Requires improvement

Pennine Care NHS Foundation Trust

Wards for older people with mental health problems

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)
RT2Y6	The Meadows	Rosewood ward Saffron ward Davenport ward	SK2 5EQ
RT204	Rochdale Mental Health Services	Beech ward	OL12 9QB
RT201	Bury Mental Health Services	Ramsbottom ward	BL9 7TD
RT202	Tameside Mental Health Services	Hague ward Summers ward	OL6 9RW
RT203	Oldham Mental Health Services	Rowan ward Cedars ward	OL1 2JH

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.

Summary of findings

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

Where applicable, we have reported on each core service provided by 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

We did not rate wards for older people with mental health problems at this inspection. This was a focused inspection, where we inspected part of the 'safe' domain. 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.

On this inspection, we found the following areas where the trust needed to improve:

- Staff were not fully managing the risks of providing mixed gender environments
- There were gaps in records where staff had identified and assessed risks but not put plans in place to manage them. For example moving and handling, falls risks and antipsychotic monitoring.
- At the time of our inspection, actual staffing levels at night on Saffron ward were not sufficient to meet people's needs or keep people safe.
- When patients received rapid tranquilisation to reduce severe agitation or aggression, staff were not always completing physical health checks to make sure that the risks to patients' physical health were managed.
- There were environmental issues including clinic rooms which were too hot, handwashing facilities that did not meet national guidance and temporary repairs to an electric plug that was a potential fire hazard.
- There were gaps in the assurance process for risk management as senior managers were not always aware of significant incidents and risks were not always fully managed when they were identified.
- There was poor access to falls risk equipment across some of the wards even when indicated on individual patient need.

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

- There was improved uptake of mandatory training of staff including improved levels of basic and intermediate life support training.
- There had been improvements to the overall environment of Cedars ward.
- We received good feedback from patients and carers who told us that they felt safe.
- Staff completed ligature risk assessments and environmental checks to ensure the wards provided safe environments.
- Apart from Saffron ward, there were sufficient staff to keep patients safe and ensure their needs were met and staffing levels at Oldham had been maintained to improve therapeutic engagement.

Summary of findings

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

Are services safe?

We did not rerate this domain as we did not look at all of the domain. We found the following areas where the trust needed to improve:

- Some wards still did not comply with the Department of Health's guidance on eliminating mixed sex. Staff were not fully mitigating the risks of providing mixed gender environments through the management of individual patient risk, environmental and relational risk management.
- Female patients on Cedars ward still did not have access to a female only lounge despite the trust telling us in their action plan that this had been addressed.
- The layout of the wards did not allow staff clear lines of sight of patients. These were not mitigated by the use of mirrors to cover all areas of the ward.
- During the inspection and immediately prior, actual staffing levels at night on Saffron ward were not sufficient to meet people's needs or keep people safe. There were three staff working across the ward split into two separate locked areas who were caring for 19 patients; many who required assistance with personal care needs including some patients that required two staff to assist them with moving and handling and personal care tasks.
- There were inconsistencies in the records and examples of risks being assessed and identified but not managed. For example, moving and handling assessments, falls risk assessments and anti-psychotic monitoring.
- There were gaps in observations, and gaps in records at Tameside and the allocations for observations were written on a white board then erased each day at the end of each shift. This meant that there was no historic record of who completed observations at any given time.
- There were gaps in the physical health monitoring post rapid tranquilisation mainly at Tameside.
- Staff on Summers ward at Tameside were not following the moving and handling guidance. We observed staff using the hook approach of holding under a patient's armpit on a number of occasions. This was used both when assisting them with walking and to facilitate a patient to get up off the floor. The moving and handling assessment for this patient did not advise the staff of how to assist the patient safely.

Summary of findings

- The trust policy on seclusion did not fully safeguard patients when patients were nursed away from other patients and was not in line with the Mental Health Act Code of Practice seclusion requirements.
- The clinic room temperatures on Rosewood, Beech, and Cedars wards were high and were above the required temperature levels for the storage of medicines.
- The handwashing sink in the clinic room on Saffron ward did not meet the hygiene code of practice. This had been identified in infection control audits but action had not been taken to mitigate the risk.
- There were gaps in the assurance process for risk management so senior managers were not always fully aware of significant incidents to ensure that incidents were monitored and escalated.
- There was poor access to falls risk equipment across some of the wards even when indicated on individual patient need.

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

- There was improved uptake of mandatory training of staff including improved levels of basic and intermediate life support training.
- On Hague ward, staff had stopped undertaking the blanket restriction of room searches which took place weekly for all patients until April 2017.
- There had been improvements to the overall environment of Cedars ward.
- Wards were clean and well maintained.
- The clinic rooms were fully equipped. Emergency equipment was checked regularly.
- We received good feedback from patients and carers who told us that they felt safe.
- Staff ensured that medicines records for routine medicines were well completed.
- Risk assessments were in place and reviewed.
- Staff completed ligature risk assessments and environmental checks to ensure the wards provided safe environments.
- With the exception of Saffron ward, there were sufficient staff to keep patients safe and ensure their needs were met and staffing levels at Oldham had been maintained to improve therapeutic engagement.
- Staff knew how to report incidents and staff received information about incidents and lessons learnt that occurred across the trust.

Summary of findings

Information about the service

Pennine Care NHS Foundation Trust had nine wards for older people with mental health problems across Bury, Rochdale, Oldham, Tameside and Stockport. The wards provided assessment, treatment and care for people aged 65 years and older who have a functional mental health problem (such as depression, schizophrenia or bipolar disorder) or organic mental health problems (such as dementia).

These were:

The Meadows at Stockport

- Rosewood ward was a ten bed ward for male and female patients with organic mental health problems. At the time of the inspection, there were five male patients and three females on the ward.
- Saffron ward was a 20 bed ward for male and female patients predominantly with delirium (acute confusion), dementia and depression. At the time of the inspection, there were five male patients and thirteen females on the ward with a locked door between the male and female areas.
- Davenport ward was a 20 bed acute ward for male and female patients mainly with functional mental health problems. At the time of the inspection, there were eight male patients and eleven females on the ward.

Rochdale mental health services

- Beech ward was a 16 bed ward for male and female patients with organic and/or functional mental health problems. At the time of the inspection, there were seven male patients and eight females on the ward.

Bury mental health services

- Ramsbottom ward was a 14 bed ward for male and female patients with organic and/or functional mental health problems. At the time of the inspection, there were seven male patients and six females on the ward.

Tameside mental health services

- Hague ward was a 14 bed ward for male and female patients with moderate to severe functional mental health problems. At the time of the inspection, there were six male patients and seven females on the ward.
- Summers ward was an 11 bed ward for male and female patients with organic mental health problems. At the time of the inspection, there were six male patients and four females on the ward.

