Greater Manchester Mental Health NHS Foundation Trust

Acute wards for adults of working age and psychiatric intensive care units

Inspection report

Prestwich Hospital
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Requires Improvement**
Are services well-led?	**Inspected but not rated**

Our findings

Acute wards for adults of working age and psychiatric intensive care units

Inspected but not rated

We carried out an unannounced focused inspection of Elm Ward at Park House. This was because we had concerns regarding the safety of patients and leadership on the Ward.

This was a focused inspection looking at the safe and well led key questions. We did not rate key questions at this inspection. However, due to a regulatory breach in safe, this domain has been limited to requires improvement.

We had carried out a Mental Health Act Review visit in August 2019 which raised concerns about the acuity on the ward, the environment, lack of space for patients to lock away their possessions and staffing levels. At this time we asked the trust for assurances that improvements would be made and a robust action plan was put in place to support the ward to make these improvements. Despite this, information we received about the ward from patients, relatives and from notifications from the trust continued to contain similar themes. We therefore, decided to carry out a focused unannounced inspection to look into these concerns in more detail.

Elm Ward is a 24 bedded female acute ward at Park House. This is a mental health unit based on the site of the North Manchester General Hospital. The acute wards for adults of working age and psychiatric intensive care units at the trust are currently rated as Good.

Summary

- The design, layout, and furnishings of the ward did not supported patients' treatment, privacy and dignity.
- The patients had no lockable space to store their belongings, this meant that patients did not feel safe leaving valuables in their bedrooms
- The action plan for improving the ward environment was not up to date. There should have been monthly walkarounds and the last one completed was in July 2020. From this walkaround, there was a long list of maintenance issues that needed addressing but the action plan did not detail what had been done to address this or an expected completion date.

However,

- The service provided safe care. The wards had enough nurses and doctors. They followed good practice with respect to safeguarding.
- With the exception of the action plan mentioned above, our findings from the other key questions demonstrated that governance processes operated effectively at ward level and that performance and risk were managed well.

Following on from our inspection, we had significant concerns about the environment on Elm Ward. We raised our concerns with the trust and they provided a response including assurance on the immediate actions being taken.

Our findings

The trust responded in the agreed time frame and told us that they had immediately reduced the number of beds on the ward from 24 to 20. They had used the dormitory that was closed to provide a quiet lounge for patients away from the main dining room. They had also provided a lockable space for each patient. All lighting was fixed and obscene language removed with blackboards installed for patients to write on. Smoking at the top of the stairs was stopped with immediate effect.

Following on from this response we decided that it was no longer necessary to take urgent action against the trust. We will monitor the progress of these actions during our routine engagement with the trust.

How we carried out the inspection.

We visited Elm Ward. We toured the ward, spoke to four staff, the ward manager and the inpatient service manager. We spoke to six patients and one carer. We also reviewed the ward rota, the observation shift planner and the action plan relating to Elm Ward that the Trust had been working on.

What people who use the service said.

We spoke to six patients on Elm Ward. All apart from one told us they felt safe on the ward. All six patients told us that there was no lockable space for their personnel possessions, one patient slept with their purse under their mattress. All patients told us that the ward was extremely busy and that there was no space for them to go to relax and have some quiet time. All patients we spoke to were unhappy with having to share a bedroom with other patients and felt this along with the level of noise and lack of private space on the ward had a negative impact on their mental health.

Is the service safe?

Requires Improvement 

- The ward was clean. However, it was not well maintained with many of the walls requiring painting. In the activity room the lighting was not working and this made the room very dark. There was offensive language painted across the wall and the rest of the walls were bare. There was evidence of graffiti in some of the bedrooms and on corridors written in pen and pencil. However, the furniture was in good condition and was well maintained. The bedrooms had no lockable space for patients to store their valuables. This meant that patients had to carry their belongings about their person for fear of it going missing. One lady told us she slept with her purse under her mattress.
- The design, layout, and furnishings of the ward did not supported patients' treatment, privacy and dignity. The ward was still in a dormitory style set up with only four single bedrooms for 24 patients. At the time of our inspection single rooms were being used for new admissions until their Covid test came back as negative. Therefore, patients who may have ordinarily needed a single room may not have access to one. The ward had 24 beds which was the largest number in Park House, despite the fact Elm Ward had the smallest space. The ward only had one lounge which was also the dining room and if all 24 women wanted to sit down for a meal the space would not accommodate them comfortably. The only other space was the activity room. This was a very narrow space which at the time of our inspection had two lights that were not working. The room was dark and bare and had obscene language painted on the wall in purple paint. There was no quiet space for privacy, and the patients in dormitories (20 out of 24) had no place they could go to be alone. The lounge was noisy and during our inspection we heard patients shouting for people to be quiet and becoming very distressed at the noise levels.

Our findings

- Access to the garden was down a flight of metal stairs. These were slippery when wet and at the time of our inspection patients were smoking at the top of these stairs throughout the day rather than going down into the garden space. This meant that the corridor smelt of smoke as the door opened and closed frequently. The top of the stairs and garden were heavily littered with cigarette ends. However, the garden had been recently refurbished and had outdoor exercise equipment and a seating area. We received an action plan from the trust outlining issues on Elm Ward and how these were being monitored. One of the points was for there to be a monthly walk around to look at maintenance issues on the ward. The action plan was last updated in November 2020 and that contained a walkaround from July that year. It contained a long list of maintenance issues that needed to be actioned. This included painting, removing graffiti from the walls and replacing missing curtains. There was no date for these actions to be completed or detail around how this had been addressed.

However,

- The service had enough nursing and medical staff, who knew the patients and received basic training to keep patients safe from avoidable harm. The ward had recently had approval from the trust to increase the number of registered nurses on shift during the day and night. This meant that there would be two registered nurses on each day shift with a third on ward round days. The ward manager had also put in a bid to increase the staff nurses on a night shift from one to two, the numbers had been increased with a view to this being approved. Vacancies had reduced dramatically from nine in June to two on the day of our visit. Although there were no support worker vacancies there were two staff members on maternity leave and two on long term sick, although all of these were due back to work in December.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Is the service well-led?

Inspected but not rated

- Leaders had the skills, knowledge and experience to perform their roles, had a good understanding of the services they managed, and were visible in the service and approachable for patients and staff. However, Elm ward had not had a permanent ward manager since June 2020, in this time there had been two interim ward managers. On the day of our inspection, their was an interim ward manager in post who was due to go back to their own ward that month. There were four new band six nurses in post who would give some stability going forward. Staff gave very positive feedback about the interim ward manager but were concerned about what would happen once that person left.
- The senior leaders in the service were visible on the wards. The staff told us that they were supportive and regularly visited the ward. The inpatient service manager came to the ward to conduct the patient meeting each month. They had good oversight of the ward and the problems it had experienced over the last twelve months. There was a robust action plan for the ward that was reviewed monthly. We were able to see how trends had improved over time. For example, increased staffing levels and recruitment, improved engagement between staff and patients, better understanding of safeguarding concerns and how to manage them, and improvements in the quality of record keeping. However, the point on the action plan regarding the environment was not up to date. There should have been monthly walkarounds and the last one completed was in July 2020. From this walkaround, there was a long list of maintenance issues that needed addressing but the action plan did not detail what had been done to address this or an expected completion date.

Our findings

- Staff felt respected, supported and valued. They reported that the provider promoted equality and diversity in its day-to-day work and in providing opportunities for career progression. They felt able to raise concerns without fear of retribution.
- Ward teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Our findings

Areas for improvement

The trust must ensure that the ward is suitable for use for its intended purpose and is used in a safe way with risks assessed and mitigated.

The trust must ensure that the ward environment provides adequate space for patients to receive safe and effective care which meets their individual needs.

Regulation 12 HSCA (RA) Regulations 2014 safe care and treatment

Our inspection team

Our inspection team consisted of one CQC inspector, a mental health act reviewer and a specialist advisor with experience in acute services.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment