Requires improvement

Pennine Care NHS Foundation Trust

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

Quality Report

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Date of inspection visit: 12 to 14 June 2017
Date of publication: 30/08/2017

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RT201	Bury Mental Health Services	North ward	BL9 7TD
RT201	Bury Mental Health Services	South ward	BL9 7TD
RT202	Tameside Mental Health Services	Saxon ward	OL6 9RW
RT202	Tameside Mental Health Services	Taylor ward	OL6 9RW
RT202	Tameside Mental Health Services	Northside ward (temporarily decant ward)	OL6 9RW
RT203	Oldham Mental Health Services	Southside ward	OL1 2JH
RT204	Rochdale Mental Health Services	Hollingworth ward	OL12 9QB

Summary of findings

RT204	Rochdale Mental Health Services	Moorside ward	OL12 9QB
RT205	Stockport Mental Health Services	Cobden ward	SK2 7JG
RT205	Stockport Mental Health Services	Arden ward	SK2 7JG
RT205	Stockport Mental Health Services	Norbury ward	SK2 7JG

This report describes our judgement of the quality of care provided within this core service by Pennine Care NHS Foundation 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 Pennine Care NHS Foundation Trust and these are brought together to inform our overall judgement of Pennine Care NHS Foundation Trust.

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

This was a focused inspection, where we inspected part of the 'safe' key question. We checked whether improvements had been made following our last inspection and followed up information we had received about incidents. We rated safe as requires improvement at our last inspection in June 2016. The trust told us that it was still implementing its action plan to address this. This was consistent with our findings, which showed improvements in some areas, but others that still needed to be addressed.

We did not rate acute wards for working age adults and psychiatric intensive care units at this inspection.

We found the following issues that the service provider needs to improve:

- The trust was not effectively managing the risks of mixed sex accommodation. There were still occasions when patients had to sleep in a room other than a bedroom, because there was not a bed available.
- Incident investigations were of a variable quality and learning was not always shared effectively.
- The trust had a policy for nursing patients away from others, but as patients were not always able to leave when they wished, this appeared to be seclusion, without the necessary safeguards or monitoring.
- There was a longstanding, persistent smell in the Taylor ward female lounge.

However, we also found the following areas of good practice:

- The trust was now storing medicines safely.
- Staff had completed most of their mandatory training. Most qualified nurses had completed immediate life support training, so there was always a suitably skilled nurse available in the event of a medical emergency.
- The patients were spoke with were mostly positive about the staff and the service they received.
- Risk assessments were carried out, and plans of care developed from these. The completeness and quality of the documentation of this was variable, but had improved since the last inspection.

Summary of findings

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

Are services safe?

We did not rate acute wards for working age adults and psychiatric intensive care units at this inspection.

We found the following issues that the service provider needs to improve:

- When no beds were available, it had been necessary for patients to sleep on a sofa in a lounge. This had happened on at least eight occasions in the six months prior to the inspection. The system that the trust had put in place to report and monitor this was very new and did not provide sufficient detail for effective monitoring.
- The trust had taken some action to address gender separation on the wards, but this was still an area of concern. Patients were still being accommodated in bedrooms that were designated for people of the opposite gender and sharing bathrooms. Incidents reviewed before and during the inspection, showed that this was not being managed safely, nor was it effectively reported and monitored.
- There were consultant, nursing and healthcare support worker vacancies which put pressure on the service. However, the trust used bank and agency staff to cover shifts and was working to recruit to posts.
- Staff were not monitoring the health of patients who had received rapid tranquilisation consistently and in line with trust policy.
- Care plans and risk assessment information were not always easy to find in patients' records. Vital signs monitoring was not recorded consistently, or the action taken in response to the monitoring.
- The trust had a policy for nursing patients away from others, usually in their bedroom or a 136 suite. Staff did not always permit patients to leave the area when they wished. We concluded that this constituted seclusion, without the necessary safeguards or monitoring.
- Incident investigations were of a variable quality and learning was not always shared effectively.

However, we also found the following areas of good practice:

- Staff carried out risk assessments of patients and plans of care reflected this.