Oldham mental health services

- Rowan ward was a 12 bed ward for male and female patients with moderate to severe functional mental health problems. At the time of the inspection, there were five male patients and seven females on the ward.
- Cedars ward was a ten bed ward for male and female patients with organic mental health problems. At the time of the inspection, there were two male patients and eight females on the ward.

Our inspection team

Our inspection team was led by:

Team Leaders: Sarah Dunnett, inspection manager, CQC

The team that inspected wards for older people with mental health problems comprised of an inspection manager, four CQC inspectors, a CQC pharmacist inspector, and two specialist advisors which were an occupational therapist and a nurse manager.

Summary of findings

Why we carried out this inspection

We undertook this focused, unannounced inspection to find out whether Pennine Care NHS Foundation Trust had made improvements to the safety of their wards for older people with mental health problems since our last inspection of the trust in June 2016 and to follow up on information we had received about incidents.

When we last inspected the trust in June 2016, we rated wards for older people with mental health problems as requires improvement overall. We rated this core service as requires improvement for safe, effective, caring and well led. We rated this core service as good for responsiveness.

Following the June 2016 inspection we told the trust that it must take action to improve wards for older people with mental health problems.

Following our inspection of the service in June 2016, we therefore issued the trust with two requirement notices that affected the safety of the wards for older people with mental health problems. This related to:

- Regulation 10 Dignity and respect

The trust must ensure that arrangements for single sex accommodation are adhered to in order to ensure the safety, privacy and dignity of patients. The bathrooms should be available for members of each sex to use without passing areas occupied by a member of the opposite sex. There must be a dedicated female only lounge on each mixed sex ward.

- Regulation 18 Staffing

The trust must ensure staff have received their mandatory training particularly in relation to intermediate and basic life support, conflict resolution level, and the management of violence and aggression level adapted for physical intervention with older people.

We also told the trust that is should improve the safety of wards for older people with mental health problems in the following areas:

- The trust should ensure prone restraint be avoided due to the increase risk from positional asphyxia.
- The trust should ensure that it improves the governance arrangements at Oldham's older people's wards through improved safeguarding action following incidents.
- The trust should ensure they improve the safeguards regarding episodes that meet the threshold of seclusion.
- The trust should ensure that blanket restrictions are reviewed and where appropriate removed. To ensure all decisions about restrictions are made on an individualised basis.

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 domain, as this was where the trust told us they had completed actions. We also wanted to follow up on incidents.

The trust was continuing to work on the other areas identified from the inspection in June 2016. As we did not look at all elements of the safe domain we have not re-rated the domain.

Before the inspection visit, we reviewed information we held about the service including statutory notifications sent by the trust. A notification is information about important events, which the trust is required to send to us via a national database. We asked other organisations to share what they knew. We carried out unannounced visits on 19 to 21 June 2017 to all the wards for older people with mental health problems. We carried out an unannounced visit in the evening of 27 June 2017 when we returned to one location, The Meadows.

The inspection took place across all wards for older people with mental health problems.

During this inspection:

Summary of findings

- We visited all nine of the wards at five hospital locations.
- We looked at the quality of the ward environments.
- We observed how staff were caring for patients.
- We spoke with 39 patients and 18 carers.
- We spoke with the managers for each of the wards and two service managers.
- We spoke with 32 members of staff from a range of disciplines and roles. Staff we spoke with included nurses, occupational therapists and nursing assistants.
- We looked at 57 care records.
- We attended four handover meetings.
- We observed care on five wards using a formal observation tool called the short observation framework for inspection.
- We observed mealtimes to check that patients were supported to receive good nutrition and hydration.
- We looked at all of the clinic rooms.
- We looked at the arrangements for the management of medicines including looking at medicine charts.
- We looked at records about the management of the service including policies, incident records, minutes of meetings and results of audits.

What people who use the provider's services say

We spoke with 39 patients and 18 carers. Patients generally commented that they felt safe on the wards and there were enough staff on the wards to keep them safe. Patients told us that staff were very helpful and supportive. They told us they did not wait long if they needed assistance from staff; some patients said that staff were very busy and did not have enough quality time with patients including activities. Patients told us that there were sufficient staff to provide escorts if they needed hospital appointments. Patients told us that staff treated them with dignity and respect. Patients commented that the wards were kept clean.

Patients said that staff responded to incidents when patients were unwell. Most patients who could communicate their wishes did not mind or were neutral about being cared for on a mixed gender ward. However two patients did express concerns. One female patient stated that she was anxious, as there was a heavily built male patient who was threatening staff, which she found frightening. After the incident, this patient told us that staff checked if she was okay. Another female patient did not like being on a mixed gender ward due to the higher noise levels with male patients shouting especially at night.

Most carers told us that they had received good information and felt their relatives were well looked after. Carers were positive about the quality of nursing care their loved ones received. Carers also recognised the challenging behaviour that staff had to manage. Two carers at The Meadows told us that they had staff had overlooked to inform them following significant Incidents. One carer commented that they were not happy about the way their relative was transferred by staff; as staff did not take into account the patients' individual moving and handling needs.

We carried out a short observational framework for inspection on five wards. The short observational framework for inspection was a tool used to capture the experiences of patients who may not be able to express this for themselves. During our observations, we saw staff responding to patients positively and anticipating patients' needs. Staff treated patients with dignity and respect, engaged with patients and showed an interest in their personal history and interests.

During lunchtimes, patients were supported and encouraged to eat and drink according to their personal needs. This meant that staff were ensuring patients' nutrition and hydration needs were met.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the risks of providing mixed gender environments are fully mitigated through the management of individual patient risk, environmental and relational risk management.
- The trust must ensure that female patients on Cedars ward have access to a female only lounge.
- The trust must ensure that staffing levels at night on Saffron ward are sufficient to meet patient's needs and to keep patients safe.
- The trust must ensure that when risks are identified these are appropriately managed including

- risk management plans reflecting fully the risks identified including observations records being fully completed

- improvements in physical health monitoring post rapid tranquilisation

- falls management planning with falls risk equipment being consistently available when indicated on individual patient need, and

- more directive moving and handling guidance.

- The trust policy on seclusion must fully safeguard patients when patients are nursed away from other patients and was not in line with the Mental Health Act Code of Practice seclusion requirements.
- The trust must ensure that timely action is taken for any environment issues identified during checks.
- The trust must ensure there are improvements in the assurance process for risk management so that incidents are properly categorised, monitored and escalated.
- The trust must continue to take action to address regulatory breaches from the previous inspection in June 2016.

