Manchester University NHS Foundation Trust

Child and adolescent mental health wards

Quality Report

Trust headquarters
Cobbett House
Manchester Royal Infirmary
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Manchester
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Website: https://mft.nhs.uk

Date of inspection visit: 22nd March 2018
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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)
R0A02	Manchester Royal Infirmary	Galaxy House	M13 9WL

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

Summary of findings

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

During our inspection we found:

- Patient risk assessments were brief, not all sections were completed. Risks identified at assessment did not have subsequent guidance for staff in the form of risk management plans.
- Patient alarms were only located in two bathrooms and patients/visitors did not have access to alarms in other locations of the ward.
- The service could not always comply with same sex accommodation guidance, this had occurred once in the previous year.
- Controlled drugs on the premises were not checked in accordance with local procedures.
- Blanket restrictions were in place, patients could not access their bedrooms or bathrooms during the day without staff assistance. No individual plans or rationale for this were in place
- Staff did not have guidance on reducing restrictive practice, procedural support was not in place
- Identified environmental risks on the ligature risk assessment did not have associated action plans and were not included on the services risk register.

However:

- All ward areas were clean and well maintained and staff followed local infection control procedures.
- Electronic rostering was used to support staff management and staffing was reviewed regularly to ensure there was enough staff with the relevant skills to deliver safe patient care.
- All incidents were recorded on the electronic incident recording system; these were reviewed regularly to monitor themes and incident analysis. The trust had an open and transparent culture to reporting incidents and learning from incidents. Lessons learnt from incidents were shared across teams and staff described changes to policy and practice in response to lessons learnt
- Systems were in place to ensure that child safeguarding was fully integrated into local systems and practices.
- There was an established governance structure with a defined hierarchy of reporting and decision making within the service.
- There were clear systems of accountability and senior managers were actively involved in the operational delivery of the service. Processes and systems of accountability were in place and performance management and quality reporting was clearly set out.
- Performance issues were escalated and discussed at relevant governance forums and action taken to resolve concerns.
- All staff we spoke with were positive about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments.
- The service was committed to improving the services on offer and continually improving the quality of care provided to patients.

Summary of findings

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

Are services safe?

- Patient observation on the ward was limited as there were no clear lines of sight in all areas. There were ligature risks evident across the ward environment. The ligature risk assessment was brief and did not cover all areas of the ward. Identified ligature risks did not have associated action plans and were not included on the trusts risk register.
- Patient alarms were only located in two bathrooms and patients/visitors did not have access to alarms in other locations of the ward.
- Systems were in place to ensure safe medicine management, however controlled drugs were stored in the clinic room area without procedural checks being undertaken in line with local policy.
- Individual patient risk assessments were brief and not all identified risks had an associated risk management plan.
- There were blanket restrictions in place. All bedrooms and bathrooms were locked and young people had to ask staff for access to these rooms. The trust did not have procedural guidance for staff to follow to reduce restrictive practice.

However:

- The ward environment was clean and tidy. There were three fully equipped classrooms and outdoor spaces for young people to access fresh air. Environmental assessments were undertaken to ensure quality standards of hygiene were being followed.
- Staffing was calculated using a safe staffing tool, staffing was regularly reviewed and was responsive to adjustment according to patient need. There was adequate medical cover, medical staff were available over a 24 hour period and staff from the wider hospital were available in case of medical emergency. Overall training compliance was in line with the trusts targets.
- Systems were in place to ensure that child safeguarding was fully integrated into local systems and practices. There was a safeguarding training frame work and a safeguarding lead within the service.
- The prevention and management of violence and aggression was bespoke to patient need and followed a least restrictive approach to violence and aggression.

Summary of findings

Are services well-led?

- Identified environmental risks were not monitored and action planning was not in place to mitigate environmental risks.
- Staff lacked procedural support to reduce restrictive practice.

However:

- Governance structures and procedures were in place with oversight for quality issues across the service.
- Staff described good leadership in the trust and staff spoke positively about their roles
- The trust had systems to support improvement and innovation work and had a staff rewards system which celebrated innovation and excellence in care, recognising staff at all levels.
- The ward was accredited with the Quality Network for Inpatient CAMHS (QNIC) and Quality Network for Eating Disorders (QNED).