Summary of findings

- Seclusion was implemented appropriately in the psychiatric intensive care unit.
- Medication was well managed. When errors occurred these were recorded and action taken.
- There was an ongoing recruitment process and vacancies were usually filled by bank and agency staff. The trust used the standard NHS 'safer staffing' tool to monitor acuity and calculate the required staffing levels.
- Staff reported incidents when they occurred, and the trust's electronic system had been updated to reflect new types of events that needed reporting.
- Staff had carried out ligature audits, and action had been taken to mitigate against environmental risks. However, where lounges were being used as bedrooms, the risk assessments had not been reviewed to check whether the controls in place still reduced the risks.
- Clinic rooms were clean, and emergency equipment was available and routinely checked.
- Staff were mostly up to date with their mandatory training. Most qualified nurses had completed immediate life support training, so there was always a suitably skilled nurse available in the event of a medical emergency.
- Staff were knowledgeable about potential safeguarding concerns, and how to report them.

Summary of findings

Information about the service

Pennine Care NHS Foundation Trust provides 10 acute wards for adults of working age, and one psychiatric intensive care unit, across five sites.

Irwell Unit is in the grounds of Fairfield General Hospital in Bury, and has two acute admission wards for working age men and women:

- North ward – 24 beds, for both males and females. At the time of the inspection, there were 12 men and 12 women on the ward.
- South ward – 24 beds, for both males and females. At the time of the inspection, there were 11 men and 13 women on the ward.

Tameside General Hospital – the Etherow Building is in the grounds of the general hospital in Ashton-under-Lyne, and has two acute admission wards for working age men and women:

- Saxon suite – 23 beds, for both males and females. At the time of the inspection, there were 11 men and 12 women on the ward.
- Taylor ward – 22 beds, for both males and females. At the time of the inspection, there were 12 men and 10 women on the ward.
- Northside ward (formerly at Parklands House, and temporarily moved during refurbishment) is also temporarily known as "decant" ward and is based in the Buckrow building in the grounds of the general hospital. This is a 19-bed acute admission ward for working age men only. There was one shared room. At the time of the inspection, there were 19 men on the ward.

Parklands House is in the grounds of the Royal Oldham Hospital in Oldham, and has one acute admission ward for working age men and women:

- Southside ward – 22 beds, for both males and females. At the time of the inspection, there were 7 men and 15 women on the ward.

Rochdale Mental Health Services – the John Elliot Unit is in the grounds of Birchill Hospital in Rochdale, and has two acute admission wards for working age men and women:

- Hollingworth ward – 18 beds, for both males and females. At the time of the inspection, there were 13 men and 5 women on the ward.
- Moorside ward – 24 beds, for both males and females. At the time of the inspection, there were 14 men and 10 women on the ward.

Stepping Hill Hospital – the Mental Health Unit is in the grounds of the general hospital in Stockport, and has two acute admission wards for working age men and women and a psychiatric intensive care unit:

- Arden ward – 24 beds, for both males and females. At the time of our inspection, there were 13 men and 11 women on the ward.
- Cobden ward – 10 bed psychiatric intensive care unit for men only. At the time of the inspection, there were 10 men on the ward.
- Norbury ward – 23 beds, for both males and females. At the time of the inspection, there were 13 men and 10 women on the ward.

Our inspection team

Our inspection team was led by:

Team Leader: Sarah Dunnett, inspection manager, CQC.

The team that inspected acute wards for adults of working age comprised a CQC inspection manager, six CQC inspectors, and a CQC pharmacist inspector.

Summary of findings

Why we carried out this inspection

We carried out this focused inspection to check whether improvements had been made following our last inspection, and to follow up on information we had received about incidents.

We undertook this inspection to find out whether Pennine Care NHS Foundation Trust had made improvements to its acute wards for adults of working age and psychiatric intensive care units since our last comprehensive inspection of the trust in June 2016. We also wanted to follow up on information we had received about incidents.

When we last inspected the trust in June 2016, we rated acute wards for adults of working age and psychiatric intensive care units as **requires improvement** overall.

We rated the core service as requires improvement for safe, effective, responsive and well-led and good for caring.