Action the provider SHOULD take to improve

- The trust should address the environmental shortfalls including the clinic room temperatures on Rosewood, Beech, and Cedars wards, the handwashing sink in the clinic room on Saffron ward and the bee's nest outside Ramsbottom ward.
- The trust should continue to review and reduce any blanket restrictions.
- The trust should continue to take action to improve the areas we identified where the provider should take action from the previous inspection in June 2016.

Pennine Care NHS Foundation Trust

Wards for older people with mental health problems

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Rosewood ward Saffron ward Davenport ward	The Meadows
Beech ward	Rochdale Mental Health Services
Ramsbottom ward	Bury Mental Health Services
Hague ward Summers ward	Tameside Mental Health Services
Rowan ward Cedars ward	Oldham Mental Health Services

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.

On this inspection, we reviewed care and treatment of patients detained under the Mental Health Act only in relation to whether safe care and treatment was provided.

We saw that information from the trust which showed seclusion had only been used once in the 12 months up to 31 March 2017 on the trust's wards for older people with mental health problems. We case tracked this seclusion episode and saw that staff had identified this as an episode of 'nursing the patient away from other patients' rather than seclusion and had not completed the trust's paperwork for episodes of seclusion. Most of the safeguards around seclusion had been met on this occasion.

However, the trust policy on seclusion did not fully safeguard patients when patients were nursed away from other patients and was not in line with the Mental Health Act Code of Practice seclusion requirements.

Detailed findings

Mental Capacity Act and Deprivation of Liberty Safeguards

We did not look at the Mental Capacity Act on this inspection. This was because our inspection focused on whether safe care and treatment was being delivered.

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

Davenport, Saffron, Beech, Hague and Summers ward had some blind spots due to that layout of the wards. Staff mitigated the problem by taking account of the blind spots when deciding the level of observation that was appropriate for each patient and staff were positioned in areas where they could observe all parts of the ward. At the last inspection in June 2016, we highlighted that sightlines could be further improved by the positioning of curved mirrors at height across the wards. Davenport ward had some mirrors fitted but these did not cover all areas in the ward. Davenport, Saffron, Beech, Hague and Summers ward continued to have blind spots that were not mitigated by curved mirrors. Following the inspection, we asked the trust of any plans to improve the sightlines on each older peoples ward and any associated documents such as project plan and timetable for work. The trust told us that their director of estates was currently undertaking an audit of sightlines in older people's services in patient wards.

The trust told us that all of the wards presented ligature risks but that staff had completed risk assessments on all wards. The trust recorded that no wards presented a high risk of patients harming themselves by use of a ligature attached to a fixed point. Staff had identified and were aware of a number of ligature risks across the older people's wards. They managed this risk with the use of staffing levels, patient engagement, observation levels and ongoing risk assessments as well as a ligature risk register. Wards had a ligature risk register, which had been reviewed recently – with all risk registers reviewed in last 12 months. Some ligature risks were clearly necessary for the patient with mobility difficulties to get around such as handrails and grab rails in disabled bathrooms.

Most curtain and shower rails were collapsible with magnetic fixings, which collapsed under weight. The trust had identified a particular ongoing ligature risk, which was identified on the trust's risk register with an amber warning due to potential self-harm from some curtain track systems in the in-patient premises. Although the current curtain and cubical track system used were safety rails, the trust identified that the loading on the curtain when bunched together could exceed the required release load and therefore become a ligature point. This had been raised with the Department of Health. The trust had carried out local adaptations to reduce the risk through reducing the number of fixings on the curtains.

Rowan ward had a bedroom modified for patients who were at higher risk of ligature with anti-ligature bathroom fittings and door alarms fitted should any weight be applied. This meant that whilst there were ligature points on the wards, the risks were adequately mitigated.

When we inspected the trust's older people's wards in June 2016, we told the trust they must improve the arrangements to make sure they comply with the Department of Health's guidance on eliminating mixed sex accommodation. We told the trust that they must ensure that arrangements for single sex accommodation were adhered to in order to ensure the safety, privacy and dignity of patients. We said that the bathrooms should be available for members of each sex to use without passing the bedroom of a member of the opposite sex and there must be a dedicated female only lounge on each mixed sex ward.

In their action plan following the June 2016 inspection, the trust told us that they had established a monthly forum that would address the issues identified regarding the elimination of mixed sex accommodation. This included the development of options appraisals, reporting of mixed sex breaches and operational management of the issue on a local ward level. The forum members were collating information to inform the options appraisal to be reviewed by the trust board by June 2017.

The trust told us that they would develop an action plan by December 2017 to remedy the problem as much as possible within existing buildings. The trust also told us that the options to eliminate mixed sex accommodation were likely to require significant financial resources, which would have to be agreed with commissioners. This meant that the trust had not yet completed their action to eliminate mixed sex accommodation, as their action was still ongoing. On this inspection, we therefore checked how staff managed the risks on a day-to-day basis.

Are services safe?

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The trust's senior managers had drafted a standard operating procedure, which provided guidance for the reporting of breaches of mixed sex accommodation on all inpatient wards. The draft procedure outlined what action ward staff should take to ensure patients were admitted to the correctly allocated bedroom for their gender and how to manage and report incidents in which this does not occur.

Despite this, we found that the trust was not managing the risks of mixed sex accommodation well. The trust continued to provide care in mixed gender wards. Some wards still did not comply with the Department of Health's guidance on eliminating mixed sex including Summers, Rosewood and Cedars wards. This was because wards were for both male and female patients, rooms were not fully ensuite and patients. Toilet and bathing facilities were grouped to achieve as much gender separation as possible. However, this was not always possible. On Hague ward whilst the bedrooms were ensuite with toilets and showers, males and females were not grouped together along particular corridors with female patients having male patients either side of them and also opposite them. This was despite the fact that the ward had two distinct corridors.

On wards that did allow for separation of bathrooms, men and women were using the same bathrooms. We saw patients using the bathrooms within the corridor areas of patients of the opposite gender on Beech and Ramsbottom ward. One bathroom on Summers ward was still out of action and not used. This was because the bathrooms did not have the correct equipment or an adapted bath for patients with limited mobility. On Rosewood ward, there was only one bathroom.

The blind spots on some wards increased the risk to patients on wards that accommodated both men and women. Beech ward was a large ward with a long corridor with bedrooms and rooms in alcoves along the corridor. Not all blind spot areas were covered by curved mirrors, which meant patient safety could not be ensured within a mixed gender environment.

