Greater Manchester Mental Health NHS Foundation Trust

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

Inspection report

Prestwich Hospital
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Ratings

Overall rating for this service	Inspected but not rated
Are services safe?	**Inspected but not rated**

Our findings

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

Inspected but not rated

We carried out this unannounced focused inspection because we had concerns about the quality of services across the acute wards for adults of working age and psychiatric intensive care units. Our inspection was carried out to consider the safety of the wards and the care and treatment being provided to patients.

This inspection was not rated as it was a focused inspection regarding the safety of the wards.

Since our last inspection of the acute wards for adults of working age and psychiatric intensive care units, the trust had acquired the Wigan Mental Health services from North West Boroughs NHS Foundation Trust in April 2021. At the time of this inspection, these services were still being integrated into Greater Manchester Mental Health NHS Foundation Trust.

We visited eight wards across five of the seven locations where the trust's acute wards for adults of working age and psychiatric intensive care units (PICU) were located. These were:

- Griffin ward, an eight bedded female acute ward at Junction 17, Prestwich
- Oak ward, a 20 bedded female acute ward at Rivington Unit, Bolton
- Priestner's Unit, an eight bedded mixed PICU at Atherleigh Park, Wigan
- Medlock ward, a 21 bedded female acute ward at Moorside Unit, Trafford
- Brook ward, a 22 bedded male acute ward at Moorside Unit, Trafford
- Poplar ward, a 20 bedded female acute ward at Park House, Manchester
- Juniper ward, a 10 bedded male PICU at Park House, Manchester
- Laurel ward, a 23 bedded male acute ward at Park House, Manchester.

We did not visit a ward at either Laureate House in Wythenshawe or the Meadowbrook Unit in Salford.

We did not rate this service at this inspection. The previous rating of requires improvement in safe remains. We found:

- The wards did not all have up to date and recently reviewed ligature risk assessments. Staff on two wards could not locate the ligature risk assessments at the time of the inspection.
- The service did not always have enough nursing staff, who knew the patients or received basic and essential training to keep patients safe from avoidable harm.
- The environment on Poplar ward was not clean on the first day of inspection and space on the ward was limited for patients.
- It was not clear that immediate concerns or learning from incidents was shared across the locations, although local learning and reviews were taking place.

However:

Our findings

- Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff had easy access to clinical information and it was easy for them to maintain clinical records – whether paper-based or electronic.

How we carried out the inspection

Before the inspection visit, we reviewed information that we held about the location. During the inspection visit, the inspection team:

- Toured the ward environment and reviewed environmental risk documentation
- Spoke with the ward manager, matron or a senior member of staff on each ward
- Spoke with 17 other staff members including registered mental health nurses and healthcare assistants
- Reviewed 51 care and treatment records
- Reviewed documentation and data for each ward.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

What people who use the service say

We did not speak directly to patients on the wards during this inspection due to the focus of our inspection being on specific areas. However, we did observe interactions as we spent time on the wards. Staff responded to patient's needs and requests. Staff spoke to patients with respect and in a caring manner.

Is the service safe?

Inspected but not rated

We did not rate this service at this inspection. The previous rating of requires improvement remains.

Safe and clean care environments

Not all wards were safe, clean, well equipped, well furnished, well maintained and fit for purpose.

Safety of the ward layout

Staff did not complete and regularly update thorough risk assessments of all ward areas. Staff did not remove or reduce all the risks they identified.

On two of the eight wards we visited, staff on the ward could not locate or immediately provide a copy of the current ligature risk assessment. On day one of the inspection at Poplar ward, a copy of the 2017 audit was provided. Staff provided a further audit on day two of the inspection from 2019.

Our findings

On Medlock ward, the last ligature risk assessment completed was from 2019. Two dates had been booked for the assessment to be reviewed in 2021, although these had been cancelled due to issues within the central trust team responsible for undertaking these audits.

Staff on the wards could describe where ligature points were located on the wards, however, it was not clear how the trust was assured that all staff working on the wards would be aware of the ligature points or that all potential risks had been identified and considered. As ward staff were unable to locate the ligature risk assessments on two wards, it indicated that these assessments were not considered very relevant or used effectively for ongoing practice and safety.

The ligature audits were stored centrally on a shared electronic drive that staff could access as required. There was a central trust team responsible for reviewing and updating the ligature audits.

