits to the wards within the service were maintained by pharmacy staff. Medication cards were checked and found to be in order. Cedar ward had patients who were living with autism , best practice was shown to be followed in relation to medication management, in keeping with National Institute for health and Care Excellence (NICE) guidance (Autism in adults: diagnosis and management, published June 2012). Cedar ward staff were working towards accreditation with the National Autistic Society.

Drug cupboards on each ward were checked, with no out of date medication found. Controlled drug registers were reviewed and were accurate. On John Denmark Unit, we saw that patients who wished to self-administer medication were assessed and supported to do so.

Psychologist input was available and utilised across the service. John Denmark Unit used a broad scope of psychological therapies relating to the treatment of deaf patients with mental health problems, including speech and language therapies and family therapies. Recovery First had four clinical psychologists on site, ensuring access for each ward.

A review of 39 care records showed evidence of a full physical examination on admission to the service. There was also documented evidence of on-going physical care needs being met. The service used the health of the nation outcome scales (HoNOS) to measure and record severity and outcomes whilst with the service.

We saw evidence of clinical audit conducted within the service by staff. At Bramley Street, staff nurses were involved in hand hygiene and care plan audits. The use of seclusion was audited by staff from the John Denmark Unit. On Copeland ward we saw that audits of the quality of information inputted onto the system by doctors was carried out by nursing staff. The trust undertook a variety of local/national audits, and the staff of the service were involved in a prescription card audit, infection prevention annual audit, hand washing techniques audit, and a safe staffing audit. An action plan was reviewed in relation to a clinical audit for the reading of rights to patients detained under the Mental Health Act, showing the service was acting positively towards ensuring rights were explained through minutes of meetings.

Skilled staff to deliver care

There was a full range of healthcare professionals providing input into the wards across the service, including psychiatrists, psychologists, occupational therapists, speech and language therapists, physiotherapists, nurses and health care assistants.

We saw experienced staff giving care across the service, and saw evidence of on-going specialist training. On John Denmark Unit, all staff were trained to a minimum of level two of the British Sign Language system for communication with deaf patients, and recruitment of deaf nurses was underway. Staff on Cedar ward had training in positive behavioural support plans, treatment of Asperger's, and self-harm treatment, all on-going autism-related training. Specialist training was available across the service. At Recovery First, positive behavioural support plan training was available, as was the knowledge and understanding framework (KUF), Personality Disorder training.

A three-day induction course was run by Greater Manchester West Foundation NHS trust for all its new employees, and the subjects covered were reflected in the Care Certificate Standards. Ward-based inductions were also used for staff entering the service.

Are services effective?

Good

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Staff stated they had regular appraisals, and it was noted across the service that those who were due an appraisal had been organised for appraisal in the near future. For non-medical staff, the appraisal rate was at 78% for Bramley Street, Copeland ward and the John Denmark Unit. At Recovery First, both appraisal and personal development review data showed 100% completed. The average percentage rate for clinical supervision in the service was 84%. This showed that appraisals and personal development reviews in the service were being undertaken.

Poor staff performance was addressed promptly: a staff member was on a performance management plan to deal with issues relating to work standards**.** There was only one staff member in the service suspended during the period from August 2014 to August 2015; procedures were correctly followed.

Multi-disciplinary and inter-agency team work

We attended two multi disciplinary team (MDT) meetings; both displayed a high standard of interaction both with staff and service users. MDT meetings were regularly scheduled across the service. Handover notes were comprehensive and included observations with planned events for the day with the ward diary.

During MDT meetings, we saw effective working relationships with care coordinators that reflected a holistic working approach. We saw evidence of involvement of outside agencies with the service; at Recovery First, the Thursday safeguarding meetings included a member of the Halton Local Authority safeguarding team. We were told that links with social services were good.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Training in the Mental Health Act (MHA) was found to be mandatory at Recovery First, with a high compliance rate of 90%. MHA training rates across the rest of the service was not as high, as the training was not mandatory. The other service locations all fell below 75%; the trust had an action plan in place and were dealing with the shortfall. This was noted in minutes from the MHA and Mental Capacity Act Compliance Committee in January 2016.

A new training schedule for both MHA and Mental Capacity Act training had been created, with a contract awarded to an outside agency to enable the training programme. A full review of consent to treatment forms and capacity requirements was undertaken across the service; adherence to the MHA was excellent.

Discussions with staff and managers showed that staff had a good knowledge of the MHA.

People had their rights explained in good time, and if they were not able to understand their rights then further attempts to explain were carried out and documented. This was audited by the trust.