Staff told us that they had male and female corridors. However, we saw that on these wards this policy was not consistently maintained. Staff told us that they considered patient mix and risks when allocating bedrooms. However, on Hague ward there was a male who had challenging behaviour, which manifested in violence and aggression and who exhibited sexually disinhibited behaviour, was placed in a bedroom across the corridor from two female patients. Whilst this patient was on constant observations, there were several gaps in the observation charts so we were not fully assured that the risks of sexually disinhibition were fully managed. We also saw that not all bedroom doors were kept shut for privacy when patients were in their bedrooms on many of the wards we visited

Within the care plans we reviewed, the care plans did not always indicate that the risks associated with the mixed gender environment or that the patient's placement within the ward had been properly considered. For example, one patient was reported as being sexually inappropriate due to their cognitive impairment but this was not reflected in their care plan or their risk management plan despite the patient being cared for in a mixed gender environment.

On some of the wards we visited, there was no fully designated day lounge for use by women only. In the action plan following the last inspection, the trust told us that Cedars ward had a female only lounge in use from 1 April 2017. On inspection, we found the room to be inaccessible and locked off from the main ward area, only accessible to staff who had a key pass and to be multi-purpose. The ward manager told us that if patients asked to use it they would facilitate this and open the locked door for them to use it. The ward manager was unaware that the action plan stated the female only lounge was open as per the action plan. Staff had not promoted its use to female patients, many of whom lacked capacity.

Following the inspection, we asked the trust about the discrepancy between what they told us in the action plan and practice on the ward. The trust acknowledged that there was not a dedicated female only lounge on Cedars ward but a lounge that was accessible for females. This would continue as a multi-functional room due to the ward layout whilst a dedicated female only lounge space was being sought within the confines of the ward. This meant that female patients on Cedars ward still did not have access to a designated female only lounge despite the trust telling us in their action plan that this had been addressed. The trust stated that in future staff would ask patients regularly if they needed private female only space and would facilitate this by overriding any usage that may be taking place in that room.

There had been a recent alleged serious safeguarding incident on Beech ward. At the time of the inspection, the

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trust was finalising the investigation report. We spent time observing the corridors on Beech ward to see if a similar incident could occur. On Beech ward, there was a long corridor with female beds at one end, male beds at the other and in the middle of the corridor, bedrooms that could be used for both men and women depending on the patient population. We observed a female patient using a shower in the male end of the corridor, patients wandering across the ward and going into areas designated for patients of the opposite gender. Staff did not encourage patients back into their own designated area. We observed a male patient standing at a female bedroom door for some minutes, rattling the door handle and then scratching at the window in the door to get in. We saw staff walk past and not take action. Care records also confirmed that patients were continuing to go into the bedrooms of patients of the opposite gender with a description of incidents but no management recorded to prevent future reoccurrences. A care record for one patient on Beech ward recorded that she had been in an altercation with a male patient after she had gone into a male bedroom. We discussed these ongoing incidents with the senior manager to consider how future risks can be minimised.

The trust is working with stakeholders on ongoing options appraisals to consider a strategic solution for the configuration of mixed sex wards but there was limited practical and contingency management plans in place at the time of the inspection.

The trust had taken limited action relating to risks of providing mixed sex accommodation. More recently and following our ongoing regular engagement with the trust on this issue, there had been improved progress by senior managers to address the mixed gender environments, which was also evidenced by recent discussions at trust board. This meant that the risks of providing mixed gender environments were not still not fully mitigated through the management of individual patient risk, environmental and relational risk management. Immediately after the inspection, the trust told us it had taken action to improve the safe management of mixed sex wards.

Moving and handling equipment was available directly on the ward or through arrangements with the neighbouring wards. These included hoists with disposable slings to promote infection control. There were falls alarm sensor mats available to patients on some wards who were at risk of falls. Saffron ward were piloting sensor alarms across the unit. The trust had ordered sensor mats for the other wards at The Meadows.

Each ward had a well-equipped clinic room. The clinic room temperatures on Rosewood and Cedars wards were high and were above the required temperature levels for the storage of medicines. There was no ventilation or air conditioning in these rooms to regulate the temperatures. The trust told us that the action taken to address the high temperatures were that if it the temperature reached above 26C, then staff should report this to estates and pharmacists. The pharmacist was then required to check the medicines stored on the ward to ensure that they were safe to use when the temperature was outside of recommended ranges and to highlight clearly on boxes when an expiration date had changed to make it clear to the nurse dispensing medication if it was safe to use. The action plan from the trust stated that this was ongoing with no clear timescales or limited action to fully resolve or properly address the high clinic temperatures.

Medicines requiring refrigeration were stored appropriately and temperatures were monitored in accordance with national guidance. Medicines were stored securely with access restricted to authorised staff. There were appropriate arrangements for the management of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

Staff checked the resuscitation equipment regularly to ensure it was safe to use.

The handwashing sink in the clinic room on Saffron ward had a plug and overflow. This meant that the sink did not meet the national hygiene code of practice. According to the senior manager, this had been identified in infection control audits but action had not been taken to assess the risk. The trust told us that following the inspection that the service manager had a conversation with building manager to look at the feasibility of installing hand wash facilities and the trust's infection control nurse had been asked to visit the ward to advise on a solution.

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None of the wards had a seclusion room or facility. If patients presented with seriously challenging behaviour, which posed risks to others, they would be managed for the shortest period usually in their own bedroom or in one of the communal rooms on the wards.

The wards were clean. There was dedicated domestic support and appropriate cleaning schedules in place. Patients told us that wards were kept clean. There were alcohol gels on the entrance to the wards for staff and visitors to use to prevent infections being carried onto the ward. The furniture across the wards was in good condition and comfortable with a range of seating to meet patients' needs.

The scores for cleanliness in the patient led assessments of the care and environment showed that the trust's wards were at 98%, which was above the national average of 97%. Patient led assessments of the care and environment were self-assessments undertaken by teams include at least 50 per cent members of the public (known as patient assessors).The trust, however, scored slightly worse in results relating to condition, appearance and maintenance (91% compared to the England average 94%). The wards at Oldham scored the lowest with 88% for condition, appearance and maintenance. Cedars ward at Oldham had recently been extended and refurbished.

Wards were well maintained. However, there was an active bees nest outside a bedroom window on Ramsbottom ward, which was situated on the second floor. The patient in the bedroom was frightened by the nest. There was a grille on the window which prevented the wasps from entering the bedroom. Staff told us they had reported the nest which had been there for some time but told it was difficult to remove because of the height of the building. The trust told us that this would be removed as soon as practicable and, in the meantime, the risks would be managed through keeping the adjacent window locked.

Appropriate health and safety checks had been carried out on equipment such as checks on the fire extinguishers throughout the wards and appropriate electrical testing. Whilst looking at the environment on Ramsbottom ward, we identified one electric plug on medical equipment, which had been temporarily repaired with sellotape which was touching the pin of the plug and parcel tape on the back of the plug. The machine was plugged in and charging. This meant that there was a risk of fire. We highlighted this to managers to address. Following the inspection, the trust assured us that this had been replaced with a new electric plug.

