Good

Mersey Care NHS Trust

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

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)
RW433	Broadoak Unit	Albert ward	L14 3PE
RW433	Broadoak Unit	Brunswick ward	L14 3PE
RW433	Broadoak Unit	Harrington ward	L14 3PE
RW4X2	Clock View Hospital	Alt ward	L9 1EP
RW4X2	Clock View Hospital	Dee Ward	L9 1EP
RW4X2	Clock View Hospital	Morris Ward	L9 1EP
RW4X2	Clock View Hospital	Newton Ward (PICU)	L9 1EP
RW403	Hesketh Centre	Rowbotham unit	PR9 0LT
RW403	Hesketh Centre	Park Unit	PR9 0LT

Summary of findings

RW454	Windsor House	Windsor House ward	L8 7LF

This report describes our judgement of the quality of care provided within this core service by Mersey Care NHS Trust. Where relevant we provide detail of each location or area of service visited.

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 Mersey Care NHS Trust and these are brought together to inform our overall judgement of Mersey Care NHS 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?	**Requires improvement** 
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

Contents

Summary of findings

Overall summary

We rated acute wards for adults of working age and psychiatric intensive care units as good because:

Although the physical environment varied across wards, the trust had actions plans in place to ensure that any risks associated with the environment were addressed. The wards were clean and well maintained and there was good evidence that infection control was monitored. There were dedicated wards for men and women, and the mixed wards complied with gender segregation guidelines. Medication was managed safely in most areas. However, on the Broadoak Unit we found that staff had limited understanding of what constituted rapid tranquilisation and how the patient should be monitored afterwards, and there were errors in the controlled drugs register.

All patients were assessed on admission to the wards, which included an assessment of their mental and physical health and a risk assessment.

Staff treated patients with dignity and respect and were responsive to their needs. Patients were given information about the service and their care and how they could make comments or complaints.

Most of the care records we looked at were person centred and recovery orientated, but there were gaps on some of the wards. Patients had their basic physical healthcare needs met, but the trust was working to improve this further.

Staff reported and investigated incidents, action was taken and learning was shared with staff through supervision, meetings and bulletins. Most patients were admitted to a hospital within the trust when they needed a bed.

We found that services were well led and that staff were familiar with the vision and values of the organisation. They were aware of the trust's initiatives that aimed to reduce the use of restraint within the trust, no force first and the zero tolerance to suicide strategy.

Managers of the service met regularly to review practices and areas of concern. They provided staff with regular supervision and appraisal and ensured that staff had under gone training, including being up to date with mandatory training.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

The trust had implemented a “no force first” initiative to reduce the use of restraint. The trust monitored the use of physical restraint through its incident management system. However, patients receiving rapid tranquilisation were not always physically monitored afterwards as required.

Medication was managed safely in most areas. However, there had been problems identified at Broadoak Unit where there was limited pharmacy input.

The trust had emergency equipment, but it had not always been checked and replaced when necessary. The trust took immediate action when this was identified.

The wards were regularly short of permanent staff, and these posts were filled with bank and agency staff, but sometimes not filled at all. However, the trust was closely monitoring staffing levels, and had recruited more staff as part of its recruitment plan.

Although the quality of the physical environment varied across the four hospital sites, action had been and was continuing to be taken to reduce ligatures and environmental risks on all the wards. The wards were clean and maintained. There were dedicated wards for men and women and the mixed wards had separate areas for men and women to sleep, segregated bathrooms and single sex lounges.

The use of seclusion was in accordance with the Mental Health Act code of practice.

Most staff were up to date with their mandatory training.

All patients had a risk assessment, and their level of risk and the action needed to manage this was reviewed regularly.

Incidents were reported and investigated, action was taken and learning was shared with staff through supervision, meetings and bulletins.

Are services effective?

Good

We rated effective as good because:

All patients were assessed on admission to the wards, which included an assessment of their mental and physical health and level of risk.

Summary of findings

Most of the care records we looked at were person centred and recovery orientated. However, there were gaps on some of the wards. Patients had their physical healthcare needs met, but the trust was working to improve this.

NICE guidance was followed in the prescribing of medication.

The wards had a multidisciplinary team of staff. However, there was limited psychology input on the wards, which the trust had recognised and was recruiting more psychology staff.

Staff received regular supervision and appraisal.

Patients' care was reviewed regularly by the multidisciplinary team.

The trust had Mental Health Act (MHA) administrators to support the effective implementation of the MHA. The sample of MHA documentation we reviewed was completed correctly in most areas. Detained patients had their rights under the MHA explained to them. However staff did not always record if this explanation had been repeated, particularly if the person hadn't fully understood.

Patients had access to an independent mental health advocate (IMHA). The trust had policies regarding the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS). Staff understanding of these was variable, but they knew how to access information and advice if required.

Are services caring?

Good

We rated caring as good because:

Most of the patients we spoke with were positive about the service and the staff who provided it.

Patients were involved in their care planning.

Staff treated patients with dignity and respect and were responsive to their needs.

Patients were given information about the service and their care and how they could make comments or complaints. There was an advocacy service that provided independent support for patients.

Are services responsive to people's needs?

Good

We rated responsive as good because:

Most patients were admitted to a hospital within the trust when they needed a bed. However, there were patients placed outside the trust. The trust had bed management processes for reviewing the availability of beds, and reviewing the needs of patients so they had a suitable place to be admitted and discharged to.