A Patient Rights Audit for 2015/2016 was carried out by the trust, showing that across the trust 94% of patients had a documented recording of rights under the MHA read and explained to them. This included Bramley Street, Copeland ward and the John Denmark Unit.

MHA administrators were employed across the service, ensuring a central contact point for information, advice, and the audit of paperwork relating to the MHA. Mental health administration was good across the service.

A full Mental Health Act review was conducted on Ash ward as part of the inspection process. This results of the review noted only minor problems requiring action, with good adherence to the Mental Health Act code of practice found.

Patients were able to access advocacy across the service, with a new service in Widnes displayed in key areas of the wards at Recovery First. The advocate at Bramley Street spoke very highly of the service provided by Bramley Street staff, and their good relationship with the advocacy service.

Good practice in applying the Mental Capacity Act

Mental Capacity Act (MCA) training figures were generally poorly recorded, and the training and audit was being considered for redesign. Documents provided by the trust showed a programme of training that was designed to enhance MCA training.

At Recovery First, training records for MCA training showed that 80% of staff had completed the foundations for growth e-learning programme.

There was a policy on MCA including Deprivation of Liberty safeguards (DOLs) of which staff were aware of and could refer. Records reviewed showed they were following policies.

Staff were asked about the MCA and capacity principles, and they demonstrated a good working knowledge. Care

Are services effective?

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records across the service indicated the MCA was considered and used appropriately. We saw evidence of capacity being considered in the care records, how it was assessed on a decision specific basis. Care plans showed that consideration was given to the patient viewpoint and feelings when assessing capacity.

Deprivation of Liberty Safeguards (DoLs) were applied when appropriate. In the six months prior to inspection, the John Denmark Unit had successfully applied for three DoLs.

At the time of inspection, monitoring adherence to the MCA was not prevalent across the service; however, wards based at Recovery First were involved in the monitoring and audit of the use of the MCA.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

We saw interaction between staff and patients that was respectful, thoughtful, considerate, timely, and professional. On Cedar ward, we saw a patient living with autism who was clearly unhappy about something, and staff immediately and calmly dealt with the situation in a manner that allowed the patient to de-escalate and return to his activity safely.

On Cedar ward, a patient living with autism was due for discharge into the community, and two carers had agreed to leave the trust and care for him, in order to ensure continuity of care.

We spoke with 22 patients across the service. Some of these patients had diagnoses complicated by hearing impairment and other physical ailments. Patients stated that they felt "very safe" across the service, "staff talk to me all the time", "we have never had leave cancelled".

There were 390 comment cards received across the trust, of which 17 (4.4%) were from long stay/rehabilitation services.

Positive statements from relevant comment cards included "staff are great and patients are listened to", and "environment is lovely and warm".

Negative statements from relevant comment cards included "staff not keeping things private", and "wish nurses did not have to sit behind computers a lot of the time".

The 39 care records reviewed across the service showed that the individual needs of patients was clearly considered and included in care plans.

The 2015 PLACE survey showed the trust performing better than the national average for food in sites which included John Denmark Unit and Copeland ward.

The involvement of people in the care that they receive

The process to welcome and orient patients to the service was thoughtful and thorough. At Cedar ward, a pre-assessment was given to each patient, with a risk formulation meeting, and a visit to the ward prior to admission. A 20-page brochure was also given to the patient, fully explaining the expectations of the patient and the ward, the facilities available.

We saw evidence of active involvement in care planning; the review of 39 care records across the service showed a holistic approach to care. We attended two multi-disciplinary meetings that confirmed patient involvement in their care.

We attended one care programmed approach (CPA) meeting in which the patient entered with a list of considerations. The team discussed the merits of each consideration with the patient, and an agreement was reached that suited all.

Access to advocacy was invited across the service. The Recovery First site had recently accepted a new national advocacy service, and signs giving contact details were on noticeboards and inside the phone booths. The advocacy service at Bramley Street was very complimentary about the manner in which their service was promoted to patients.

We saw evidence of family involvement in the care of patients. On John Denmark Unit, video conference facilities were in place so that patients far from home could communicate with family, and involve them in their care. The carer of the patient detained on Beech ward stated she was actively involved in the care of the patient.

The minutes from patient community meetings were reviewed: they clearly indicated the impact of patient involvement on the running of the service. On Dove ward, a reflection meeting was held each day at 1800 hrs to discuss any issues with patients from that day.

The activity coordinator on Dove ward was recruited by a panel including a service user. On Copeland ward, an assistant psychologist was recruited by a panel including a former patient.

On John Denmark Unit, 'all about me' files are maintained and we saw copies of advanced statements within those files. These files were used with the patients to chart and monitor time in the service, and were up to date and clearly designed to be accessible by deaf patients.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The average bed occupancy over the last six months for the service was 90%. Copeland ward had average bed occupancy of 102% over the six months prior to inspection. That was due to the occasional use of a leave bed to allow an urgent admission; we saw no evidence that a patient had been refused access to a bed on return from leave.

There were no out of area placements attributed to the service in the six months prior to the inspection.

The service strived to remain accessible to people within the catchment area. However, the John Denmark Unit is one of only three NHS specialist units for deaf people with mental health problems; as such, some patients were from Scotland, due to the lack of specialist beds available.

At Recovery First site, no leave beds were filled (when a patient was on approved leave from the ward); they remained open for the return of the patient.

Movement between wards was usually due to a step-down process: patients on Ash ward were moved to Dove ward as their presentation and mental health status improved. It was reported to be unusual for the reverse to happen. The rehabilitation aspect of the service meant movement forward was stressed, not backwards.

In the six months prior to inspection there had been no delayed discharges, referral to assessment or referral to treatment waiting lists, or readmissions for this core service.

Average length of stay for patients discharged in the twelve months prior to inspection was 317 days. The Bramley Street service had an average length of stay of 227 days, and the average at the time of inspection was 193.

The facilities promote recovery, comfort, dignity and confidentiality

The service was well equipped with therapy rooms and activity rooms for patients. The clinic rooms were generally well equipped; the clinic room on John Denmark Unit was very well equipped, including an ECG machine. A sensory room at the John Denmark Unit allowed deaf patients to experience aspects of music that would otherwise be denied to them.

Each ward had rooms that could be used to have private meetings with visitors, or rooms outside of the ward area should they be required. There were facilities to make private telephone calls; at the Recovery First site, each ward had a small telephone room, which had a seat and contact numbers for various services.

There was access to outside space across the service. Gardens were well maintained, some wards had vegetable gardens maintained as an activity by patients. Cedar ward had access to bicycles that patients and staff could use on the cycle path around the hospital.

All wards on Recovery First site had kitchenettes that could be used by patients at any time during the day. On other wards, there were kitchen facilities that allowed service users to get either their own drinks or access cooking facilities. There were also activities of daily living kitchens that allowed patients to practice cooking full meals. On John Denmark Unit, patients would often cook full meals with staff at the weekend, rather than use food provided by the trust.

All bedrooms in the service were personalised, some more than others depending on the occupant. Patients had access to their rooms at all times, unless their care plan recommended otherwise. Some wards, such as Cedar ward, allowed patients to have their own key to the room.

Rooms had a safe inside to which patients had their own key, with a master key kept by staff should the key be misplaced. Personal mobile telephones could be used by patients.

Activities were available across the service over a seven-day period. Wards had activity coordinators who worked weekends. Petting zoo activities were popular with patients in the service, with a variety of animals being brought to the ward; photographs of their interactions were placed on noticeboards. Cedar ward were in the process of procuring an autism dog: this is a dog trained to interact with people with autism.

Patients were actively encouraged to find voluntary or paid work. On Ash ward, we attended a CPA meeting in which the patient had requested more leave due to securing a job. After consultation with the team, it was agreed that the psychiatrist would prepare a reference for the patient, and he agreed to more unescorted leave.

Are services responsive to people's needs?

Good

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

Meadowbrook Hospital (site of Copeland ward) scored 95% for Privacy, Dignity and Wellbeing and 100% for Condition Appearance and Maintenance in the 2014 PLACE scores.

Meeting the needs of all people who use the service

Wards had designated rooms for patients with physical disabilities. Bathrooms had specialist hoists and baths to assist in the care of patients.

At Bramley Street, information leaflets were also available in Somalian, Ethiopian, Czechoslovakian and Hindu. We were told that if required leaflets could be produced from the computer system in almost any language.

All wards visited had noticeboards with information relating to patient rights, how to complain and services available within the community. We saw minutes of patient community meetings at Recovery First that raised issues of access: action had been taken.

John Denmark Unit trained its staff to a minimum of level two of the British Sign Language format. We saw cleaning staff as well as nurses communicating with patients using sign language.

The choice of food available was varied and wide, with extensive menus laid out either on tables or on large charts on the wall. We were told that the facility to prepare special food requests was available should the need arise.