There were nurse call systems in key patient areas and bedrooms.

Safe staffing

The staffing establishment levels for each ward were as follows:

Stockport - Davenport ward

- Eleven qualified nursing staff nursing staff
- Fifteen nursing assistant staff
- There was one nurse vacancy and one nursing assistant vacancy.

Stockport - Rosewood ward

- Nine qualified nursing staff
- Thirteen nursing assistant staff
- There was one nurse vacancy and one nursing assistant's vacancy.

Stockport - Saffron ward

- Eleven qualified nursing staff
- Twenty-four nursing assistants staff
- There were one nurse vacancy and three nursing assistants' vacancies.

Bury – Ramsbottom Ward

- Nine qualified nursing staff
- Twelve nursing assistants staff
- There were no nursing staffing vacancies and two nursing assistant vacancies.

Rochdale - Beech ward

- Ten qualified nursing staff
- Thirteen nursing assistants staff
- There were two qualified nursing staff and two nursing assistants vacancies

Tameside - Hague ward

- Ten qualified nursing staff

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• Eleven nursing assistants staff

• There were four nursing staff vacancies and no nursing assistant vacancies.

Tameside – Summers ward

• Nine qualified nursing staff

• Eleven nursing assistants staff

• There were two nursing staff vacancies and no nursing assistant vacancies.

Oldham - Cedars ward

• Nine qualified nursing staff

• Eight nursing assistants staff

• There were one qualified nursing staff vacancies and no nursing assistant's vacancies.

Oldham - Rowan ward

• Ten qualified nursing staff

• Nine nursing assistants staff

• There were two qualified nursing staff nurse vacancies and three nursing assistants

The trust used safer staffing information to show patients, staff and the public the expected and actual staffing levels. The expected and actual staffing levels were written on a board outside each ward for each day. On our inspection, the number of staff on duty on each shift matched that of the establishment for each ward. The exception was Saffron ward who did not have a twilight member of staff working on either the 19 June or the 27 June when we returned on an unannounced evening inspection.

The figures calculating overall actual and expected staffing levels were also published per ward per month on the trust website monthly. The overall fill rate for April and May 2017 for day nursing staff was 101% the overall fill rate for April and May 2017 for day nursing assistant staff was 123%. The overall fill rate for April and May 2017 for night nursing staff was 99%; the overall fill rate for April and May 2017 for night nursing assistant staff was 122% and 130%. In March and April 2017, seven out of nine wards had nursing staffing levels at or above the expected levels. Two wards fell below expected nursing staff levels during the day – these were Ramsbottom and Summers ward.

Each ward's staffing levels had evolved over time based on clinical judgement. The trust carried out a comprehensive baseline assessment of ward staffing levels in 2014, which reviewed staffing establishments, shift patterns, complexity and dependency of patients on the wards over a period of time using a tool supported through a safer staffing steering group. This resulted in the agreement of the current staffing establishments. The trust was reviewing these staffing levels in July 2017.

Staff told us that there were sufficient staff on duty to meet patients' needs including to assist patients to attend for appointments at the nearby general hospital, to go on escorted leave or to ensure ward activities occurred. The exception was staff on Saffron ward where the night staff on duty told us that the lack of availability of the twilight member of night staff made caring for patients safely difficult. Ward managers told us that they could increase staffing levels based on clinical need such as planned leave and increased observations

Consultant psychiatrists covered both community and in-patient wards so patients received continuity of care and therefore psychiatrists attended the wards on a sessional basis to attend multidisciplinary ward rounds. There were also speciality doctors and junior doctors in training available on the wards. The exception was Saffron ward, which was a GP led service with the GP attending the ward daily and access to out of hours primary care support at night. Staff and ward managers told us there was adequate medical cover at night and a doctor was able to attend the ward within reasonable times in an emergency. Where the wards were based at a local acute hospital site then access to the on call doctor was available from the out of hour's medical cover, which covered the mental health wards or the mental health services provided at the emergency department.

The overall staff turnover rate for the trust's older peoples mental health wards in the previous 12-month period was 10% which included both qualified nurses and nurses assistants.

The overall average sickness rate for the trust's older peoples mental health wards between April 2016 and March 2017date was 6% which included both qualified nurses and nurses assistants. Cedar ward had the highest sickness rate at 14% and highest turnover at 14% as at

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March 2017. Looking across the 12-month period, staff sickness was relatively consistent; however, the final two months of the period (February and March 2017) recorded the highest rates of 6.5% and 6.4% respectively.

At the time of the inspection, we saw that the actual staffing levels at night on Saffron ward at night were not sufficient. Saffron was a ward for people with acute confusion. There were 19 patients - many with acute confusion and physical health problems. Some patients were on observations and some patients required two members of staff present to provide personal care, moving and handling or to keep patients and staff safe due to risks. There were three members of staff for a ward split in two with a locked door in between. There should have been four members of staff on Saffron up until midnight including one member of staff working a twilight shift and three after midnight. The twilight staff member was off sick and had been for a number of days and there had been no effort to secure a replacement across each shift where there was a shortfall.

During our time on Saffron ward on the unannounced evening inspection, we observed patients attempting to get up unaided when they required staff assistance and patients unable to retire to bed at their request because there were not enough deployed staff. This included one patient who requested to go to bed at 8.30 pm but their request was repeatedly refused, as the person required two staff to support them with mobilisation – when we left the ward at 10.30 pm the patient had still not been assisted to bed. The sole nurse on duty had to move between different sides of the wards whilst being in charge of medicines to help with observations. This had the potential for medicines errors as the nurse had other duties in addition to administering medicines.

At the time of our inspection, the risks relating to the temporary staffing difficulties on Saffron ward had not been appropriately managed to ensure that sufficient staff were deployed.

The trust told us that no attempts were made to fill the twilight shifts due to a clinical decision being made that activity levels were low and bed occupancy levels were not 100%. The trust told us that further discussions had taken place following our feedback to the trust and agreement reached that the ward should always have at least four members of staff on duty until midnight. The trust also told us that further guidance had been issued to all night staff emphasising who was responsible for coordinating staff and highlighting the process for escalation when numbers fell below the staffing establishment.

Following our inspection of the service in June 2016, we issued the trust with a requirement notices that affected the safety of the wards for older people with mental health problems as not all staff had received their mandatory training. This was particularly in relation to training in intermediate and basic life support, conflict resolution level, and the management of violence and aggression level adapted for physical intervention with older people. In particular, staff on all wards apart from Beech ward had not received their mandatory training in basic life support. Staff on Cedars, Rowan and Ramsbottom ward had not received their mandatory training in intermediate life support.

We also highlighted the lack of specialist dementia training as part of this breach of regulation. We did not look at the uptake of dementia training on this inspection as this related to whether older adult wards were effective and the focus of this inspection was whether services were safe. We will review this when we follow up the effective key question at a later date.