Summary of findings

Information about the service

Galaxy House is situated within the grounds of Manchester Children's Hospital and forms part of the children's services offered by Manchester University NHS Foundation Trust. Galaxy House is a 12 bedded in-patient unit that provides mental health care for children up to the age of 18 years and also specialising in pervasive refusal syndrome and eating disorder.

Our inspection team

The inspection team consisted of four CQC inspectors, one specialist advisor and one expert by experience

Why we carried out this inspection

This service was last inspected in November 2015. At this inspection the overall rating was outstanding with the key questions of safe rating as good and well led as outstanding.

We undertook this focussed, unannounced inspection in response to concerns raised by a member of the public. This was an unannounced inspection and we looked at two key questions relating to safe and well led. We did not look at the key questions of caring, effective and responsive at this inspection.

How we carried out this inspection

During the inspection visit, the inspection team:

- visited the ward and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 4 patients who were using the service and one carer
- spoke with the manager of the ward
- spoke with 10 other staff members; including doctors, nurses and social workers

We also:

- Looked at 6 treatment records of patients and 9 prescription charts
- carried out a specific check of the clinic room and medication management
- 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 four patients and one carer. Patients told us that staff were always available and three of the four patients felt staff were kind and respectful. Staff were described as responsive, supportive and encouraging towards patients. One patient did not feel listened to, although this patient was generally not happy with admission to the hospital. All those we spoke with said the environment was always clean and tidy and there were opportunities to engage in meaningful activities. All were aware of their care plans, their rights under the Mental Health Act and knew how to complain. All felt supported by advocacy services.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The provider must ensure that patients are subject to a full risk assessment and associated risk management plans are available to guide staff on how to manage identified patient risk.
- The provider must develop systems to ensure procedures for checking controlled drugs are followed.
- The provider must ensure that identified environmental risks are subject to trust scrutiny and action.
- The provider must ensure that procedural guidance is available to staff on reducing restrictive practice.
- The provider must ensure patients have a call system in place in the event of an emergency.

Action the provider SHOULD take to improve

The provider should consider designing systems for recording training compliance for individual mandatory courses

Manchester University NHS Foundation Trust

Child and adolescent mental health wards

Detailed findings

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Galaxy House	Manchester Royal Infirmary

Are services safe?

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

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

Summary of findings

- Patient observation on the ward was limited as there were no clear lines of sight in all areas of the ward environment. There were ligature risks evident across the ward. The ligature risk assessment was brief and did not cover all areas of the ward. Identified ligature risks did not have associated action plans and were not included on the trusts risk register.
- Patient alarms were only located in two bathrooms and patients/visitors did not have access to alarms in other locations of the ward.
- Systems were in place to ensure safe medicine management, however controlled drugs were stored in the clinic room area without procedural checks being undertaken in line with local policy.
- Individual patient risk assessments were brief and not all identified risks had an associated risk management plan.
- There were blanket restrictions in place. All bedrooms and bathrooms were locked and young people had to ask staff for access to these rooms. The trust did not have procedural guidance in place to reduce restrictive practice.

However:

- The ward environment was clean and tidy. There were three fully equipped classrooms and outdoor spaces for young people to access fresh air. Environmental assessments were undertaken to ensure quality standards of hygiene were being followed.
- Staffing was calculated using a safe staffing tool, staffing was regularly reviewed and was responsive to adjustment according to patient need. There was adequate medical cover, medical staff were available over a 24 hour period and staff from the wider hospital were available in case of medical emergency. Overall training compliance was in line with the trusts targets.
- Systems were in place to ensure that child safeguarding was fully integrated into local systems and practices. There was a safeguarding training frame work and a safeguarding lead within the service.
- The prevention and management of violence and aggression was bespoke to patient need and followed a least restrictive approach to violence and aggression.

Our findings

Safe and clean environment

The ward was clean and tidy and in general good repair. There were good communal spaces which supported patients requiring quiet or communal activities, lounges could be designated for male or female occupation. There were three fully equipped classrooms off the ward area, where patients were encouraged to follow the national curriculum. Environmental assessments were undertaken by the ward manager annually. The service did not undertake patient led assessments of the care environment (PLACE) assessments.

All patients had single bedrooms with two bedrooms with ensuite facilities; the remaining ten bedrooms shared bathroom facilities. At the time of the inspection the ward complied with guidance on same sex accommodation, although if there were more than two male patients admitted at any one time, the service would not always meet the definition of accommodation that is same sex. This had occurred once in the previous 12 months.

The ward layout did not allow staff to observe all parts of the ward and there were blind spots across the ward. There were ligature risks evident throughout the communal and bedroom areas. Annual ligature risk assessments were undertaken on the ward; however the ligature risk assessment was limited and did not identify all the risks noted at the inspection. There was no associated action plan that detailed the mitigation of these environmental risk assessments, however for those patients with a known

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risk of harm, mitigation to reduce these risks was in place such as constant observation. Staff had nurse call systems to summon support, however only two patient bathrooms had an emergency call system for patient use.

The ward had fully equipped clinic room with resuscitation equipment and emergency drugs accessible in case of emergency.There was a schedule to check medical equipment for electrical testing and calibration. Fridge and room temperatures were checked daily. Staff were trained in infection control precautions including hand hygiene and sharps management. Hand washing facilities and antibacterial hand gel were available for staff use. The equipment and premises were cleaned in line with local policies and adequate personal and protective equipment was available to staff. Laboratory specimens were handled and stored in line with local policy and all staff were offered appropriate immunisation.

Medicines reconciliation was undertaken on admission and medicines were appropriately prescribed and administered in line with national prescribing guidance. Medicine alerts were available to staff and the ward had pharmacy support. Staff were able to describe recent safety measures put in place in response to medicine errors and incidents.

We looked at nine prescription charts and checked medicine storage. Medicines were dispensed from and stored in the ward clinic room, transport and most medicine storage was in line with procedural guidance. There was an established checking system to ensure stock balances and expiry date rotation, however we found on inspection that there were controlled drugs in secure storage (Methylphenidate) that had not been checked since December 2017.

Safe staffing

Staffing was calculated using a safe staffing tool, staffing had undergone a recent review and staffing increased in response to patient need. The ward worked with four shifts per 24 hour period. Long day shifts from 7am till 9pm, and two short day shifts: 7am to 1pm, 1pm to 9pm. Night staff worked from 8.30 pm to 7.15 am. Handover between shifts was factored into the staff alignment, with overlapping of shifts. Handovers between staff occurred three times daily and were recorded on an electronic system which was printed off and available to all staff who came on shift. An electronic staffing system was in place to support rota planning and allocation of staffing. Rotas demonstrated that actual staffing levels and skill mix compared with planned levels, cover for staff absence was provided with the use of bank staff.

Agency staff were not used in the service, bank staff were sourced from an internal trust bank provided by NHS Professionals. Of 1229 shifts where bank staff were required, 1200 were filled, a fill rate of 98%.

The ward manager was able to adjust staffing levels in accordance with patient need and a qualified nurse was present on the ward at all times. Patients were able to have regular one to one time with nurses and there were enough nurses to facilitate escorted leave.

The staffing compliment for the ward was:

Registered nurses:

- 1 wte Band 7
- 3.47 wte Band 6
- 10.73 wte Band 5
- 12.0 wte Band 2

With the following vacancies:

- -0.26 wte Band 6
- 1.33 wte Band 5
- 2.15 wte Band 2

Staff turnover at Galaxy House for the previous twelve months was at 16%. Opportunities for staff to move into newly commissioned services in the community had been the main reason for an increase in staff leavers; a staff skill mix review was scheduled to take place.

Staff sickness was monitored on a monthly basis, the average sickness levels were generally low. There were peaks in staff sickness with registered nurses highest level of sickness in October 2017 at 14% and unregistered nurses highest level at 14% in September 2017.

Staff records demonstrated that the service promoted safety in recruitment with evidence that staff were subject to identity checks, employment history, professional registration and qualifications, right to work in the UK, health assessment, checks from the disclosure and barring service and reference checks.

The ward was also supported by: psychology staff: 0.5 wte band 8c and 0.5 wte band 8a, systemic therapy: 0.3 wte band 7, psychotherapy 0.4 wte band 7. occupational

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therapy: 0.8 wte band 7, 1.0 wte band 5, physiotherapy: 0.2 wte band 7, dietetics: 0.7 wte band 7 and 0.8 wte Band 6.Teaching staff included: wte teacher and 2.0 wte teaching assistants with peripatetic teacher support.

There was adequate medical cover day and night. Medical cover was provided by two consultant psychiatrists 1.8 wte, and two junior doctors on rotation. The consultants were on call 1 in 20, emergency medical cover was available from the wider hospital site and intermittently the team was supported by a clinical fellow.

Training figures were only available as an overall competency compliance report. The trust did not the service had 79% compliance with corporate training and 84% compliance with clinical training.

Assessing and managing risk to patients and staff

A risk assessment process was in place which was carried out by medical and nursing staff and followed the mental health risk assessment and management process (RAMP). Records were paper based and handwritten. A review of the records for six patients found that the risk assessments were brief and contained little information of the reason for the risk identification. Although risk information was available in the care records and multidisciplinary meeting notes there was no guidance to staff in the form of care planning in risk management in line with identified risks and local policy.

There were blanket restrictions in place which included locking all bedroom and bathroom doors. The Mental Health Act Code of Practice defines blanket restrictions as "rules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application." Reasons for this restriction were given, however patients on the ward did not have individualised risk assessments relating to the restrictions or management plan which detailed the individual reasons for this. A policy was in place to guide staff on the use of 'high input and low stimulus nursing', this policy was due for review in July 2017 and did not guide staff on current Mental Health Act Code of Practice guidance on the use of blanket restrictions.

The local safeguarding procedure provided guidance for staff on their responsibilities for the safety and wellbeing of patients, this included best practice standards and local safeguarding children board (LSCB) policy and procedures.

Systems were in place to ensure that child safeguarding was fully integrated into local systems and practices. There was a safeguarding training frame work and a safeguarding lead within the service. Safeguarding Level 3 training was required by registered staff every 3 years in addition to that provided in mandatory training, fourteen of the fifteen staff eligible for this training were up to date with level 3 safeguarding training. Reporting structures were in place to ensure staff worked in partnership with local agencies to ensure patients were supported and protected from identified risks.

The prevention and management of violence and aggression training was developed specifically for this service. All of the techniques and interventions taught did not utilise or demonstrate the deliberate application of pain as a means of compliance and focuses on supportive holds and physical disengagement. Prone restraint was not taught and never used in this service. There were 289 instances of physical intervention holds recorded over the previous twelve months. All but three of these were initiated to pass nasogastric tubes or administer medication to detained patients.

The service had not been required to use rapid tranquillisation for several years. There was a seclusion room on site but this was not used as it did not comply with current seclusion room specification, the room was used for storage only. There was a diversion from seclusion policy in place. There was a room on the ward which had padded walls and cushioned flooring which was described as a time out and de-stimulation area, staff were aware of what constituted seclusion and we were informed by staff that patients were able to leave this room on request.

Track record on safety

There had been one serious incidents in the previous 12 month period. Staff were able to explain the governance systems on sharing information of serious incidents across the service. Email alerts and team discussion about learning from serious incidents was evident in the service and staff described incidents were lessons had been learnt. Staff were consulted and their opinions of improvements to service safety were sought such as the suggestion to install CCTV.

Reporting incidents and learning from when things go wrong

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An incident reporting and investigation policy was in place to capture and record incidents electronically via the trusts intranet. Incidents were graded in accordance with the severity of the incident. A reporting system was in place which detailed staff responsibility for reporting and recording incidents. Incidents were reviewed by senior members of the team in a monthly management meeting, trends were noted and actions implemented where appropriate.

De briefing after incidents was available to staff and staff were supported through on-going clinical supervision following an incident with reflective practice sessions available to staff.

Lessons learnt were shared across the organisation with staff briefing via email and cascaded following the monthly governance meetings or in response to incidents. Staff gave us examples of recent lessons learnt and the actions that had been taken to reduce the likelihood of a repetition of these incidents.

Duty of candour

The duty of candour is a legal duty on hospital, community and mental health services to inform and apologise to patients if there have been mistakes made in their care that have led to significant harm. Duty of candour aims to help patients receive accurate, truthful information from health providers. A duty of candour policy was in place and all staff we spoke with were aware of the policy and were able to describe the steps necessary when something went wrong and when an apology was required.

Are services well-led?

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

Summary of findings

- Identified environmental risks were not monitored and action planning was not in place to mitigate environmental concerns.
- Staff lacked procedural support to reduce restrictive practice.

However:

- Governance structures and procedures were in place with oversight for quality issues across the service.
- Staff described good leadership in the trust and staff spoke positively about their roles
- The trust had systems to support improvement and innovation work and had a staff rewards system which celebrated innovation and excellence in care, recognising staff at all levels.
- The ward was accredited with the Quality Network for Inpatient CAMHS (QNIC) and Quality Network for Eating Disorders (QNED).

Our findings

Vision and values

Staff were aware of the trusts visions and values prior to the merger of Central Manchester University Hospitals NHS Foundation Trust with the University Hospital of South Manchester NHS Foundation Trust on 1st October 2017.

Values and behaviours and the leadership and culture strategy were under review at the time of the inspection and due for ratification in May 2018.

Good governance

There was a governance structure with a defined hierarchy of reporting and decision making. There was oversight of quality issues including patient safety, clinical effectiveness, patient experience and performance scrutiny. Senior managers were involved in the delivery of the service. Regular systems audits took place; organisation performance was reviewed and benchmarked against local and national outcome measures.

Monthly management meetings which included all ward managers reviewed day to day operational issues, governance reports such as complaints, incidents, lessons learnt. Information relating to new and revised policy and procedure and quality initiatives across the trust were also discussed at these meetings.

The ward manager undertook local quality care round audits which covered a wide range of local quality checks. Trust wide key performance indicators were shared in the form of a CAMHS dashboard where performance was monitored for issues such as compliance with training, incidents, clinical supervision, delayed discharges and patient feedback.

The service had a risk register in place, risk mitigation and action planning was reviewed regularly, however identified environmental risks were not included on this register.

Leadership, morale and staff engagement

Staff described good communication recent changes in leadership and structures following the trust merger. They described the local senior management team as accessible and helpful in relation to their roles.

Staff we spoke with talked positively about their roles and were passionate about service development. Staff felt able to raise concerns without fear of victimisation and spoke positively about the organisation. They told us that they felt valued, had input into the service and were consulted and involved in service quality developments.

Staff were able to describe the governance arrangements that supported their roles. They were clear about the quality assurance and performance structures in place and how they would input and record data locally and externally. Staff described good support with supervision and peer review and opportunities to attend training.

Staff sickness was monitored. Action was taken where appropriate to support staff to attend work and flexible working arrangements were in place. There were no bullying and harassment cases on the ward at the time of the inspection. The trust had a whistleblowing policy. All staff were aware of this policy and knew the mechanisms in place to report issues that arise.

Information on patient experience was reported and reviewed alongside other performance data. Concerns were shared across teams and staff were aware what patients thought about their care and treatment.

Are services well-led?

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

Recruitment procedures included identity checks, employment history, professional registration and qualifications, right to work in the UK, health assessment, and reference checks. All staff, including temporary staff were subject to a Disclosure and Barring Service (DBS) check and were checked against the Protection of Children Act (POCA) register before appointment.

Commitment to quality improvement and innovation

The trust had systems to support improvement and innovation work and had a staff rewards system which celebrated innovation and excellence in care, recognising staff at all levels.

The trust took part in national audits such as the National Confidential Inquiry into Suicide and participated in research such as an evaluation of a new recovery measure within an inpatient CAMHS service both undertaken by the University of Manchester.

The ward had also been accredited with the Quality Network for Inpatient CAMHS (QNIC) and Quality Network for Eating Disorders (QNED).

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Risk assessments were brief and not all sections were completed. Not all patients had risk management plans in place.** **Controlled drugs were not being checked in line with local procedure.** **Patient alarms were only located in two bathrooms and patients/visitors did not have access to alarms in other locations of the ward.**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Family planning services Management of supply of blood and blood derived products Maternity and midwifery services Surgical procedures Termination of pregnancies Transport services, triage and medical advice provided remotely Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Identified environmental risks on the ligature risk assessment did not have associated action plans and were not included on the trusts risk register.** **There was no procedural support for staff relating to reducing restrictive practice.**