Following the June 2016 inspection, we told the trust it must make the following actions to improve acute wards for adults of working age and psychiatric intensive care units:

- The trust must ensure that clinical staff meet the needs of patients and respond to requests by patients in a timely manner.
- The trust must ensure that all care plans are personalised.
- The trust must ensure that all wards are compliant with the Department of Health guidance on same sex accommodation in order to ensure the safety, privacy and dignity of patients.
- The trust must ensure that the layout of the wards and access to outside space ensures the safety privacy and dignity of patients.
- The trust must ensure that all wards comply with national guidelines and trust policy on rapid tranquilisation. Physical observations must be monitored following rapid tranquilisation on the approved form and within the correct timescales.
- The trust must ensure that staff follow trust policy when cancelling a medicine on a patient's chart.
- The trust must ensure that fridge temperatures are properly monitored and maintained.
- The trust must ensure that the temperature in clinic rooms is within recommended guidelines.
- The trust must ensure that medications are administered and recorded as prescribed.
- The trust must ensure that staff receive supervision in line with trust policy.
- The trust must ensure that mandatory training reaches trust targets in all areas.
- The trust must ensure that the continuity of care for patients is maintained and patients are not routinely moved wards or areas during their period of admission.

These related to the following regulations under the Health and Social Care Act (Regulated Activities) Regulations 2014:

- Regulation 9 Person-centred care
- Regulation 10 Dignity and respect
- Regulation 12 Safe care and treatment
- Regulation 18 Staffing

How we carried out this inspection

At our inspection in June 2016 we found areas where the trust needed to make improvements. The trust sent us an action plan which set out when it would make these improvements. At this inspection we looked only at parts of the safe key question, as this was where the trust told us they had completed actions. We also wanted to follow up on incidents that had been reported to CQC.

The trust was continuing to work on the other areas identified in June 2016. Because we did not assess all elements of the safe key question we have not re-rated the key question.

Before the inspection visit, we reviewed information that we held about these services.

During the inspection visit, the inspection team:

Summary of findings

- visited the psychiatric intensive care unit and nine of the ten acute wards for adults of working age across five hospital sites, and looked at the ward environment and observed how staff were caring for patients
- spoke with 39 patients, and four carers or family members of patients
- spoke with the managers or deputy ward managers for each of the wards, and other senior managers
- spoke with 36 other staff members including nurses, healthcare support workers and doctors
- looked at 47 treatment records of patients
- looked at other patient-related information such as incident forms, handover sheets and observation charts
- carried out specific checks of medication management
- looked at 114 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 39 patients and four carers or family members of patients. Most of the patients we spoke with were positive about the staff and said they found them helpful and responsive. Most patients said they felt safe on the ward. A small number of patients said the wards could feel unsafe when it was very busy, or when other patients were aggressive.

Patients told us that the staff were often very busy, but usually made time for one-to-ones or other activities. They said that these could be delayed if the ward was busy, but usually happened.

Patients who had been on leave said they usually had a bed when they returned, but this may not be the same one. There were patients who had slept in the lounge, and had been unhappy about this.

Areas for improvement

Action the provider MUST take to improve

The trust had actions that it must take to improve from the previous inspection in June 2016.

- The trust must review the use and monitoring of interventions where patients are nursed away from others to ensure that patients are safe, and practices are effectively monitored and reviewed.
- The trust must review how it manages risks to patients when allocating beds, including with regards to sleeping in rooms that are not designated bedrooms, or are in areas shared with the opposite gender.
- The trust must ensure that investigations into incidents are investigated thoroughly and learning is shared to prevent recurrence.

Action the provider SHOULD take to improve

- The trust should review its incident policy to ensure that incidents are investigated by the most suitable staff.
- The trust should ensure that its policies are clear, and that patients are monitored appropriately following the administration of medication for rapid tranquilisation.
- The trust should ensure that patients' vital signs are monitored and recorded when necessary, and appropriate action is taken in response.
- The trust should ensure that risk assessments and care plans are easily identifiable in patients' records.
- The trust should ensure that the wards are free from offensive smells, such as the longstanding smell in the Taylor ward female lounge.