In their action plan following the June 2016 inspection, the trust told us there has been a very significant compliance improvement for basic life support and intermediate life support against the identified wards. The majority of the staff working in older adults mental health wards now compliant and those staff who were not compliant had confirmed bookings to ensure compliance in place. The trust told us that this action was ongoing.

On this inspection, we found that improvements had been made to uptake of mandatory training including basic and intermediate life support training across all the wards.

As at 13 March 2017, the overall training compliance rate for older adult mental health wards was 90%. Overall mandatory training for staff across all the trust's older people's wards showed overall training compliance of 75% or above. Training compliance rates ranged from 98% for conflict resolution level one training and moving and handling level one training to 75% for infection control level two training. The uptake of basic life support training overall for staff from older people's mental health wards was 79%; the uptake of Intermediate life support was 88%.

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As at 13 March 2017, there were areas of low compliance in certain training courses for specific wards including moving and handling level two (below 75% compliance on four of the nine wards), infection control level 2 (below 75% compliance on five of the nine wards), and basic life support - below 75% compliance on two wards. Ramsbottom ward was the only ward to fall below 75% compliance benchmark overall for mandatory training. This was because two courses had low uptake, which were infection control level two course at 39% compliance followed by information governance level one at 45%.

When we asked about the latest training figures on the inspection, managers assured us, and training matrixes confirmed that there had been improvements in these rates. We saw that staff had completed courses or were booked on them at a future specific date. For example, all older people's wards were at 86% above for uptake of intermediate life support training. There was also a small number of staff who were off on maternity or sickness, which were still counted in the numbers. We also saw team meetings routinely asserted the need to ensure mandatory training levels were maintained.

Assessing and managing risk to patients and staff

We saw that information from the trust which showed seclusion had only been used once in the 12 months up to 31 March 2017 on the trust's wards for older people with mental health problems. We case tracked this seclusion episode and saw that staff had identified this as an episode of 'nursing the patient away from other patients' rather than seclusion and had not completed the trust's paperwork for episodes of seclusion. Most of the safeguards around seclusion had been met on this occasion.

However, the trust policy on seclusion did not fully safeguard patients when patients were nursed away from other patients and was not in line with the Mental Health Act Code of Practice seclusion requirements.

The trust told us that there were 370 episodes of staff restraining patients used across the nine wards between 1 April 2016 and 31 March 2017. The highest uses were reported on Cedars ward with 86 episodes and Ramsbottom ward with 55 episodes. The trust reported that there were no episodes of restraint in the prone position between 1 April 2016 and 31 May 2017, and that there had been one episode of prone restraint between 1 April 2017 and 31 May 2017. This was to administer medication. Prone restraint was when patients were placed faced down whilst being held by staff. National guidance states that prone restraint should be avoided where possible as patients were at higher risk of respiratory collapse.

We looked at a number of incident records which showed why restraint was used, how long it was used for and which staff was involved in the restraint. The records also asked staff to record if prone restraint was used. We saw a record relating to an episode of prone restraint. This restraint in this position was for a very short period to administer medication. Managers were alerted to restraint episodes but not always proactively informed of prone restraint episodes to review their use. This was confirmed by a senior manager we spoke with who was not aware of the prone restraint episode we saw. Staff told us that restraint should only used as a last resort only after de-escalation had failed. Staff had been taught techniques particularly to aid safe restraining of more frail elderly patients.

We looked at 57 care and treatment records. Staff completed a risk assessment of every patient on admission. The staff used a trust approved risk assessment, which looked at a number of risks relating to the patients' own health, safety or their risk to others. Some risk assessments were lacking in detail. For example, many records identified past risk incidents without detailing how current risks would be managed. On Hague ward, a patient with aggressive behaviour had a comprehensive care plan about managing their violence and aggression written at admission at the beginning of May. Despite prolonged episodes of violence and aggression, use of rapid tranquilisation and observations, the care plan had only been reviewed once in their admission and the behaviours had not been effectively reviewed to try to reduce incidents in the form of positive behavioural support. This was despite the fact that useful distraction techniques were highlighted in the patient's running records.

Some files contained information about patient risks in the initial assessment, daily records or care plans but these were not reflected on the current risk management plan. For example, one patient was reported as being sexually inappropriate to their relatives prior to their admission due to their cognitive impairment but this was not reflected in their management plan despite the patient being cared for in a mixed gender environment. Another patient was an absconsion risk but this was not identified in their risk

documentation. This meant that staff caring for patients including temporary bank or agency staff were not fully aware of the risks patients could pose based on past incidents.

There were overall good risk assessments relating to the management of the monitoring of likely physical health risks faced by older adult patients. For example, the risks of developing pressure ulcers was assessed and managed through regular assessment using the waterlow pressure ulcer risk assessment tool. Patients were assessed as whether they were at risk of malnutrition with evidence of dietician input where this was indicated. When patients were admitted and following any incident, patient injuries and marks were body mapped and reviewed to ensure patients' skin integrity was appropriately treated.

Patients were assessed for the risk of developing venous thromboembolism as part of their admission assessment process. Venous thromboembolism was the collective term for deep vein thrombosis or a blood clot that forms in the veins of the leg, which can cause strokes or other health conditions. The one shortfall relating to physical health risks was on one record the patient was recorded as having marked dysphagia (swallowing difficulties) but there was no corresponding care plan or risk management plan to record and guide staff how to manage the patient's swallowing difficulties. Overall, this meant that patients received routine and ongoing assessments to ensure they did not acquire further physical health problems whist in hospital.

Some patients on the wards had limited mobility and required assistance with moving and handling. Most patients had moving and handling assessments but these were of differing quality. Although we saw detailed moving and handling plans which were person centred, detailed and descriptive, we saw others which lacked detail to guide staff how to move the patient where patients were identified and assessed as needing assistance with moving and handling. The moving and handling assessment did not then fully detail the particular recommended moving and handling techniques for the particular patients according to their own abilities and needs, for example full assistance by staff with a wheelchair for transfers but did not direct how to transfer into the wheelchair.

We saw examples of staff using incorrect moving and handling techniques. We observed several examples of staff on Summers ward using the hook approach of holding under a patient's armpit. This was used both when assisting the patient with walking and to facilitate a patient to get up off the floor. This meant they were not following the moving and handling guidance and their own mandatory training which clearly stated this form of handling should not take place. Figures from the trust showed that 100% of eligible staff on Summers ward had received moving and handling level two training. The moving and handling assessment for the patient in question did not advise the staff of how to assist the patient safely.