Summary of findings

There were adequate facilities for patients which included activity rooms, quiet areas, and outdoor space.

Patients had access to food throughout the day, and were able to use a ward phone or their own mobile phone.

There were activities and therapy groups available for patients.

Facilities were accessible by people using a wheelchair.

Translation services were available for patients who did not speak English.

There were multi faith rooms, access to spiritual support, and food available to meet people's religious and ethnic need.

Patients knew how to make a complaint. Patients could also raise their concerns through the community meetings, by local resolution with ward staff, and through the patient advice and liaison service (PALS) officer.

However, at the time od the inspection, the trust had psychiatric intensive care unit (PICU) beds for men, but was not commissioned to provide bed for women. Until the PICU was ready to admit women in August 2015, female patients who needed a PICU bed had to be placed outside the trust, which could lead to delays.

Are services well-led?

Good

We rated well led as good because:

Staff were familiar with the trust's initiatives that aimed to reduce the use of restraint within the trust, and the incidence of suicide by its patients.

Managers throughout the service met regularly and reviewed practices and areas of concern within the service.

Routine audits were carried out which fed into trust and commissioner-led targets.

Incidents, including restraints, were recorded, but there was not a direct way of recording the use of rapid tranquilisation on the system.

There was a divisional risk register, which staff could request to add concerns to.

Staff felt supported by their teams and local managers, but felt under pressure because of the staffing problems on the wards.

Staff told us they felt they could raise concerns about the service. Six of the 10 wards were accredited through the Royal College of Psychiatrists' AIMS programme.

Summary of findings

There were specific pilots and research projects being carried out on some of the acute wards which included working with veterans and people who had experienced trauma.

Summary of findings

Information about the service

The acute wards for adults of working age and psychiatric intensive care units (PICU) provided by Mersey Care NHS Trust are part of the trust's local services division.

Acute wards for adults of working age and psychiatric intensive care units are provided across three sites in Liverpool: Broadoak Unit, Clock View Hospital and Windsor House; and the Hesketh Centre in Southport.

Broadoak Unit has three acute wards for adults of working age: Albert ward, Brunswick ward and Harrington ward. Albert ward has 17 beds for men, Harrington ward has 17 beds for women, and Brunswick ward has 24 beds and admits both men and women.

Clock View Hospital has three acute wards for adults of working age: Alt ward, Dee ward and Morris ward. All three wards have 17 beds. Morris ward is for men, Dee ward is for women, and Alt ward is for both men and women. There is one PICU for the trust called Newton ward. At the time of our inspection Newton ward had eight male beds and work was underway to open a further four beds for women.

Windsor House has one acute ward for adults of working age. This is called Windsor House ward and has 24 beds for both men and women.

The Hesketh Centre has two units for adults of working age: Park unit and Rowbotham unit. Park unit has 20 beds for men and women. The Rowbotham unit is a four bed assessment unit for men and women.

We have inspected the services provided by Mersey Care NHS Trust 16 times between 2011 and 2015. At the time of the last inspections, all service at these locations had met the essential standards inspected.

Our inspection team

The team was comprised of:

Three inspectors, a Mental Health Act reviewer, two experts by experience, an independent mental health advocate (IMHA), an occupational therapist, a pharmacist, a psychologist, two psychiatrists, five registered mental health nurses and a social worker.

Why we carried out this inspection

We inspected this core service as part of our ongoing comprehensive mental health inspection programme.

How we carried out this inspection

To fully understand 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?

Before the inspection visit, we reviewed information that we held about these services, and asked a range of other organisations to tell us what they knew;

During the inspection visit, the inspection team:

- visited all 10 of the wards at four hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 52 patients

Summary of findings

- spoke with the managers or acting managers for each of the wards
- spoke with 64 other staff members; including doctors, nurses, health care assistants, occupational therapists, psychologists and pharmacists
- interviewed the matrons or senior staff with responsibility for these services
- attended and observed hand-over meetings, multidisciplinary meetings, community meetings, and activity groups which included mindfulness and anger management
- collected feedback from 29 patients using comment cards
- Looked at 51 treatment records of patients
- carried out a specific check of the medication management on two wards, observed medication rounds, and looked at prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the provider's services say

We spoke with 52 patients. Most of them were positive about the service that they received and the staff who provided it. They told us that most staff were respectful, helpful and caring and even when the ward was busy, they made time to spend with patients. When staff were less helpful, patients tended to attribute this to temporary staff who were less familiar with the ward.

Most of the patients we spoke with said they felt involved in their care planning.

During our inspection we observed mostly positive interactions between staff and patients. Staff were friendly and responsive, and accommodated patients and relatives' needs.

Good practice

- Morris ward at Clock View Hospital was piloting a veteran's programme, which focused on working with military personnel with mental health concerns. There were two beds on the ward available for former veterans, which were located in a quiet area of the ward.
- Windsor ward was piloting a "restrain yourself" project, as part of a pilot with a university. This was for patients who had experienced trauma, and provided them with the option of going to a quiet room with adjustable mood lighting.
- Harrington ward at Broadoak Unit had an established reflective practice group for staff, that focused on supporting staff to work effectively with women with a personality disorder.