The service provided access to spiritual support, with various religious denominations represented. Recovery First had a multi-faith room on site; a recent Jewish patient on Cedar Ward had access to a local rabbi. On John Denmark Unit a deaf priest and vicar, as well as a deaf imam, were contactable by patients; they worked in conjunction with Manchester Deaf Centre.

Listening to and learning from concerns and complaints

There were 26 complaints across the service in the 12 months prior to inspection. Eleven complaints were upheld, with five complaints partially upheld. We saw evidence throughout the service of notification of how to complain. In John Denmark Unit, each patient bedroom had a laminated visual complaint leaflet, in easy-read format for deaf patients.

Staff showed knowledge of the complaints policy, explaining informal and formal ways to process complaints.

After a complaint in December 2015, a meeting of the Recovery First quality governance group was held on 18 December 2015. Minutes from that meeting show the complaint was discussed and dealt with, and the findings passed on for inclusion in team meetings.

The service received 21 compliments during the 12 months prior to inspection; nine of those compliments were for John Denmark Unit.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Our findings

Vision and values

Staff knew the values and objectives of the trust. Team objectives incorporated the values of the trust. On Cedar ward the team objective was identified by SPELL (structure, positive, empathy, low arousal, links), giving an easily remembered identifier.

Staff could identify senior managers in the organisation. Staff at Recovery First stated that senior management visited on a regular basis.

Good governance

The average mandatory training rate for this service was 78%. The Recovery First training rate was improved by the use of foundations for growth (FFGs) training supplied by the partner organisation. However, trust monitoring of mandatory training figures was not considered effective.

The staff appraisal rate across the service stood at 78%, although the Recovery First appraisals and personal development review completed rate stood at 100%.

Staffing was covered adequately, using a staffing ladder process that allowed staff to be brought in to cover casemix.

Staff were seen to spend time with patients, with activities that required interaction prevalent across the service.

There were 1801 incidents reported across the service in the period 01 January 2015 to 31 December 2015, showing that staff were not afraid to voice concerns and report incidents.

Clinical audit was carried out by nursing staff.

We saw evidence of complaints being dealt with and feedback being given to staff.

Safeguarding, Mental Capacity Act and Mental Health Act procedures were all being followed.

Key performance indicators (KPIs) were used across the service to monitor and improve performance. The Recovery First quality performance indicator report for January 2016 showed medicine issues, agency usage, complaints and incident reporting levels amongst the indicators. Minutes from meetings showed that these details were reported back to staff.

Ward managers stated that they felt they had sufficient authority and support. The manager of Cedar ward stated he was very happy with support from other departments within the trust.

Staff said that they could raise risks to the ward manager, who would take the risks further for consideration for the trust risk register. The Salford risk register showed that incidents of violence and aggression against staff had been raised and given a high-risk rating on the register. The trust had responded to the risk raised.

Across the service, there had been a total of four doctors revalidated, two at Recovery First and two at the John Denmark Unit.

Leadership, morale and staff engagement

The staff sickness rate across the service averaged at 5.4%. There were no on-going reports of bullying or harassment cases in the service.

Staff stated that they knew how to apply and use the whistle-blowing process. There were no recorded reports of whistle-blowing in this service. Staff told us they felt able to raise concerns without fear or victimisation or reprisal.

Staff told us that morale and job satisfaction was high in the service. Data provided relating to staff surveys was trust wide, not specific to the core service.

Managers stated they had opportunities for leadership training. There were two-day training courses available; at the time of the inspection, the ward manager for Copeland ward was attending a leadership course. Staff reported that they felt team working in the service was good, and that support was available if needed. Some staff mentioned that the team would work better if there were more staff.

The trust had a duty of candour policy, ratified in January 2015. Staff were able to show knowledge of the need to inform patients and carers when something went wrong. In staff minutes from November 2015, Copeland ward staff completed two questionnaires related to candour, Duty of Candour and lessons learned, with good results. Minutes from the Recovery First quality governance group described a medication error that was being dealt with by duty of candour policy, and family were kept informed.

Minutes of meetings at both staff and management level showed staff being allowed to give input into service development. Staff at John Denmark reported they felt confident that their feedback was considered.

Are services well-led?

Good

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Commitment to quality improvement and innovation

The trust was implementing the Safewards project, an internationally recognised project covering planning, compromise, positive environments and reduction of incidents and degree of harm. The project was aimed at mental health inpatient wards.

Cedar ward was working towards accreditation in the National Autistic Society.