Pennine Care NHS Foundation Trust

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

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
North ward	Bury Mental Health Services
South ward	Bury Mental Health Services
Saxon ward	Tameside Mental Health Services
Taylor ward	Tameside Mental Health Services
Northside ward (temporarily decant ward)	Tameside Mental Health Services
Southside ward	Oldham Mental Health Services
Hollingworth ward	Rochdale Mental Health Services
Moorside ward	Rochdale Mental Health Services
Cobden ward	Stockport Mental Health Services
Norbury ward	Stockport Mental Health Services

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 trust had carried out ligature audits of all wards between July 2016 and March 2017. These identified that risks were present, and that these were reduced by the use of control measures. However, these had not been reviewed to ensure that they captured the risks when lounges were used as bedrooms. The audit was online and used the trust's standardised tools. It included curtains, rails, windows and doors. We noted that on some of the wards not all rooms had been included. For example, the ligature audit for Saxon ward did not include the bathrooms. However, staff had identified these as high risk areas. Some of the ligature audits did not include all the bathroom furniture. However, the guidance did include reference to these items, such as paper towel dispensers and toilet cisterns. Many of the bedrooms and bathrooms had anti-ligature fittings, such as fixed beds, modified bathroom doors, taps and door handles. Curtain rails were collapsible and/or had limited numbers of hooks in accordance with national guidance.

Ward managers completed an annual risk control questionnaire of their ward, and took action to address any areas of concern. Window audits had been carried out on the wards. These showed that windows were safe because they were of an anti-ligature design, had limited opening, or were in high observation areas.

In the six months up to this inspection, there had been eight recorded occasions when patients had been admitted and slept in a lounge, because there were no beds available. A further incident occurred during our inspection. Of the eight recorded incidents, three patients were admitted to Arden ward, and one patient on each of Norbury, Saxon, Southside, Taylor and South wards. Two of the eight incidents did not record the date or time the person was admitted to the lounge – of the remainder five were admitted during the night (the earliest at 9pm, and the latest at 6am), and one returned during the day. Two patients returned early from leave to find that their bed had been allocated to another patient. The other six were new patients who had no bed to be admitted to. For two of the incidents the date had not been recorded. There was one incident in March, four in the last week of May, and one in June. Two patients were admitted to a bed the following day, but no information was recorded about how long the other six patients had remained without a bed. When there was no bed available patients had been admitted to a lounge and slept on a sofa. We saw that on many of the wards this was a small two seater sofa, which did not allow an individual to lay down flat. There were no blinds and no place for storing patient's valuables. There was no effective system that staff could report up to the board the use of lounges.

The trust had policies for managing beds, and this included two bed managers covering the north and south of the trust. The bed management policy included the use of lounges or the 136 suites as a last resort, and was only specified as an option out of hours. The trust told us that there had been no incidents of a patient sleeping in 136 suites as an alternative to a ward bed in the six months prior to this inspection. The incident reporting system had been updated to include bed management issues. This included reporting when lounges or 136 suites were used instead of bedrooms, and when men or women were admitted into a bed in an area designated for the opposite gender. There was a policy titled "draft standard operating procedure guidance for the reporting of breaches of mixed sex accommodation." This was due to be ratified at the end of June, but had not been implemented at the time of our inspection.

Staff in the psychiatric intensive care unit managed their own beds. If a patient was deemed suitable for the psychiatric intensive care unit but there was no bed available, staff there co-ordinated arrangements for a bed elsewhere.

At our last inspection in June 2016 we found that the trust was in breach of national guidance about same sex accommodation. The trust had an action plan that they were still implementing to address this, and it expected to have achieved this by December 2017.

Nine of the ten acute wards for adults of working age were mixed gender. Northside ward was temporarily a male ward, as it was on a different site during refurbishment. Cobden unit, the psychiatric intensive care unit, was also all male.

Are services safe?

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

Staff were aware of ensuring that men and women had separate sleeping areas, and they carried out regular checks of the ward. All the mixed wards had separate male and female areas, with a small number of beds that could be used for either gender. We did not observe any male patients going into female designated areas, or vice versa, during our inspection. However, some wards were difficult to monitor due to their configuration. For example, Taylor ward had an L shaped bedroom corridor with a dead end. The female bedrooms were at the end of the corridor. During the inspection, we observed long periods where staff were not available in the main lounge or on the corridor, this meant that these areas were not being monitored at all times.

In the four months from November 2016 to March 2017 there had been 17 reported incidents between men and women on the acute wards for working age adults. There had been incidents where male patients had known histories of violent or sexual assaults against women, but they had still been admitted to a mixed ward. During our inspection there was a patient sleeping in a bedroom, that was in the corridor of the opposite gender. The suitability of this was questioned with the trust, because the room and surrounding bedrooms did not have ensuite facilities, and because of the history and needs of clients of both genders on the corridor. It was not clear that a suitable risk assessment had been carried out prior to the move, and this was not identified or reported as a breach of same sex accommodation guidance.

Following feedback, the trust took immediate action to review their processes for managing mixed sex accommodation and the use of lounges.

Resuscitation equipment for use in a medical emergency was available on all the wards. Staff carried out routine checks, which were mostly satisfactory. We found some out-of-date items on some of the wards, such as syringes and spare defibrillation pads, but these were replaced immediately. Emergency drugs were available and in date. There were ligature cutters on all the wards, which staff could access quickly.

The female lounge on Taylor ward had an unpleasant smell which staff said was from drains and they reported that this was worse in the summer. Staff confirmed that this was a long standing problem. During our visit, a patient told us they could not use the room because of the smell.

Safe staffing

The trust used safer staffing reporting to monitor and adjust its staffing levels. This captured the acuity, or 'busy-ness' of the wards, which included by recording the number of patients and enhanced observations. Managers told us they managed their own budgets, and were able to book extra staff when required. Staff on all but one of the wards we visited told us they were very busy, and although they thought the wards were safe, they had less time to spend with patients. Additional staffing pressures on the wards included the number of patients on one-to-one nursing, and most of the wards had multiple ward rounds each week, with Tameside and Stockport wards having up to nine ward rounds a week which impacted directly on staff being available for patients.

The number of staff vacancies on each of the wards we visited varied, but was typically one or two qualified nurses and one or two healthcare support workers. There was an ongoing programme of recruitment, and the shifts these vacancies left short were covered by bank or agency staff, whilst waiting for new staff to start. On Saxon ward the ward manager had worked with human resources to use social media effectively to recruit into four vacancies.

Most of the wards were paired with another, and shared a healthcare support worker at night. There was a band seven nurse working across each unit at night, who provided senior support when required.

Acute wards for adults of working age and the psychiatric intensive care unit had a staff turnover rate of 15% in the 12 months between 1 April 2016 and 31 March 2017. The sickness rate for healthcare support workers was 6% overall. The highest rates were recorded on Taylor Ward at 14% and Hollingworth ward at 11%. The lowest recorded sickness rates for healthcare support workers were on Southside ward and the Cobden unit at 1%.

There were consultant psychiatrist vacancies on six of the eleven wards. Four whole time equivalent vacancies were covered by locum doctors. The psychiatric intensive care unit vacancy was covered by another consultant within the directorate. The consultant on North ward was supporting a staff grade doctor, who was covering on South ward, pending the appointment of a consultant who was due to start in August 2017. The trust was in the process of recruiting to the remaining vacant posts.

Are services safe?

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

Most staff had completed their mandatory training. Up to the 13 March 2017, 89% of staff were up to date with their mandatory training. Staff we spoke with told us they had completed their mandatory training, and this was consistent with training information held on each of the wards.

At our last inspection in June 2016 we found that many staff were not trained in immediate life support, so it was not clear that there would always be an appropriately trained member of staff available in the event of a medical emergency. At this inspection we found that most qualified nurses had completed immediate life supported training. This meant that there would always be a member of staff available to provide immediate life support in the event of a medical emergency. The average level of training across the ten wards we inspected was 91%, with five wards having 100% of qualified nurses trained. The lowest level of training was on North ward at 71%, but there were two nurses who were due to complete the training by the end of June 2017. Up to the 13 March 2017, 79% of eligible staff (219 out of 276) were trained in basic life support. We observed staff responding to a medical emergency during our inspection. Staff attended quickly but calmly, brought the necessary equipment, and appeared to manage the situation appropriately.

Assessing and managing risk to patients and staff

Staff were generally aware of how to manage violence and aggression. This included the use of de-escalation and enhanced level of observations, awareness of ligatures, and policies about searching and safely restraining patients.

All the wards had 'patient status at a glance' boards in the staff offices. These included key information about patients, which included observation levels, adult and child safeguarding, physical observations, and when care plans and risk assessments were due for review. Most of the wards also included a nominal map of the ward, which indicated male, female and flexible beds. Staff were aware of specific rooms on the wards which were highlighted as being at higher or lower risk, either because of the location of the room or the furniture within it.

We reviewed 47 care records. New care planning and risk assessment templates had been introduced on the wards on 22 May 2017, and were still in the process of being implemented. All patients had a risk assessment, and within most of the care records there was evidence that these had been reviewed and the plan of care changed as a result. However, this was not always easy to find within the paper records. Some records contained blank or sparse care plans and risk assessments, but information about risk and the plan of care was in the daily records and multidisciplinary team reviews. Managers and staff acknowledged that the new documents were still in the process of being implemented. We saw two records of patients with significant physical healthcare needs – one of these had a detailed care plan for how to meet their needs, but the other had very limited information about this.

The trust used the modified early warning score template for recording and monitoring patients' vital signs, such as blood pressure and pulse. The forms were colour-coded, and used a simple scoring system, so that staff could quickly identify concerns or changes in a patient's observations. The forms were used on all the wards, but they were not completed consistently. For example, many forms did not specify how often observations should be taken, so it was not easy to see if they had been completed. Some records had been incorrectly scored, or did not indicate if further action had been taken in response to the score. Errors or gaps were found on forms on all wards we inspected.

All wards gave a verbal and written handover between shifts. Each ward had a handover document, which was different on each ward, but typically included a summary of key points for the shift, and information about risks and level of observation, and whether the patient was detained under the Mental Health Act.

Patients were signed in and out of the wards, following a brief discussion with staff. There was a signing in and out book, and this included for taking out and returning cigarette lighters.

The trust had a seclusion room on Cobden ward, which was the psychiatric intensive care unit. There were no seclusion or de-escalation rooms on the acute wards for adults of working age.

There had been 23 recorded incidents of seclusion in the 12 months up to the 31 March 2017, and no recorded incidents of long-term segregation. We reviewed the seclusion records for two patients. There were two medical reviews missing from one of the records, but they were otherwise completed in accordance with the Mental Health Act Code of Practice.

Are services safe?

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

Managers and staff told us that seclusion was only used on the psychiatric intensive care unit, in the seclusion room. However, patients were sometimes taken to their bedrooms or one of the 136 suites, in accordance with the trust's procedure for "nursing in in a separate area away from other patients". Staff told us that if patients were very aggressive or distressed they may be taken to their room to be nursed away from other patients. They did not class this as seclusion as the door was not locked. Staff told us that some patients were allowed to leave the room if they wished, but others were not if they remained aggressive. We looked at three records for patients who had been nursed away from others. On two occasions a 'nursing in a separate area away from other patients' form had been completed, in one it had not. The Mental Health Act Code of Practice defines seclusion as "the supervised confinement and isolation of a patient, away from other patients, in an area from which the patient is prevented from leaving, where it is of immediate necessity for the purpose of the containment of severe behavioural disturbance which is likely to cause harm to others." As such, the practice appeared to be seclusion as defined by the Mental Health Act Code of Practice, even though it was not taking place in a seclusion room. As it was not recorded as seclusion the necessary safeguards and monitoring were not implemented. Staff and managers confirmed that when patients were nursed away from others this may be logged as an incident, for example if they had been restrained, but it was not logged as a specific event in itself. As such, there was no way for the trust to monitor how often this practice was being used.

There were 774 incidents of restraint during the 12 months to 31 March 2017, on acute wards for adults of working age and psychiatric intensive care units. Thirty-two of these restraints included in a prone or chest-down position, which poses an increased risk for the safety of the patient. In the sample of incident forms we reviewed, we found three occasions when prone restraint had been used for three minutes, and for five minutes on two occasions. Staff told us that they tried to turn the patient over as quickly as possible, but if they were very agitated this was difficult.

Restraints were recorded on the trust's incident reporting system. This included the position of the restraint, which staff were involved and which part of the body they held, and the duration of the restraint. All incidents of restraint were reviewed by the trust's leads for management of violence and aggression. Following reviews, the leads fed back or followed up incidents. The trust told us that restraint information was collated by the risk department on a monthly basis (since the beginning of 2017) and that this looked at patients who had been restrained most – this information went to the two leads. There were plans for higher level review (such as at board level) by 2018, but this was not in place at the time of our inspection. This is not in line with National Institute for Health and Care Excellence guidance NG10.

There were no blanket restrictions in place on the wards. Staff were generally responsive and, where possible, offered patients choices. Items such as alcohol, drugs and weapons were barred from the ward. Energy drinks were not allowed on the ward, and patients could buy takeaways, but this was limited to certain nights or numbers of times a week on most of the wards. Staff told us this was to promote healthy eating, and it was discussed in patients' community meetings.

Patients had mobile phones, except on the psychiatric intensive care unit, and there was Wi-Fi available on some of the wards. Staff told us that if they needed to temporarily remove a patient's mobile phone, this was risk assessed and there was a policy to follow and form for documenting this. There were more restrictions on the psychiatric intensive care unit, as patients presented a higher level of risk. They had controlled/supervised access to mobile phones and other items such as toiletries, but these were locked away between uses.

There were dedicated outdoor smoking areas for patients, unlike many hospitals which were now smoke-free. For patients who had restricted leave from the building, there were scheduled smoking breaks. Lighters were not allowed on the wards, and patients signed these in and out of the ward.

All the wards were locked, and patients were signed in and out when they left the wards. Northside ward was temporarily sited within a building at Tameside General Hospital that was shared with the secure service. This involved patients having to be escorted through several security doors to get in and out of the building. This was for several months during refurbishment.

Staff were aware of potential safeguarding issues and how to report them. Up to the 13 March 2017, 93% of eligible staff had completed adult safeguarding training, 96% had completed child safeguarding level 1 training and 90%

Are services safe?

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

child safeguarding level 2 training. Staff were able to identify potential safeguarding concerns, and were aware of issues such as domestic violence and anti-radicalisation initiatives. Safeguarding concerns were reported online, and the trust had safeguarding leads staff approached for advice. Staff knew how to raise a safeguarding concern, and how to contact the local authority safeguarding teams.

At our last inspection in June 2016 we identified a number of areas of concern regarding medication. At this inspection we saw that improvements had been made. General storage of medication was satisfactory, and clinic rooms were clean and secure. The temperature of rooms and fridges where medication was stored were monitored, and within an acceptable range. Regular checks were made of the room, and where problems were identified these were rectified. Pharmacists or pharmacy technicians regularly visited the wards, and checked the management of medication.

When drug errors were identified an incident form was completed and action taken. Many of these did not require detailed investigation, but were followed up locally. For example, a nurse administration error was followed up through supervision and additional training.

The prescription charts we reviewed were mostly completed satisfactorily. At the last inspection we identified a number of charts were medication was not cancelled correctly, by scoring through with a date and signature. At this inspection we found that prescriptions were cancelled correctly on most of the wards, but there were charts on Northside and North wards that had been scored through. However, we saw no evidence that patients had been administered medication that had been stopped. Most charts were completed with the all the necessary basic information such as allergies and Mental Health Act status.

The trust reported that in the 12 month period to 31 March 2017 there had been 317 incidents of rapid tranquilisation, in which Southside ward and the Cobden unit had the highest instances of rapid tranquilisation at 52 and 48 incidents respectively. This included oral and intramuscular medication. The trust had a policy for the monitoring of patients after they had received rapid tranquillisation, and a form for its use, although it was unclear if this was for oral as well as intramuscular medication. This was implemented differently on each of the wards. However, staff were consistent that the use of intramuscular rapid tranquilisation should always been monitored, even though it was less clear with regards to oral medication. This is consistent with guidance from the National Institute for Health and Care Excellence.

We reviewed 18 instances of stated intramuscular rapid tranquilisation, although this included the use of zuclopenthixol acetate (commonly called “acuphase”) which does not have a ‘rapid’ effect. A rapid tranquilisation monitoring form was completed on 15 occasions. Overall, the patients had been monitored, but this was not always carried out in accordance with the trust policy with regards to frequency of monitoring, or for as long as specified. When a patient refused to have their observations taken, staff had not recorded the patient’s level of consciousness or their respiration level (breathing) which does not depend on the cooperation of the patient.

The most recent rapid tranquilisation audit was produced in April 2016, covering September and October 2015, and was reviewed at the last inspection. The trust told us that the national Prescribing Observatory for Mental Health (POMH-UK) had carried out an audit in Sep-Nov 2016 but the findings had yet to be reported. The prescribing and use of rapid tranquilisation was overseen by the trust’s drugs and therapeutics committee.

Staff carried out a general check of all patients on their ward at least once an hour. Patients were routinely assessed to determine if they needed to be checked on more frequently than this, or if they needed a member of staff with them at all times. Staff were allocated to do routine checks each hour, and they recorded these on observation sheets that were generated a day at a time. This included basic information about risk factors for patients who were on higher levels of observation. The sample of forms we reviewed had occasional gaps, but were mostly fully completed.

Track record on safety

In the 12 months to 31 March 2017 there were ten serious incidents in the acute wards for adults of working age and psychiatric intensive care units. These were all categorised as a form of self-harm, with one involving a patient who left the ward without permission.

Are services safe?

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

Staff told us that in response to a number of incidents where patients had left the ward without permission, or not returned when they were expected to, they had introduced signing in and out sheets which staff completed with patients at the entrances to the wards.

The trust's risk register included the risk of self-harm presented by curtains and tracks, following an incident in another trust. Curtain rails within the trust are non-load bearing, but problems had been noted with the potential bunching of curtains. The trust had taken action to mitigate against the risk on all the wards, and was piloting a new type of fixing to remove the risk.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents. We tracked a sample of incidents recorded in care records and handover books, and found that they had been reported in accordance with trust policy.

Staff reported incidents through the trust's electronic incident reporting system. When submitted, incidents were automatically shared with local managers and specific leads within the trust, relevant to the nature of the incident. For example, all incidents of restraint were shared with the managing violence and aggression leads. The leads then asked further questions or provided feedback where necessary.

The trust's policy on the management of incidents specified the types of incidents, and how they should be responded to, but was not specific about who should or should not carry out an investigation to ensure its neutrality. Ward managers told us that they would always carry out an investigation of their own service, unless it involved them specifically or was a graded as the most severe incident. The quality of investigations was variable with poor root cause analysis and non-specific action plans. The sharing of learning from incidents was not always effectively carried out. This meant that staff were not always able to identify lessons learned and this meant that there was a risk of recurrence.

Staff told us that they received feedback from the managing violence and aggression leads about how incidents had been managed. Other examples included when a fire was started on the one of the wards, information was shared with the adjoining ward. Blutack had been barred from the wards, as it had been used to detrimental effect. The trust issued a periodic "7 minute briefing" which was a summary of a serious incident that had occurred in the trust. This was shared across the trust with an action plan for any learning or recommendations to be developed by individual teams. This was discussed in the ward managers' meetings.

The national reporting and learning system, which collates all NHS patient safety incidents, reported that in the six months up to 30 September 2016 the trust was in the upper middle 50% of reporters. This is positive, as organisations that report more incidents usually have a better and more effective safety culture.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The trust had not implemented appropriate systems for managing the risks to patients with regards to sleeping in rooms that were not designated bedrooms and in areas designated as belonging to the opposite gender, and being nursed in a separate area away from other patients. The quality of investigation of incidents was variable which meant that causes were not always identified and actions taken. Staff were not always aware of learning from incidents. **Regulation 17(2)(b)**