During our tour of Oak ward, we observed that loose, unattached electrical cables had been left in the quiet room. The quiet room was unlocked and could be accessed by patients. We raised this as a concern with staff and the cables were removed.

Staff could not observe patients in all parts of the wards. Staff mitigated this risk through the use of observation and mirrors. Staff were aware of their responsibilities regarding observations.

The wards complied with guidance on mixed sex accommodation. Priestner's Unit was mixed sex and patients had single bedrooms with ensuite bathrooms. A separate quiet lounge was available for female patients.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were not all clean, well maintained, well furnished and fit for purpose.

On Poplar ward, the ward was not clean and smelled unpleasant. The ward was re-visited on day two of the inspection and some improvements had been made. Poplar ward had limited space for patients to use which did not enable patients to have space for themselves or to spend time away from their peers. The quiet lounge was being used as a surge bed which further limited available space on the ward. The trust confirmed following the inspection that the ward was due to be re-decorated later in September.

On Medlock ward, two of the four toilets on the ward were blocked on the day of the inspection. The toilets had been blocked since the day before. The issue had been reported to maintenance although action had not yet been taken. Staff reported that one of the toilets on the ward frequently blocked. The wards at Moorside Unit were due for refurbishment in the coming months.

Staff made sure cleaning records were up-to-date and the premises were clean. Staff followed infection control policy, including handwashing.

Safe staffing

The service did not always have enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Our findings

Nursing staff

The service did not always have enough nursing and support staff to keep patients safe. Staff and managers on the ward reported concerns about the level of staffing across the wards and pressures on the wards as a result of lower staff numbers.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. Each location held daily safety huddles to assess staffing on each unit and consider any shortfalls. This enabled management at the locations to move staff where necessary or request additional staff to attend. Staff reported that they felt that the base number of staffing for the number of patients on the wards was lower than required.

We undertook a focused review of staffing for the wards we visited at Park House and Moorside Unit by reviewing staffing rosters and safety huddle minutes.

For the four weeks prior to the inspection, on the two wards at Moorside Unit, there was regularly no qualified nurse specifically allocated to the wards overnight. On Brook ward, 16 night shifts of 28 did not have a qualified nurse on shift. On Medlock ward, 11 of 28 night shifts did not have a qualified nurse on duty. We were informed that a floating band 6 nurse had been used at the location to provide support over nights. The qualified nurse night shifts were covered by bank and agency nurses. The wards attempted to ensure a permanent healthcare assistant was on shifts over nights, although this did not always happen.

On Brook ward, when we reviewed the staffing rotas, three late shifts did not have a qualified nurse allocated to the shift. The ward manager was on duty for one of these shifts. There were no day shifts on Medlock that did not have a qualified nurse on duty, although the staffing roster indicated that there were three shifts that a band 5 nurse had worked 15 hour shifts.

We reviewed the staffing rosters against the base number of staff we had been informed were required on inspection. On Brook ward, 22 shifts did not meet the base numbers although for seven of the day shifts the ward manager was present. Ten of the 22 shifts were night shifts.

At the three Park House wards we visited, three night shifts on Poplar ward had no qualified nurse. The staffing rosters indicated that the wards were also regularly not meeting the base staffing numbers that we were informed of on inspection, although they were generally able to ensure at least one qualified nurse was on shift on each ward.

Where the trust identified significant shortfalls in staffing, the trust put contingency plans in place to manage these. The trust indicated that this would be by internal redeployment of staff from wards at each location; asking the bleepholder to base themselves on a particular ward; redeploying staff from other trust locations or through the use of floating qualified nurses at the locations.

We reviewed the daily staffing huddle notes for both locations. There were occasions where the identified bleepholder on each shift was not recorded in these minutes. For Moorside Unit, five of the 15 notes we reviewed did not have an identified bleepholder for every shift considered at the meeting. There were two occasions that this occurred in the Park House daily huddle meetings.

Our findings

Staff reported that they did not always feel safe on the wards, particularly when there was fewer permanent staff on shift. Staff noted that bank and agency staff were predominantly not trained in the Prevention and Management of Violence and Aggresssion (PMVA) which reduced the number of staff available to support during an incident. Each location visited had a process in place to support and respond to incidents, however, this required support from other wards which impacted on staffing levels for those wards.

The trust provided figures following the inspection of shifts covered by bank and agency staff on the wards visited at Park House and Moorside Unit. Between 09 August 2021 and 05 September 2021, Poplar ward had 186 shifts covered by bank and agency, Juniper ward had 156 shifts covered, Laurel ward had 179 shifts, Brook ward had 140 and Medlock ward had 138.

The trust provided data in respect of shifts where bank and agency either late cancelled, within eight hours of the shift starting, or did not attend. Between 09 August 2021 and 05 September 2021, Poplar ward had eight days where a bank or agency staff late cancelled or did not attend, Juniper had five, Laurel had one, Brook had six & Medlock had 11.

The first one to one observation would be included within the base staffing numbers of the ward. If more than one patient required one to one observations, the base staffing numbers would be increased to accommodate this.

A patient on Oak ward had a specific physical health requirement that required staff action every two hours. Staff informed us that there had been recent occasions where, due to staffing issues and the acuity of the ward, they had not been able to complete this task as per the patient's care plan. We observed that this had been recorded within the patient's daily progress notes. We brought this to the trust's attention during and after the inspection. We requested further information following the inspection and it was confirmed that these incidents had not been escalated or recorded as an incident. The trust put a process in place within the patient's care plan to address this.

The trust had implemented 11 surge beds across this core service due to the demand for acute beds across the region. The trust had introduced surge beds as a contingency to enable patients to be admitted to hospital and remain in their local area. Figures provided by the trust indicated that surge bed usage was high across the acute wards.

Four of the wards we visited were using surge beds. The three month average surge bed occupancy was 34% on Griffin ward, 72% on Oak ward, 73% on Brook ward and 39% on Poplar ward. The longest episode of surge bed usage was 11 days on Griffin ward in July 2021. The total number of surge bed days used from June 2021 to August 2021 was 200 days. Staffing figures on the wards were not routinely increased when the surge bed was in use.

Medical staff

The service had enough daytime and night time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could call locums when they needed additional medical cover. Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

The mandatory training programme was comprehensive and appropriate to meet the needs of patients and staff. However; staff had not all completed and kept up-to-date with their mandatory and essential training.

The trust's compliance figures for immediate life support (ILS) were low on four of the eight wards visited. The compliance rates were 38% on Priestner's Unit; 60% on Oak ward; 50% on Juniper ward and 38% on Brook ward.

Our findings

The Brook ward figure was impacted by two staff not being in work to complete the training and three new starters who had not yet been on the training. This meant that three staff had completed ILS training on Brook ward.

On the three Park House wards that we visited, 12 staff were required to be trained in ILS; four on each ward. At the time of the inspection, only Band 6 & 7 nurses were trained in ILS at Park House. This contrasted with the other locations visited where all registered nurses were required to be ILS trained. It was not clear why there was not a consistent policy across all locations that all qualified nurses should be ILS trained. We were informed that this decision had been re-considered and that all qualified nurses would be ILS trained in the future.

There were further mandatory training courses that had low compliance rates. We reviewed figures for basic life support training across the wards we visited. On Poplar ward the compliance rate was 50%, on Priestner's Unit it was 74%, on Medlock ward it was 67% & on Brook ward it was 71%. Training compliance rates were also low for PMVA, with Laurel ward being 68%, Poplar ward at 64%, Oak ward at 71%, Brook ward at 69% and Medlock ward at 72%

The training rates for the trust's 'Moving and Handling – inpatient' training course across the majority of wards visited were low. On Priestner's Unit it was 26%, Oak ward was 48%, Medlock ward was 33%, Juniper ward was 44%, Laurel ward was 57% and Poplar ward was 50%.

Managers had noted that access to certain training courses had been difficult where they were face-to-face sessions due to the COVID-19 pandemic and the lack of availability of certain courses. This had impacted on the training compliance rates.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and most were reviewed regularly, including after any incident.

We reviewed 51 care and treatment records. Staff used a recognised risk assessment tool. Staff generally reviewed and updated risk assessments in line with trust policy and expectations.

We reviewed six risk assessments on Priestner's Unit at Atherleigh Park. Four of the six risk assessments had not been reviewed in line with the trust's policies and procedures. Two had not been reviewed since 30 July 2021 and two had not been reviewed since 04 August 2021. The other two risk assessments reviewed were for patients who had been admitted to the unit in the week prior to the inspection. These risk assessments were present and completed. For the four risk assessments that had not been recently reviewed, there was evidence that incidents had occurred since the last review date and it was therefore not clear that the current risk level for these patients had been considered or updated.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. Staff identified and responded to any changes in risks to, or posed by, patients. Staff followed procedures to minimise risks where they could not easily observe patients.