Areas for improvement

Action the provider MUST take to improve

Action the provider SHOULD take to improve

Action the provider SHOULD take to improve

- The trust should continue to monitor its staffing levels and recruitment strategy to ensure there are enough appropriately skilled staff to provide safe and effective care for patients.
- The trust should ensure that staff are knowledgeable in its use, and that this is recorded consistently in the incident management system.
- The trust should ensure that staff are familiar with the recording requirements for keeping an accurate record of the administration and disposal of controlled drugs.
- The trust should review its pharmacy input into Broadoak Unit, to ensure that medication is managed effectively.

Summary of findings

- The trust should ensure that adequate emergency equipment is available for staff to use in the event of a medical emergency.
- The trust should ensure that informal patients' rights are understood by staff and patients.
- The trust should ensure that detained patients have their rights explained to them routinely, and are that this is repeated in accordance with the Mental Health Act code of practice.
- The trust should review its provision of psychology services to the acute wards and psychiatric intensive care unit, to ensure they meet the needs of patients and reflect with NICE guidance.
- The trust should ensure that all care plans are person centred and recovery focused.
- The trust should review its provision of psychiatric intensive care unit (PICU) beds for women.
- The trust should keep under review its bed availability, to ensure it is responsive to the needs of its patients.

Mersey Care NHS Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location

Mental Health Act responsibilities

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

Staff considered mental capacity and consent as part of their multidisciplinary review meetings. Most of the sample of Mental Health Act (MHA) documentation we reviewed was found to be completed correctly. However, there were some gaps on four charts in the Park Unit which we raised with the trust. Staff completed consent to treatment forms for patients detained under the MHA, and attached to the patient's medication charts. The pharmacist checked the consent forms once a week to ensure they were completed correctly.

Staff gave detained patients an explanation of their rights under the Mental Health Act, and record whether the patient had understood. However, on Broadoak Unit there was limited evidence of patients having their rights explained to them again, which included when patients had not fully understood them.

Staff told us that they had had training in the MHA, which had been provided through different routes. For example, some staff had in-house training by a MHA lead, others had completed eLearning, and others via an external solicitor, or "on the job".

All the wards had MHA administrator support, who provided scrutiny of MHA paperwork, advice about the MHA, and scanned the papers into the electronic record. They carried out audits of MHA documentation and fed this back to the wards.

Detailed findings

An independent mental health advocate (IMHA) was available for all patients detained under the MHA. Information and contact details of the IMHA service was on display in the wards.

Mental Capacity Act and Deprivation of Liberty Safeguards

There were no patients subject to deprivation of liberty safeguards (DoLS) on any of the acute wards or the psychiatric intensive care unit (PICU) at the time of our inspection.

There was training available on the Mental Capacity Act (MCA) and DoLS, but the staff we spoke with had a mixed understanding of what this meant. However, staff did know how to access advice and support about the MCA and DoLS, and knew that information was available on the trust's website.

Patients routinely had their capacity assessed by medical staff on admission, and this was reviewed throughout their stay in hospital. This was recorded on EPEX, the trust's electronic care record.

Requires improvement

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

Summary of findings

Our findings

Safe and clean environment

- The physical environment varied across the four hospital sites. Clock View Hospital was a new unit and its design incorporated good observation and minimal access to ligature points in unobserved areas. The other units had some blind spots, but these were mitigated by the use of staff observation and CCTV and mirrors on some of the wards. Ligature audits had been carried out on all the wards. These were reviewed annually and an action plan developed. Progress had been made on reducing environmental risks on the wards. Following three deaths on the Broadoak Unit changes had been to the environment across the trust. The included that the wards on the Broadoak Unit had been fitted with anti-ligature wardrobes, beds, sinks and rails. There were plans to implement these on the remaining two sites.
- The trust provided both single sex and mixed wards. The mixed wards had separate sleeping and bathing areas for men and women that were compliant with Department of Health guidance on same sex wards.
- The clinic rooms were clean and appropriately equipped. All the wards had resuscitation equipment for use in the event of a medical emergency. The resuscitation lead checked all the boxes, and secured them with a dated seal. Ward staff did not check the contents of the boxes, but routinely checked the expiry date on the seal. All the boxes were sealed and in date. However, on the Broadoak Unit we broke the seals and found that the boxes on all three wards contained missing or expired items. This included items with expiry dates in 2013 and 2014. We raised this with the trust, and they took action to ensure that all the boxes in the trust contained the correct equipment, that was in date. The trust said they would investigate and review how they monitored resuscitation equipment to prevent this happening again.
- There were seclusion rooms in the Park unit and in Clock View Hospital, but none at the Broadoak Unit or on Windsor ward. Both seclusion rooms contained the necessary features specified in the Mental Health Act (MHA) code of practice which included clear observation, view of a clock, and toilet and shower facilities. The room at the Park Unit did not contain an intercom, but staff were able to communicate with patients through the closed door which was not soundproof.
- The units were of different ages and designs, but all the wards were clean and tidy and generally well maintained. However, there were two broken showers on one of the women's wards which were awaiting repair, and a patient had been waiting three weeks to have the keypad on their bedside cabinet fixed. This was resolved during our inspection.
- There were emergency alarms and nurse call systems on all of the wards, which staff knew how to respond to.

Safe staffing

- The trust acknowledged that they had staff shortages across the wards, particularly for nurses and health care assistants. This was due to staff vacancies and staff absence, which other staff provided cover for. The trust reported that as of the 31 January 2015, the staff vacancy rate for acute wards across the trust was 17.25%. Patients told us that they could tell that the wards were short staffed, but that staff still spent time with them. Activities and section 17 leave for detained patients was sometimes cancelled but not often. Gaps in the nursing rota were filled by bank and agency staff. We had mixed feedback about the quality of bank and agency staff. Some were new to the wards, but others were the trust's own staff, or had worked there regularly and were familiar with the wards and the patients.
- There were times when shifts could not be filled. The trust used "safer staffing" which is a recognised tool for monitoring staffing levels. This included when shifts could not be filled, which was also recorded as an incident in the trust's incident management database (DATIX). The trust had new staff waiting to start, and was working to recruit further staff.

Requires improvement

Are services safe?

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

- Managers told us they were able to adjust their staffing levels in response to how busy the ward was.
- There was adequate 24 hour medical cover for the wards. Each ward had its own consultant psychiatrist, although some of these posts were covered by temporary or locum doctors.
- The trust had a system for monitoring training. Mandatory training was monitored centrally by the trust, and by ward managers and matrons at ward level. There was a training list for each staff role, which stated what training was required and how often it should be completed. This included management of violence and aggression, basic life support, Deprivation of Liberty Safeguards (DoLS), infection control, health and safety, equality, moving and handling, complaints, rapid tranquilisation and medication. The ward managers were provided with a matrix each month which highlighted the training that had been completed, and what was due. Most staff had completed most of their mandatory training, or were booked into future sessions. Training had been scheduled and booked for 2015 and 2016.

Assessing and managing risk to patients and staff

- All patients had a risk assessment carried out on admission and this was updated as necessary.
- All patients, including informal patients, had a risk assessment carried out before they went on leave.
- There were signs on the doors telling informal patients that they could leave if they wished. However, it was not clear that informal patients always understood this. One patient on Broadoak Unit said they had been there for some time before it had been explained to them by another patient. Informal patients in the Park unit had "agreed leave" and some told us that they thought they may be detained if they tried to leave.
- Risk based observation and search policies were implemented on all the wards. Observation levels were discussed on admission, and routinely as part of the multidisciplinary ward reviews. There was discussion in local management meetings about improving training for staff on how to carry out enhanced observations.
- The trust reported that in the 6 months up to 16 February 2015 there had been 179 incidents of restraint across it's acute wards and psychiatric intensive care unit.The trust had implemented a "no force first" initiative to reduce the number of restraints, and this had been effective. Staff were familiar with the initiative, which promoted a person centred and de-escalation approach to manage potential violence and aggression. Most patients we spoke with had not been restrained. Of the patients who described their experience of restraint – one felt it was handled well, another thought it was unnecessary but they could understand why it had happened. Restraints were recorded on the trust's electronic incident database. The restraint form prompts staff to record detailed information which included who was involved, which part of the patient they held, and how long for. Any medication given was also recorded. The trust policy was that prone, or face down, restraint should not be used if possible. Again, the incident reporting form prompted staff for information when a patient was restrained in the prone position, which included the reason why and for how long. This information was then reviewed so that lessons were learnt from it.
- The trust told us that they did not regularly use rapid tranquilisation. On the Broadoak Unit we found that staff had limited understanding of what constituted rapid tranquilisation and how the patient should be monitored afterwards. We looked at 13 instances where rapid tranquilisation had been administered, and found that physical health checks (such as blood pressure and pulse) had only been carried out afterwards on one occasion. Staff suggested that the observations had been taken but not recorded. However, other staff said they did not know that observations should be taken at all. Staff told us that the monitoring would be completed on the incident form. However, although the forms included prompts to record the medication administered (in some instances), they did not include a way of identifying rapid tranquilisation or prompt staff to monitor physical observations. The trust acknowledged that their rapid tranquilisation policy did not reflect the latest NICE guidance, issued in May 2015, and that this was due to be reviewed by the Chief Pharmacist.
- There were procedures for the management and administration of medication. With the exception of the Broadoak Unit, all of the wards had a pharmacist who attended ward rounds and provided advice and monitoring. Broadoak Unit had limited pharmacy input.

Requires improvement

Are services safe?

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

The trust had acknowledged this was a gap and put it on the risk register. They were recruiting for a band 5 pharmacy technician to fill the gap. We found a number of medication issues at the Broadoak Unit. These included missing signatures in the controlled drugs register on all three wards, and we observed the incorrect disposal of medication. The trust took immediate action to address these concerns.

- Seclusion facilities were only available on two wards: Newton ward, the psychiatric intensive care unit (PICU) at Clock View Hospital and on the Park unit. They were not used regularly, but when they were records were completed appropriately.
- Staff had received safeguarding training. They knew what may constitute a safeguarding concern, and either the action to take or who to seek advice from to make a safeguarding referral.
- Children were not allowed on the wards. All the wards had access to a family room that was used when children visited patients.

Track record on safety

- Three deaths had occurred on the wards at Broadoak Unit over a six month period. These were still being investigated at the time of our inspection. However, we saw that changes had been made to the Broadoak Unit, and other wards within the trust, to make the environment safer, and specific staff training had been implemented.

Reporting incidents and learning from when things go wrong

- The trust used the "DATIX" system for recording and monitoring incidents. Staff knew what to report and how to report it on DATIX. Once reported, the electronic forms were sent to managers and other relevant staff for review. For example, if there was a fire then the form would also be sent to the fire officer. If further information was required, this was requested and provided through DATIX.
- We tracked a serious incident in detail to see how the process had worked. It included meeting with and keeping relatives informed, and appointing an appropriately trained investigator and a consultant psychiatrist to provide medical input. A 72 hour report was completed which summarised the incident and the action taken so far, and any other urgent action that needed to be taken. After a further detailed investigation, a report was produced which included a root cause analysis of the incident and recommendations for action. This was reviewed by the risk manager, the validation group, board members and the director of patient safety. The clinical commissioning group (CCG) were sent the investigation report and reviewed the trust's action plan. The approved plan went back to the service leads and wards for information and implementation. Learning that could be shared across the trust went into the Quality Practice Alert (QPA) bulletin, which was forwarded to all staff.
- The trust policy was to offer staff debriefing after serious incidents. This was confirmed by most of the staff we spoke with.
- Following incidents, information was shared with staff through meetings and the QPA bulletin. Incidents and learning from them were standing agenda items at team meetings.
- Following a medication error on Alt ward, action was taken to prevent its reoccurrence. This included removing topical medications from the out of hours dispensing system and a reflective practice session and medication competency training took place with staff.

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.

Summary of findings

Our findings

Assessment of needs and planning of care

- All patients were assessed on admission to the wards, which included an assessment of their mental and physical health and a risk assessment.
- The quality of care records varied across the wards. The care we observed was patient centred, but this was not always reflected in the care records, particularly on the Rowbotham unit and Park unit. Care records at Clock View Hospital were personalised and recovery focused. At Broadoak Unit the records were person centred, but the plan of care was not always clear from the care plan, as it was documented in the daily record.
- All patient records were stored securely on an electronic system, which staff had access to from the wards and in the community teams. Paper based documents were often scanned into the electronic record. This included Mental Health Act paperwork and seclusion records. Paper records were stored securely in staff offices.

Best practice in treatment and care

- Patients had limited access to psychological therapies, which was inconsistent with NICE guidance. The Park unit and Newton Ward psychiatric intensive care unit (PICU) had a psychologist for 1.5 days each week, Windsor ward could refer patients for psychology services, and the Broadoak Unit had a psychologist for 3 days a week across three wards. The current role of psychology was primarily to provide support to staff and advise in multidisciplinary meetings. The trust have recognised this as a gap in their service and are recruiting more psychologists or psychology assistants. Harrington ward, the women's ward at Broadoak Unit, had a regular session with a consultant psychotherapist who provided a reflection group for staff every two weeks. This focused on working effectively with women with a personality disorder.
- Patients with ongoing physical health problems were monitored. Referrals were made to specialists when required. The trust had identified the need to provide consistent physical healthcare for patients. There was a physical healthcare lead at Clock View Hospital and the Broadoak Unit. The trust had implemented the modified early warning score (MEWS) system on 12 out of 16 wards. This is a chart for recording patient observations such as blood pressure, and is colour coded so that staff can easily see if it is outside the normal range and take further action or advice. The implementation on Broadoak Unit had been delayed because other training had been prioritised following serious incidents in the unit. A GP had been appointed to provide a session a week on Albert Ward at the Broadoak Unit, and to develop secondary and primary care pathways. If successful this would be considered for other wards.
- Staff used the health of the nation outcome scale (HoNOS) and payment by results (PbR) to monitor outcomes for patients.

Skilled staff to deliver care

- The wards had staff from a range of mental health disciplines which included psychiatrists, mental health nurses, occupational therapists, pharmacists and healthcare assistants. There was limited access to psychologists on all the wards. The wards had or were in the process of employing activity workers to increase the availability of activities for patients, which included in the evenings and at weekends.
- Staff had regular team meetings and supervision.. The trust had a system for monitoring the uptake of appraisals, and most staff had had an appraisal within the last year, or had one planned.
- Staff had access to additional training, but there were areas that some staff found lacking, which varied between the wards. For example, some staff had received training on working with people with a personality disorder, but others on a different unit did not feel they had the necessary skills to be effective. Suicide prevention training had been implemented across the trust.

Multi-disciplinary and inter-agency team work

- There were regularly multidisciplinary team (MDT) meetings where each patient's care was reviewed. The format varied between wards, but most patients were seen and discussed by the whole team at least once a week. For example, the MDT meetings at Broadoak Unit

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.

included a detailed review of the patient's mental and physical healthcare, discussion of their rights under the Mental Health Act if they were detained, and involved community workers and families where appropriate. A recovery approach was taken which included an estimated discharge date. Clock View Hospital also had an acute care team meeting each weekday morning where every patient was discussed and necessary actions taken.

- There were effective handovers between nursing staff at the beginning and end of each shift.
- Inpatient staff described positive working relationships with the community teams, particularly those whose geographical areas the wards served. However, they stated that there could be difficulties getting staff from social services or care coordinators to attend on a regular basis. The wards had reviewed how they scheduled reviews to make it easier for community staff to plan this into their schedule. For example, in Broadoak Unit reviews took place every day, but patients would be given a specific day and time which would be the same each week.

Adherence to the MHA and the MHA Code of Practice

- We do not rate responsibilities under the Mental Health Act 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.
- Capacity and consent were reviewed as part of the multidisciplinary review meeting. Most of the sample of Mental Health Act (MHA) documentation we reviewed was found to be completed correctly. However, there were some gaps on four charts in the Park unit which we raised with the trust. Consent to treatment forms for patients detained under the MHA were completed and attached to the patient's medication chart. The pharmacist checked the consent forms once a week to ensure they were completed correctly.
- All detained patients had their rights under the MHA explained to them and their understanding documented. However, on Broadoak Unit there was limited evidence of patients having their rights explained to them again, which included when patients had not fully understood them.
- Staff told us that they had had training in the MHA, but it had been provided through different routes, so was not consistent. For example, some staff had in-house training by a MHA lead or an external solicitor, others had completed eLearning, and others said their training had been "on the job".
- All the wards had MHA administrator support who provided scrutiny of MHA paperwork, advice about the MHA, and scanned the papers into the electronic record. They carried out audits of MHA documentation and fed this back to the wards.
- An independent mental health advocate (IMHA) was available for all patients detained under the MHA. Information and contact details of the IMHA service was on display in the wards.

Good practice in applying the MCA

- There were no patients subject to deprivation of liberty safeguards (DoLS) on any of the acute wards or the psychiatric intensive care unit (PICU) at the time of our inspection.
- There was training available on the Mental Capacity Act (MCA) and DoLS, but the staff we spoke with had a mixed understanding of what this meant. However, staff did know how to access advice and support about the MCA and DoLS and knew that information was available on the trust's website.
- Patients routinely had their capacity assessed by medical staff on admission, and this was reviewed throughout their stay in hospital. This was recorded in the trust's electronic care record.

Good

Are services caring?

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

Summary of findings

Our findings

Kindness, dignity, respect and support

- The patients we spoke with were mostly positive about the service they received and the staff who provided it. They told us that most staff were respectful, helpful and caring, and even when the ward was busy they spent time with patients. When staff were less helpful, patients tended to attribute this to temporary staff who were less familiar with the ward.
- During our inspection we observed mostly positive interactions between staff and patients. Staff were friendly and responsive and accommodated patients and relatives' needs.
- Most staff we spoke with were person centred in their discussions about patients and their care.

The involvement of people in the care they receive

- Patients were given an admission pack when they arrived on the ward, and shown around by staff. The admission pack included information about the daily routine of the ward, care and treatment, how to make a complaint and their rights.
- Most patients we spoke with said they felt involved in their care planning. This included some patients who did not have copies of their care plans. The care records and multidisciplinary team meetings we observed engaged, or attempted to engage patients in decisions about their care. We saw that where, for example, a patient didn't wish to come into the multidisciplinary ward round, the consultant psychiatrist went to see them individually and then fed back the discussion to the team. Patients told us that their families were involved as much as they wished in their care.
- Patients had access to an advocacy service. The advocacy service had previously been based at the Broadoak Unit but had recently moved to Clock View Hospital. Posters and information leaflets advertised the service on the wards. There had been initial problems with contacting the service, because of problems with the phone number provided, but this has been resolved. The trust has a contract with an independent service to provide the service.
- Community meetings were held on all the wards. The frequency varied, but most were held weekly. Patients raised their concerns and made suggestions. Notes of the meetings were displayed on the wards, and used a "you said, we did" format to demonstrate the action that had been taken.
- Patients were involved in the recruitment of staff.

Are services responsive to people's needs?

Good

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

Summary of findings

Our findings

Access and discharge

- The hospital a patient was admitted to was normally determined by the address of the GP practice they were registered with. For example, if a patient had a GP in Liverpool they would be admitted to the Broadoak Unit. If their GP was in Sefton they would go to Clock View Hospital. The person would be admitted to where there was a bed, taking account to their gender and if they had been admitted to a particular ward before.
- There were multiple points of referral to the inpatient service and the decision to admit did not sit with one gatekeeping team. Once a decision had been made to admit a patient, the referral was sent to the non-clinical bed management team to find a bed. The team sent out a bed state twice a day, which included all inpatient wards in the trust. The bed state included a traffic light or red/amber/green rating for each ward which indicated the acuity or levels of activity. This took account of the number of leave beds, patients who were absent without leave and any enhanced observations. It did not include other factors that may influence the acuity of the ward, such as staff vacancies, admissions, or the current patient group.
- Staff confirmed that the wards were usually full and that the beds of patients on leave were often used when other patients needed to be admitted.
- Bed management meetings were held twice a week and attended by modern matrons, service leads, ward managers and community staff.
- At the time of our inspection there were six patients in private beds, which included in hospitals some distance away from the trust such as London and Harrogate. There were two patients in other NHS trusts. The trust had a capacity and flow manager, whose role included reviewing patients in out of area placements and prioritising when they could return to the trust.
- The trust had one psychiatric intensive care unit (PICU), Newton ward at Clock View Hospital. This provided care for up to 8 men and there were no men in out of area PICU beds at the time of our inspection. There were no female PICU beds in the trust. There was an arrangement with a PICU in another NHS trust, but they did not always have beds available. We saw an example where a female patient had been assessed as needing a PICU bed, but the transfer was delayed because there were no beds available. Another female patient was temporarily transferred to a forensic bed whilst waiting for a PICU bed to become available. Newton ward was in the process of being finished so that it would be able to admit up to four female patients. Staff recruitment was underway and the trust were planning to open this part of the ward in August 2015.
- The staff we spoke with had a differing understanding of what the criteria was for a "delayed discharged". However, there were patients who could not be discharged until a suitable placement had been found for them. The capacity and flow manager also identified patients who may have complex needs, and ensured that inpatient and community staff were focused on early discussion and action around a suitable placement for the patient when they were discharged. Staff told us that a significant block to discharging patients was the length of time it could take for funding for accommodation to be approved, which was out of the control of the trust.

The facilities promote recovery, comfort, dignity and confidentiality

- Services were provided across four different sites, so the facilities varied across the wards. For example, Clock View Hospital was recently built and was bright and modern. Clock View Hospital and the Broadoak Unit had rooms available for activities on the wards and access to spaces outside the ward which were shared with the rest of the hospital. This included dedicated activity and therapy rooms. The Park unit, Rowbotham unit and Windsor ward had less shared spaces, so relied on space on the ward.
- All the wards had activity rooms, quiet rooms, and places for patients to make phone calls. Payphones were in the corridor on some of the wards, so were not private. However, most patients had their own mobile phones which they used. Some wards had cordless phones available for patient use.

Are services responsive to people's needs?

Good

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

- All the wards had access to outdoor space, though this varied across the sites. For example, at Clock View Hospital the outdoor areas were spacious with plenty of seating. At Broadoak Unit access from the upstairs wards was via a metal spiral staircase, and the wards had 30 minutes of each hour when it could be used, so that only one ward had access at a time. The landing and stairs were boxed in with metal bars. This reduced the risks of self-harm, but created a caged-in effect.
- Patients on all four sites gave us mixed views of the quality of the food. There were drinks and snacks available 24 hours a day.
- Patients said that there were plenty of activities available, and staff spent time with patients. Activities available included pool, board games, football, puzzles, art, and tai chi. Occupational therapy groups included a breakfast group, recovery groups and cooking. Activities were provided primarily by occupational therapy staff during the week, and by nursing staff and health care assistants outside of this. The trust had employed activity workers to support the availability of activities in the evenings and weekends.
- The bedrooms at Clock View Hospital were all single and ensuite. They had bi-coloured floors, with areas marked in one colour to show the personal space of the patient and the other to show the area that staff would use on entry to the room. Beds in other parts of the trust were mainly provided in dormitories with shared bathroom and toilet facilities.
- Patients on Morris ward at Clock View Hospital had keys to their rooms. Patients on the other acute wards had a lockable bedside cabinet to safely store their possessions in.

Meeting the needs of all people who use the service

- The wards were wheelchair accessible, but some provided better facilities than others. For example Windsor ward was on the ground floor, and Clock View Hospital had rooms that could be assigned to patients who used a wheelchair.
- Information leaflets were available on the wards. Staff told us that different translations were available online. Staff told us they could access face to face interpreters, but used the phone interpretation service if the need was urgent. Staff booked interpreters for multidisciplinary meetings, but also so nurses could have effective 1-1 sessions with patients.
- Patients could access a multifaith room on all of the hospital sites. A chaplaincy service was available, and staff supported patients to contact the appropriate religious leader when requested.
- Food was available for patients who had religious or ethnic dietary needs.

Listening to and learning from concerns and complaints

- Information about how to make a complaint was provided to patients on admission, and was on display on the wards. The patients we spoke with told us they knew how to make a complaint. There were community meetings on all the wards where patients could raise their concerns. The patient advice and liaison service (PALS) officer attended some of the community meetings and was available to speak directly with patients.
- Staff were familiar with the complaints process. There was a policy for dealing with formal complaints and a local resolution policy. Staff used the local resolution policy for dealing with minor complaints, which they attempted to resolve quickly and prevented them becoming formal complaints. All complaints were reviewed by the matron and the deputy director of operations. A decision was taken as to whether it was suitable for local resolution or if it was a more significant issue, which the matron would deal with. Staff told us that they had not received lots of complaints, but a common theme was the lack of activities, particularly in the evenings and at weekends. In response to this the trust had employed activity workers.
- We saw examples of complaints raised directly with the ward manager and with the complaints team. A record was kept of the time taken to complete the investigation and informing the complainant. The examples showed that the complaints had been investigated and responded to appropriately and took account of the complainant's point of view. Themes and learning from complaints were fed back to staff through team meetings, supervision and quality practice alerts, which is an information sharing bulletin for staff.

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.

Summary of findings

Our findings

Vision and values

- Staff were aware of the trust's values . They were familiar with the trust's initiatives such as "no force first" to reduce the use of restraint, and their "zero tolerance" approach to suicide.

Good governance

- The trust monitored and managed staffing levels through the "safe staffing" tool, which was completed at ward level, and fed into the trust's management information and targets. This was reviewed at board level. A number of routine audits were carried out, some of which related to the trust's key performance indicators (KPIs) and the commissioning for quality and innovation payment framework (a national initiative where trusts benefit financially by achieving local quality improvement goals). For example, audits were carried out on the care programme approach (CPA) records, risk assessments and management plans and supported or enhanced observations.
- Ward managers used reports that were generated from the information on the electronic care record system, to monitor patient care. For example, on Brunswick ward at Broadoak Unit, there were ten occasions when a patient's body mass index (BMI) was not recorded. BMIs are used to determine is a healthy weight, and the missing information was flagged as a breach of a KPI. The ward manager told us she knew the reason behind the missing information and had addressed the problem.
- Ward managers told us they felt they had sufficient authority to carry out their role.
- The trust had a number of different meetings that fed into one another. A local management meeting happened every week, which included discussion of complaints and adverse incidents. It was attended by managers from the Broadoak Unit, Windsor ward and occupational therapy.
- There was a leadership hub meeting that occurred once every 5-6 weeks. The matron chaired this and it was attended by a variety of staff from the multidisciplinary team. They reviewed a range of issues which included staffing levels and the care of patients with complex needs.
- Modern matrons met regularly with matrons from from other local division services. These meetings looked at standardising processes within the trust and having theses agreed by the group and signed off by the director of nursing.
- There were also professional meetings for the consultants and the allied health professionals, which the occupational therapists attended.
- There were various divisional meetings, with the acute wards and psychiatric intensive care units (being part of the local services division. These included the surveillance meeting, where monitoring information was reviewed, and any issues of concern discussed. This included complaints, incidents, safe staffing, patients who are absent without leave, sickness absence, and the 72 hour reporting process.
- Restraints were recorded on DATIX, and this produced a number of prompts for information that must be entered to ensure that patients are kept safe, and that a proper record is kept that can be audited by the trust. However, we found although the use of medication was recorded, there was no question asking if a patient had received rapid tranquilisation. Staff confirmed that the only way to do this would be to search for the specific words, or manually review the records. We saw an example where a patient had been restrained and given rapid tranquilisation. This appeared to have been carried out safely and the patient had had their physical observations monitored afterwards. However, the incident was recorded on DATIX as a "breach of security" as the patient had been trying to leave the ward. This meant that it was not formally recorded as a restraint, so the checks and audit trail for this were not generated by the form. Consequently, when generating reports this incident would not automatically flag as a restraint or as a use of rapid tranquilisation. However, the trust reviewed all incidents during surveillance meetings.
- There was a divisional risk register for local services, which included the inpatient wards and community

Are services well-led?

Good

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services. There was a template for staff to add items to the risk register. Any member of staff could submit this and it was reviewed by the divisional safety group and/or the divisional governance board. The divisional board decided if it would be added to the risk register and the action that needed to be taken to manage the risk. The risk register was updated monthly and emailed to ward managers to share with teams.

- We looked at the local services divisional risk register dated 27 May 2015. This included a traffic light or red/amber/green rating for each item, a description of each risk, who was responsible for managing the risk, the action taken and the assurances about this. There was one red item (extreme risk) around staffing. There were multiple amber items (high risk) which included access to beds, psychology input, ligature issues and physical healthcare KPIs not met. We saw that action was been taken to address these issues. The lack of female psychiatric intensive care unit beds was not recorded on the risk register.

Leadership, morale and staff engagement

- Staff said they felt able to raise concerns about the service within the trust. This included with their immediate managers, and by using the "tell Joe" email address, which sent concerns directly to the chief executive.
- Staff had mixed views about staff morale within the service. Most staff felt supported by their local managers, but under pressure because of staffing problems. Some staff were generally satisfied with their role, but others felt that morale was low following incidents that had occurred. Most staff felt supported by their team and thought that the multidisciplinary team worked well. Staff in Clock View Hospital were positive about the service, especially now that they had moved into the new hospital. They felt that their opinions had been considered in the development of the service and there had been regular meetings to suggest changes and the direction of development.

Commitment to quality improvement and innovation

- Both acute wards at the Hesketh Centre, Windsor ward, Newton ward (PICU) at Clock View Hospital, and two of the three wards at the Broadoak Unit had achieved accreditation for inpatient mental health services (AIMS), a nationally recognised set of standards for mental health care from the Royal College of Psychiatrists.
- Newton ward was also a member of the national association of psychiatric intensive care and low secure units, a member organisation which promoted the development of PICU and low secure services.
- Morris ward at Clock View Hospital was piloting a veterans programme, which focused on working with military personnel with mental health conditions. There were two beds on the ward available for former veterans, which were located in a quiet area of the ward. The ward provided a list of available services and referred former military personnel onto suitable community support services for veterans.
- All of the wards were involved in the trust's "no force first" programme to reduce the use of restraint in the trust, and its zero tolerance to suicide strategy. No force first was initially piloted on Morris ward and PICU at Clock View Hospital.
- Windsor ward was piloting a "restrain yourself" project, as part of a pilot with a university. This was for patients who had experienced trauma and provided them with the option of going to a quiet room with adjustable mood lighting. The patient was not secluded, but was alone in the room and checked on by staff intermittently.

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 Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment Rapid tranquilisation was not carried out in accordance with NICE guidance, as patients did not always have physical healthcare checks carried out afterwards, which may put them at risk. This was in breach of regulation 12(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.