There were inconsistencies in the records and examples of risks being assessed and identified but not managed. For example, moving and handling assessments, falls risk assessments and anti-psychotic monitoring. On Hague ward, one patient had episodes of falls and a falls risk assessment completed. Through speaking to staff and looking at the care records, we saw that the outcome of the assessment that the person was to be referred to physiotherapy assessment in early May. There was no evidence that a physiotherapy assessment had taken place by the time of the inspection and no explanation as to why this had not happened. On Summers ward, one patient had a falls risk assessment in March and this lacked detail and had not been reviewed since then. On Cedars ward, two patients' notes indicated that they were a falls risk but there was no falls care plan and there was no detail relating to falls management in the new care planning documentation this ward was piloting. On Saffron ward one patient had an undated falls risk assessment, had three unwitnessed falls recorded in the running records that were not recorded in the falls log. On average, there were two or three records on each ward where various risks recorded as being assessed and identified but which were not fully managed.

Where patients were on anticoagulants and had fallen, neurological observations were carried out; such patients were sent to the emergency department to ensure they received a full medical examination and received a medicines review. Where patients had fallen resulting in any head injury, they were assessed by a doctor as soon as practicable and ongoing neurological observations were carried out. This meant that staff were taking practical action when patients fell to make sure any serious health concerns were identified and managed.

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There were gaps in observations, and gaps in records at Tameside and the allocations for observations were written on a white board then erased each day at the end of each shift. This meant that there was no historic record of who completed observations at any given time, which could identify who was responsible for observing patients if there were gaps.

We found ongoing risk management shortfalls including moving and handling and falls risk management that had not been fully addressed by the trust's quality assurance processes. The trust had identified that there were falls hotspots however had not taken the next step to identify what actions were needed to reduce these. For example, in one unit, one ward was trialling sensor mats which alert staff when patients get out of bed. These had been made available for all patients on one ward but not in response to individual need. There had been no consideration of other technology which could assist in reducing fall risks to patients falls such as when standing from chairs.

There were a small number of blanket restrictions on the wards. Some of these were deemed necessary for patient safety such as items that could cause significant self-harm were not allowed. Other restrictions were in place such as locking off bedrooms to help prevent missing property as there were no facilities to lock belongings. On Hague ward, staff had recently stopped undertaking the blanket restriction of room searches, which took place weekly for all patients. The ward was still awaiting patient safes for patients to lock away their belongings.

We checked the medicine charts on the wards we visited. The charts were up-to-date and clearly presented to show the treatment patients had been prescribed and received. Medicines including controlled drugs were securely stored and emergency medicines were regularly checked to ensure they were available if needed. Where required, the relevant legal authorities for treatment were in place for detained patients and monitored by the ward pharmacist and nurses. There were a small number of missed doses of medicines and some medicines which were recorded as not given as they were out of stock but these did not relate to critical medicines and there was no subsequent identified impact on patients. The wards were supported by a clinical pharmacist who completed regular checks of the prescription charts and participated in the weekly multi-disciplinary team where appropriate.

Where patients were given covert medicines (where medicines were disguised in food or drinks when

patients lack capacity). In all cases we saw, the decisions to give medication covertly was agreed with the multidisciplinary team with family members consulted and pharmacist input.

Whilst the management of medicines was largely good across the majority of patient records, we found some minor issues regarding the monitoring of medicines.

On some patient notes, we saw a lack of detail in the records to explain the prescribing and ongoing monitoring of antipsychotics for patients with organic conditions to alleviate the behavioural and psychological symptoms of dementia, where this was relevant. For example, on Summers ward one patient was on covert regular anti-psychotics but its use was not incorporated into a care plan to record the rationale, the monitoring of its ongoing use and efficacy. Another patient at Tameside had such a care plan in place but there was no discussion with family members and no explanation why the family had not been involved.

On occasions, people may be prescribed medicines to help with extreme episodes of agitation, anxiety and sometimes violence. This is known as rapid tranquillisation. We saw information about the use of rapid tranquillisation and the trust had an up to date policy covering this type of treatment. Following rapid tranquilisation, nursing staff were required to record regular observations of the patient's blood pressure, temperature, oxygen saturation and respiratory rate.

We looked for completed observation forms, which showed that the patient had been properly cared for after being given intramuscular rapid tranquilisation. However, when we checked the care records for patients who had been given rapid tranquillisation, we found these observations had not always been recorded. The trust's policy on rapid tranquilisation stated that regular monitoring of the patients vital signs, blood pressure, pulse, and respirations must be recorded following rapid tranquilisation. The policy recognised that there might be occasions where it would not be practical to monitor the patients pulse or blood pressure. The policy requires that staff must document where they had deviated from the policy and

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stated at the very minimum staff must observe and record the patients breathing every 15-20 minutes following rapid tranquilisation for a period of at least two hours then hourly for the next six hours.

In some cases, observations were carried out for the first hour and then no further observations took place following intramuscular rapid tranquilisation. At Tameside, staff told us that they did not complete rapid tranquilisation monitoring unless it was a combination of lorazepam and haloperidol together. This was despite the trust policy stating that after any intra-muscular treatment, or physical restraint, as a minimum, the level of consciousness and the breathing rate should be monitored every 15 minutes up to 2 hours after administration, then every hour for 4 hours(with 1:1 observations if sleeping), and every 4 hours up to 12 hours. This meant that there was a risk to patients' health and welfare as patients were not having their vital signs checked when they received strong intra muscular sedatives and staff were not fully clear on their duties as prescribed by the trust's policies.

We asked the trust for any audits of rapid tranquilisation. They provided an audit carried out in Oldham in 2015 and published in April 2016, which highlighted the need for improved post rapid tranquilisation monitoring and recommended that the audit be replicated across other boroughs.

Track record on safety

We looked at the incidents that had occurred recently at this trust relating to wards for older people with mental health problems. All NHS trusts were required to submit notifications of incidents to the National Reporting and Learning System.

There had been no never events on the older people's wards. Serious incidents known as 'never events' are events that were classified as so serious they should never happen. In mental health services, the particular relevant never event was the failure of a collapsible curtain or shower rails to collapse when an inpatient suicide is attempted or is successful.

Between 1 April 2016 and 31 March 2017, the trust told us that there were five serious incidents reported through its internal reporting system relating to wards for older people with mental health problems. There had been two incidents recorded on Saffron and Davenport wards in September 2016 related to healthcare associated infection control incidents. This was due to an outbreak of diarrhoea and vomiting which affected multiple patients and staff. There was one incident on Davenport ward regarding an unwitnessed fall which resulted in the unexpected death of a patient. The remaining two incidents were pending review on Summers Ward and Rowan Ward. Both related to the unexpected death of patients, which occurred in October 2016.

In the last 12 months, there had been no coroner reports to prevent future deaths that involved patients receiving in-patient care on older people's wards at Pennine Care NHS Foundation Trust.

Staff in older adult mental health wards reported 1,746 incidents to the National Reporting and Learning System between 1 April 2016 and 31 March 2017. Of these incidents, 59% (979) resulted in no harm, 31% (507) of incidents were reported as resulting in low harm, 10% (157) in moderate harm, no incidents were categorised as resulting in severe harm and 6 incidents resulted in the death of the patient. The National Reporting and Learning System considers that trusts that report more incidents than average and have a higher proportion of reported incidents that are no or low harm have a maturing safety culture.

Of the incidents relating to older people mental health wards, 60% (994) related to patient accidents and 21% of the incidents reported were in relation to disruptive, aggressive behaviour (including patient to patient aggression).

Reporting incidents and learning from when things go wrong

Staff we spoke with knew how to report incidents on the electronic risk management system used by the trust. Staff were able to describe what should be reported. The system escalated incident reports to ward managers, and if appropriate to senior managers and others throughout the trust, dependent upon the circumstances and the severity of the incident.

During our routine monitoring of the trust's incidents and through our ongoing engagement with senior executive managers in the trust, we identified some recent incidents, which had been wrongly categorised as lower harm than would be expected. For example, an alleged serious sexual assault on one of the older people's wards was categorised as low harm and there was a delay in reporting the

incident. This meant that senior managers were not always aware of significant incidents because incidents were not correctly categorised and therefore these incidents were not always appropriately escalated internally.

Managers were also requested to sign off incident forms but the incident process did not always highlight incidents that required closer scrutiny for assurance. For example, we saw an example of prone restraint on an incident form on one of the older people's wards. We spoke to the senior manager about this incident and they were not aware that prone restraint had been used. This meant that there were gaps in the assurance process for risk management as senior managers were not always cited on significant incidents to ensure that incidents were monitored and escalated.

There were inconsistencies in the quality of investigations and implementation of learning from incidents. Following a serious safeguarding incident on Beech ward in February 2017, we received the concise incident report 2 May 2017 with a further review date of 24 May 2017. We judged that the incident report provided recommendations only partly addressed the shortfalls identified. The investigation had not reviewed all available evidence., The report recommendations and actions related to providing guidance, training and supervision to the individual members of staff involved with no wider trust action for ongoing monitoring or action to prevent a reoccurrence. Actions and recommendations did not address all the identified gaps. At the time of the inspection, the senior member of staff on duty had still not received supervision, which discussed the incident recommendations; the action plan stated that this was required by 1 July 2017 without any explanation why significant lessons learnt should not be shared very shortly after the incident report.

The incident identified that lessons learnt could be disseminated within the monthly governance review document for shared learning between mental health services and to be discussed at the forthcoming continuous learning forum in relation to mixed sex accommodation. The mixed sex accommodation forum was going to be superseded by an executive level meeting; the trustwide regulatory accommodation group (with an initial meeting planned for the Friday the 14th July). The trust hoped that this group would draw together all the work being undertaken across the trust and develop a more cohesive and formal action plan.

Following a serious incident on Rowan ward in Autumn 2016,relating to emergency response, lessons had been learnt in terms of having improved guidance on how to summons assistance and trust wide changes to practice so that bank staff now routinely undertake intensive life support training.

The trust produced a regular governance briefing newsletter to staff that summarised information across the trust in relation to incident investigations, complaint outcomes and other events where learning was identified. This included a 'seven-minute briefing' that presented learning from incidents in an easy-read visual format, which could be read in a short time. This briefing was discussed in team meetings and available in the nursing office. This helped to ensure lessons were learnt across the trust and not just at the location where incidents occurred and across staff groups.

The trust's systems and processes assessed health and safety risks but action was not always taken to fully mitigate the risk relating to health, safety or welfare of service users. This was because we identified a number of issues, which highlighted that risks had not been fully managed by the trust's assurance processes. There was also a lack of proper assurances expected by senior managers relating to action taken following the action plan produced by the trust following our last inspection. For example, the discrepancies in the progress of the female lounge on Cedars ward.

Duty of Candour

Staff were aware of the need for openness and transparency if there was an incident. The duty of candour regulations ensured that providers were open and transparent with patients and people acting on their behalf in general in relation to care and treatment. It also set out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. Staff knew about the requirements placed on them to meet these requirements.

When staff completed incident forms, there was a prompt reminder on the form regarding the duty of candour requirements. However, in one serious incident seen, the family had requested a copy of the report and this had not been provided because it would include another patient's information.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way for service users. This was because staff were not always fully assessing risks and were not doing all that was reasonably practicable to mitigate risks to the health and safety of service users. Staff were not fully assessing and managing risks in a number of areas including observations recording, rapid tranquilisation observations, moving and handling risks and falls risks. The trust were not mitigating the risks as there were limited practical assessment and management plans in place to ensure patient safety through ongoing individual patient and environment risk management. This was a breach of Regulation 12 (1) (2) (a) and (b).

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 Systems and processes were not effective. The trust had assessed health and safety risks but action was not always taken to mitigate the risk relating to health, safety or welfare of service users. This was because we identified a number of issues highlighted that risks had not been fully managed by the trusts assurance processes. There was limited practical and contingency management plans in place to manage the risks of mixed sex wards which were not effective.

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Requirement notices

We found ongoing safety issues that had not been fully identified, addressed or managed by the trust's quality assurance processes.

We found ongoing gaps in the staff following the trust's policy when patients received medicines in the form of rapid tranquilisation.

We found the trust's guidance on 'nursing patients away from others' did not provide the full safeguards for patients as required by the Mental Health Act Code of Practice.

We found that the trust's assurances around incident management required improvements. Incidents were not always managed appropriately in a timely manner, incidents were not always correctly categorised and there was shortfalls in the escalation of incidents internally within the trust.

We identified a small number of environmental issues which had been identified by the trust's quality assurance systems but which had not been fully addressed in a timely manner.

The trust systems had not identified the risks relating to the temporary staffing difficulties on Saffron ward and these had not been appropriately managed to ensure that sufficient staff were deployed.

There was a lack of proper assurances expected by senior managers relating to action taken following the action plan produced by the trust following our last inspection.

This was a breach of Regulation 17 (1) (2) (a) and (b)

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified staff were not deployed. At the time of the inspection, we saw that the actual staffing levels at night on Saffron ward were three members of staff for a ward split in two. There were 19 patients - many with acute confusion and physical health problems, some patients were on observations and

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Requirement notices

some patients required two members of staff present to provide personal care, assistance with moving and handling or to keep patients and staff safe due to risks. The twilight staff member was off sick and there had been no or little effort to secure a replacement across each shift where there was a shortfall.

This was a breach of Regulation 18 (1).