Our findings

Staff understood the level of observation for each patient and wards allocated staff appropriately to manage these observations. Staff were aware of their responsibilities when undertaking and recording observations.

On Poplar ward, staff told us that they were anxious about placing patients on one to one observations. Staff informed us that they felt pressure from senior management if they did this and would be asked questions to as to why these decisions had been made. Staff felt that this was due to budgetary reasons. Although staff told us that they were anxious about placing patients on one to one observation, they confirmed they would continue to do so where this was clinically appropriate.

The trust had a central list of contraband and restricted items on the ward. Staff at the locations informed us that items could be added to this list for their location if there was an identified risk. It was not clear that there was consistency across the locations or that historical risks and learning about specific items were shared across the trust.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff generally kept up-to-date with their safeguarding training.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. Staff on the wards were aware of what factors they needed to consider regarding safeguarding. Managers were confident that staff could recognise potential safeguarding issues and would report these as required.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Managers reported positive links with safeguarding teams and knew how to make referrals if they had concerns.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain clinical records – whether paper-based or electronic.

Patient notes were comprehensive and all staff could access them easily. When patients transferred to a new team, there were no delays in staff accessing their records. Records were stored securely.

Track record on safety

The service had recent serious incidents across the locations. Managers could describe these incidents and the learning from them. The trust had processes in place to review these incidents.

We reviewed incident data in respect of the wards we visited at Park House and Moorside Unit. Between 09 August 2021 and 12 September 2021 there were 183 incidents reported across the five wards.

For the same wards, there were 128 incidents reported of physical abuse or violence towards staff for the six months prior to the inspection. Twenty three of these incidents occurred in August or September 2021.

Our findings

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Overall, staff recognised incidents and reported them appropriately. However, we found some examples where staff had not reported staffing issues which had impacted on patient care. Managers investigated incidents and shared lessons learned with their local team, although not always the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff did not always report staffing issues which had impacted on patient care. There were examples of concerns and incidents where patient care had been impacted by either the staffing level or acuity of the ward that had not been reported using the trust incident process.

The service had no never events on any wards.

Staff generally understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident.

Managers investigated incidents. The locations had local learning and incident reviews that took place. The trust had shared high level alerts about key messages they felt staff should be aware of.

Learning across locations was limited and staff were not aware of incidents and learning outside of the localities. Staff from other locations were not all aware of a recent death at one of the locations. It was not clear how staff may have been able to review and consider the learning or circumstances of this incident at the other locations, should they need to take any actions.

Staff received feedback from investigation of local incidents. Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. Managers gave examples of where changes on the wards had been implemented as a result of incidents or learning.

Our findings

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

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

- The trust must ensure that all wards have an up-to-date ligature risk assessment and ensure that these are reviewed in line with trust policies and procedures. The trust must ensure that staff are aware of and consider all ligature risks on the wards. The ligature risk assessments must be meaningful and useful for staff. (Regulation 12(2))
- The trust must ensure that staff are appropriately trained and qualified for their roles. (Regulation 18(1)(2))
- The trust must ensure that there are appropriate numbers of PMVA and ILS trained staff at each location, especially where bank and agency staff are being predominantly used on shifts. (Regulation 18(1))
- The trust must consider the environment and cleanliness of Poplar ward to ensure that is appropriate and safe to provide care and treatment to patients. (Regulation 15(1)(2))
- The trust must ensure that the toilets on Medlock ward are maintained and usable. (Regulation 15(1))
- The trust must ensure that learning from incidents is shared across locations and that there are processes for staff to be made aware of any potential risks or issues for their wards. (Regulation 17(2))
- The trust must consider staff concerns and feedback about staffing levels on the wards and anxieties that staff have in relation to this. (Regulation 18(1))
- The trust must ensure that there are enough suitably qualified staff members on each shift for all wards and continue to monitor and address this. (Regulation 18(1))

Action the trust Should take to improve:

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

- The trust should ensure that staff are reporting any incidents where patient care is impacted by staffing issues or the acuity of the ward.
- The trust should consider how to support staff to make decisions regarding increasing observations which are clinically appropriate.
- The trust should ensure that all patient risk assessments are updated and reviewed in line with trust policy and procedures.
- The trust should consider how locations are consistent in terms of practice and restrictive interventions / items.

Our inspection team

The team that inspected the service comprised a CQC lead inspector and four other CQC inspectors.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

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

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing