Requires improvement

Greater Manchester West Mental Health NHS Foundation Trust

Wards for older people with mental health problems

Quality Report

Greater Manchester West Mental Health NHS
Foundation Trust
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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)
RXV80	Moorside Unit	Bollin Ward	M41 5SL
RXV80	Moorside Unit	Greenway Ward	M41 5SL
RXV15	Woodlands Hospital	Delamere Ward	M28 0FE
RXV15	Woodlands Hospital	Hazelwood Ward	M28 0FE
RXV15	Woodlands Hospital	Holly Ward	M28 0FE

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

Summary of findings

Ratings

We are introducing ratings as an important element of our new approach to inspection and regulation. Our ratings will always be based on a combination of what we find at inspection, what people tell us, our Intelligent Monitoring data and local information from the provider and other organisations. We will award them on a four-point scale: outstanding; good; requires improvement; or inadequate.

Overall rating for the service	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Good**
Are services well-led?	**Good**

Mental Health Act responsibilities and Mental Capacity Act / Deprivation of Liberty Safeguards
We include our assessment of the provider's compliance with the Mental Health Act and Mental Capacity Act in our overall inspection of the core service.

We do not give a rating for Mental Health Act or Mental Capacity Act; however we do use our findings to determine the overall rating for the service.

Further information about findings in relation to the Mental Health Act and Mental Capacity Act can be found later in this report.

Summary of findings

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Overall summary

We rated wards for older people with mental health problems as requires improvement because:

- Bollin and Greenway wards did not comply with Department of Health's guidance on eliminating mixed sex accommodation.
- The layout of the wards did not allow staff clear lines of sight. This risk was not mitigated on any of the wards by the use of mirrors, risk assessments or staff observations. Staff had identified ligature points (places where someone intent on self-harm might tie something to strangle themselves) and took action to remove or minimise risks.
- On all of wards National Institute for Health and Care Excellence (NICE) guidance was not being followed in relation to rapid tranquilisation. On Bollin and Greenway wards staff we spoke to were not aware of the trust policy in relation to physical health monitoring following rapid tranquilisation. On Holly ward one episode rapid tranquilisation had not been logged as an incident as required by the trust policy.
- The staff did not always follow best practice with respect to recording of capacity assessments and best interest decisions. There were issues on all five wards with the recording and reviewing of patients' rights when detained under the Mental Health Act (MHA). There was a lack of evidence that leave was routinely risk assessed prior to authorisation or that the outcome of any specific period of leave was reviewed consistently. The leaflets provided to patients detailing their rights under the MHA did not include the most up to date contact details for the Care Quality Commission.
- Training levels were poor for the MHA and Mental Capacity Act. This was at 21% at the time of our inspection. Only 60% of staff across the older adult wards had received an annual performance appraisal.

However:

- The wards were clean and tidy and maintained to a high standard.
- There was a sufficient number of staff on the wards to provide people with the care and treatment they required.
- There was good multidisciplinary team working and staff engaged well with community teams as well as external organisations.
- The clinical leadership on the ward was clear and all staff said that they felt supported and listened to. Staff were aware of the trust vision and values and were committed to providing good care in line with this.

Summary of findings

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

Are services safe?

Requires improvement

We rated safe as requires improvement because:

- Bollin and Greenway wards did not comply with Department of Health's guidance on eliminating mixed sex accommodation.
- The layout of the wards did not allow staff clear lines of sight. This risk was not mitigated on any of the wards by the use of mirrors, risk assessments or staff observations.
- On all of wards there was evidence that National Institute for Health and Care Excellence (NICE) guidance was not being followed in relation to rapid tranquilisation. On Bollin and Greenway wards, staff we spoke to were not aware of the trust policy in relation to physical health monitoring following rapid tranquilisation. On Holly ward, one incident had not been logged on the trust incident reporting system. This is a requirement in the trust policy for rapid tranquilisation and therefore the policy had not been followed on this occasion.
- overall compliance with mandatory training was 77% and did not meet the trust target of 85%.

However:

- The wards were clean, tidy, and well maintained. The clinic rooms were fully equipped and emergency equipment was checked regularly.
- The staffing levels were adhered to at all times. When the wards did use bank or agency staff they received a full local induction. Where possible the wards used the same staff that knew the wards well.
- The trust used a recognised risk assessment tool called the star risk assessment V2. This was regularly updated by staff and risks were managed appropriately.
- Staff only used restraint as a last resort and debriefs took place for both staff and patients following this.
- Staff knew how to report incidents and did this using the electronic reporting system.

Are services effective?

Requires improvement

We rated effective as requires improvement because:

- Staff did not always record mental capacity assessments and best interest decisions that had been discussed with patients and their families.
- The recording and reviewing of patients' rights were inconsistent across all five wards for people detained under the

Summary of findings

Mental Health Act (MHA). There was a lack of evidence that leave was routinely risk assessed before authorisation or that the outcome of any specific period of leave was reviewed consistently.
- The leaflets provided to patients detailing their rights under the MHA did not include the most up to date contact details for the Care Quality Commission.
- Training levels were poor for MHA and Mental Capacity Act training. This was 21% at the time of our inspection.
- Only 60% of staff across the older adult wards had received an annual performance appraisal.

However:

- Care plans were individualised and completed in collaboration with the patient or carer.
- There was good evidence of physical health examinations both on admission and throughout a patient's stay.
- There was good multidisciplinary working with the community mental health team and with outside agencies.
- There was a wide range of activities available.
- There was a full multidisciplinary team in place and staff had good levels of experience in their field.
- There were regular team meetings and supervision to support staff.

Are services caring?

Good

We rated caring as good because:

- We saw positive interactions between staff and patients.
- All patients we spoke with told us they were treated in a dignified, respectful and caring manner.
- The staff we spoke with knew the patients well and this was reflected in the care plans of the patients.
- Patients all had a copy of their care plan if they wanted one and they were fully involved in developing them along with their family/carers.
- The robust admission process ensured patients were orientated to the ward.
- There were arrangements in place for carer support on all of the wards.

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Beds were not used when a person went on leave so patients always had a bed to come back to.

Summary of findings

- The discharge of patients was always planned and at an appropriate time for that person and their carers.
- There was access to a range of rooms to support treatment and care.
- Patients were able to personalise their bedrooms with pictures, posters and items from home. This included reminiscence and orientation items for patients who were cognitively impaired.
- The ward scored 95% in their patient led assessment of the care environment (PLACE) for privacy, dignity and wellbeing which is above the trust and national average.
- There was a wide range of activities available seven days a week including evenings and weekends.
- The wards all had full disabled access.
- Information leaflets were available in languages other than English and were displayed on the ward.

Are services well-led?

Good

We rated well led as good because:

- The staff were all aware of the trust vision and values and they were displayed on staff lanyards and in both staff and patient areas.
- Staff told us that they felt supported by their immediate managers.
- The senior management team were visible and staff told us they felt they could approach them if they needed they would be listened to.
- Staff were able to tell us the names of the most senior staff in the trust.
- Ward managers felt they had autonomy to run the wards and that they could increase staffing levels should they need to.
- Every member of staff we spoke to told us they were happy in their role and felt they made a difference to patient care.

However:

- The issues highlighted in the safe and effective domains around Mental Health act, Mental Capacity Act, medication management and guidance on same sex accommodation highlight some gaps in the governance structure.

Summary of findings

Information about the service

Greater Manchester West Mental Health NHS Foundation Trust provides inpatient services for people aged 65 and above with mental health conditions. The services treat patients who are admitted informally as well as patients who are detained under the Mental Health Act 1983.

The trust had five inpatient wards for older adults;

At Trafford General Hospital there were two wards;

- Bollin ward, a 10 bed mixed sex assessment ward for patients with a diagnosis of a functional mental health problem.
- Greenway Ward, an 11 bed mixed sex assessment ward for patients with a diagnosis of an organic illness. Greenway ward also provides care for people at the end of their life.

At Woodlands Hospital in Salford;

- Delamere Ward, a 15 bed mixed sex assessment ward for people with a diagnosis of a functional mental health problem.
- Hazelwood ward, a 15 bed mixed sex assessment ward for patients with either a functional or an organic illness.
- Holly ward, a 20 bed mixed sex assessment ward for patients with a diagnosis of an organic illness. Holly ward is for patients who are in the later stages of their organic illness and also cares for people at the end of their life.

Our inspection team

The team was led by:

Chair: Dr Peter Jarrett

Head of Inspection: Nicholas Smith, head of Inspection, Care Quality Commission

Team leader: Sarah Dunnett, inspection manager (mental health), Care Quality Commission

The team that inspected this core service comprised: two CQC inspectors, a Mental Health Act reviewer, three mental health nurses and a psychiatrist who specialises in older adults in mental health.

Why we carried out this inspection

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

How we carried out this inspection

To fully understand the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients at focus groups.

During the inspection visit, the inspection team:

Summary of findings

- Visited all five of the wards at the two hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients.
- Spoke with 11 patients who were using the service and 10 carers and collected feedback from 14 patients using comment cards.
- Spoke with the manager for each of the wards.
- Spoke with 35 other staff members including doctors, nurses and social workers.
- Interviewed the dementia quality lead with responsibility for these services.
- Observed one multidisciplinary meeting and two board rounds.
- Carried out a Mental Health Act review on Delamere ward.
- Attended one "singing for the brain" group.
- Looked at 37 treatment records of patients.
- Carried out a specific check of the medication management on four wards.

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 11 patients across the five wards and 10 carers.

All the patients we spoke to told us that they felt safe on the wards. They reported that staff treated them with kindness and respect and were available if they needed to talk. Patients felt they had good relationships with the staff. They said that the environment was always clean and tidy and that domestic staff did a brilliant job. Patients reported the meals tasted good and there was a good amount of choice.

Patients told us that they enjoyed the activities that were available on the ward each day.

Carers of patients told us they were supported by the staff and that they felt welcomed whenever they visited their loved one. Carers felt they were involved in their relatives' care where appropriate and their concerns were always listened to.

Good practice

At both sites there was a room to provide end of life care for patients. The wards had good links with the local hospice and Macmillan nurses to ensure that patients were looked after in the best possible way in the final weeks of their life. There was an end of life care lead who provided staff with training in relation to end of life and any issues surrounding this. This person was available on site whenever a patient was nursed to end of life and on the ward each shift to see if they needed any extra advice or assistance.

The older adult wards were heavily involved in the trust research and development programme. There was a dementia research event at the trust headquarters in November 2015. This was in order to raise awareness of current dementia research available both within the trust and outside the trust. The trust had an opt out policy for research in order to boost research participants within the trust. On all the wards there was information about this on noticeboards and in welcome packs for patients and their families to read about.

The wards were all taking part in the Advancing Quality (AQ) dementia measures programme. These quality standards covered care provided by health and social care staff in direct contact with people with dementia in hospitals, community, home-based, group care, residential or specialist care settings. AQ aims to give patients a better experience of the NHS by making sure every patient admitted to a north west hospital is given the same high standard of care no matter which hospital you attend. This standard was recommended by the National Institute for Health and Care Excellence.

Summary of findings

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that arrangements for single sex accommodation are adhered to in order to ensure the safety, privacy and dignity of patients. Clear signage should be in place at the entrance to each gender area informing patients who can enter. There must be a dedicated female only lounge on each mixed sex ward and bathrooms should be available for members of each sex to use without passing the bedroom of a member of the opposite sex.
- The trust must ensure all staff understand the application of the Mental Capacity Act in practice. Documentation should contain evidence of recording of any decisions made about a patient's capacity.
- The trust must ensure that older adult wards comply with both national guidance and trust policy on rapid tranquilisation. Physical observations should be monitored following rapid tranquilisation on the trust approved form and within the correct timescales. All incidents of rapid tranquilisation should be recorded as an incident as per trust policy.
- The trust must ensure that patients detained under the Mental Health Act 1983 are read their rights at key points during their detention, in particular when progressing from one section to another.

Action the provider SHOULD take to improve

- The trust should ensure all older adult wards display notices both on the inside and the outside of locked entrance doors to inform informal patients of the reason for the ward being locked and their right to leave at any time
- The trust should ensure all staff have an annual performance appraisal
- The trust should ensure that leaflets provided to patients detailing their rights under the MHA include the most up to date contact details for the Care Quality Commission
- The trust should ensure that mandatory training is completed for all staff to achieve the trust target of 85%.

Greater Manchester West Mental Health 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
Bollin Ward	Moorside Unit
Greenway Ward	Moorside Unit
Delamere Ward	Woodlands Hospital
Hazelwood Ward	Woodlands Hospital
Holly Ward	Woodlands Hospital

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.

At the time of our inspection, 21% of staff had attended training in the Mental Health Act (MHA). This was highest on Bollin ward at 54% and lowest on Hazelwood and Holly wards at 9%. MHA training was not mandatory for the trust at the time of our inspection and therefore relied on managers at ward level encouraging staff to attend. However, despite the lack of training staff had a general understanding of the MHA relevant to their role. However, we specifically asked staff what training or briefing they had had about the expectations of the new code of practice and were told that although such training was planned none had been made available to date. Staff told us that MHA Training was not mandatory and some told us that it had recently become mandatory.

During our inspection a MHA reviewer looked specifically at the care records of people who were detained under the MHA. In total we reviewed 37 care records. All patients' files included a record of the responsible clinicians assessment of capacity and their discussions with the patient. However, for one patient on Delamere ward the assessment was

dated seven weeks after the first administration of medication and for another the date of first administration did not take into account medication prescribed whilst the patient was subject to section 2.

Staff were inconsistent in recording and reviewing of patients' rights across all five wards. We found good evidence of rights being read on admission and being repeated for patients who did not have capacity or were too distressed at admission. However, staff did not review patients' rights at key points during their detention such as when patients' detention was changed from a section 2 to a section 3. Also, the leaflets provided to patients detailing their rights under the MHA did not include the most up to date contact details for the Care Quality Commission (CQC), however, this information was clearly displayed on the notice boards and in the patient information racks on the ward. In addition, staff on none of the wards completed risk assessments directly prior to patients going on leave or updated them on their return. This provided us with no evidence of a clear link between patients' current risks and the decision to agree leave. Similarly patients' views or that of their carers were not recorded on return from leave to assess whether the leave had been beneficial or not. Also, the electronic recording system (PARIS) caused some confusion with regards to current leave as all previous leave forms were recorded on the same page with no way of differentiating between current and past leave.

We found good evidence of an effective MHA administration system, which ensured the required documents were received and scrutinised in accordance with the MHA and Code of Practice (CoP). The legal section of each patient's file contained detention papers and medical recommendations. However, in three files the AMHP report was not present.

There was evidence that an independent mental health advocate (IMHA) was available for patients on the wards. When a patient was deemed to lack capacity a referral to the IMHA was made on their behalf by the MHA administrator.

Mental Capacity Act and Deprivation of Liberty Safeguards

At the time of our inspection 28% of staff had received training in the Mental Capacity Act (MCA). However, similar to Mental Health Act Training MCA training was not mandatory and again relied on managers encouraging staff to attend. Despite the lack of training staff had a good understanding of the key principles of the MCA relevant to their role and were able to explain these to us. There were 20 Deprivation of liberty safeguards (DoLS) applications made in the last 6 months. These applications were made on Holly Ward (twelve) and Delamere Ward (8).

We reviewed 37 treatments cards of patients across the five wards. Staff we spoke to understood the principles of the MCA and were able to give us examples of how they had appropriately assessed people's capacity. Examples of this were around do not attempt resuscitation, covert medication and best interest decisions around future care settings. We spoke to patients' relatives who told us how they had been involved in these meetings and what their understanding was of the decisions being made.

However, at both Greenway and Holly wards there was examples of these discussions not being documented in patients care records. This meant that it was difficult for staff to identify when these decisions would need to be reviewed and show evidence of this being done, as a baseline discussion was not recorded. On Holly ward there was one example of a patient who had a 'do not attempt resuscitation' form in place but no capacity assessment or best interest decision were recorded.

Requires improvement

Are services safe?

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

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

Our findings

Safe and clean environment

All wards were clean and tidy at the time of our inspection. Cleaning schedules were in place and up to date. These were completed by the domestic staff on duty. All wards had access to an outside space. The furnishings were well maintained and there were bright pictures of the local area.

The ward layout did not allow staff to observe all parts of the wards. This risk was not mitigated on any of the wards by the use of mirrors or staff observations. On Hazelwood ward the patients sleeping in bedrooms in these areas were risk assessed prior to being allocated those rooms. However, there was nothing to stop other patients walking into these areas who may have been a higher risk.

Up to date ligature audits were in place in each ward. A ligature point is a place where a patient intent on self-harm might tie something to strangle themselves. All wards had ligature points which were referenced on the ligature audits. Mitigations were in place to manage these risks which included locking rooms where ligatures were, for example some bathrooms; observations of staff and individual patient risk assessments.

All wards provided care and treatment for both male and female patients. However, Bollin and Greenway wards did not meet Department of Health's guidance on eliminating mixed sex accommodation. At the time of our inspection there was only one bath on Greenway ward which was on the female bedroom corridor. This meant that male patients would have to pass by female bedrooms to go for a bath. On Greenway ward there was a designated female only lounge but during our inspection this was used for a singing group and male patients were involved in this. On Bollin ward, the female and male bedrooms were all along one side of the corridor. Although females took up the first part and males the second, there was no signage to identify that the area was specifically for either sex and that members of the opposite sex should not enter. The male toilet and shower room was in the female part of the corridor, which meant males would have to pass female bedrooms to use it. The female bathroom was in the middle of the corridor so this meant that depending on how many males were on the ward, females would have to pass by male bedrooms to get to the bathroom. There were no risk management arrangements in place to minimise the associated risks of this happening.

All wards had a fully equipped clinic room with accessible resuscitation equipment and emergency drugs. The clinic rooms were clean, tidy, and well arranged for access. Appropriate equipment for examinations and monitoring of basic medical observations were available such as blood pressure machine and weighing scales. Daily temperature checks of drug cupboards showed they were within the required range. Weekly cleaning of medical equipment took place and records showed these were completed and up to date.

There were no seclusion room facilities on the ward and seclusion was not used. If a patient required a more intensive level of nursing they would have access to one of the psychiatric intensive care beds within the trust.

Nurse call points, to attract the attention of staff as required, were present in all patient bedrooms and bathrooms. Personal alarms were carried by all staff members working on the wards. At Holly, Hazelwood and Delamere wards staff were also alerted when patients who were at risk of falls got out of bed. This was done using a passive infrared sensor which set off the alarms when patients pass by the sensor so staff can assist them.

Handwashing facilities were available throughout the ward. Staff were observed to wash their hands at appropriate times, for example after giving out medication.

Safe staffing

The staffing establishment for the five wards was 38.9 (WTE) qualified staff and 54.5 (WTE) for unqualified staff. At the time of the inspection, 8.2 and 9.9 qualified nurses and nursing assistant posts respectively were vacant. The average total turnover rate for the 12 months leading up to our inspection across the service was 13%. It was highest on Holly Ward at 24%. Vacancy levels were highest on Delamere ward at 25%. The overall staff sickness rate was 11% It was highest on Holly Ward at 17%. During our inspection, we reviewed staff files on each of the wards. We saw that managers were using the trust policy to manage any sickness absence that triggered their internal

Requires improvement

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procedures. We saw evidence of staff being supported to return to work via phased returns and occupational health referrals. There is a staff wellbeing academy where counselling and other support is offered. Ward managers were supported by human resources to manage high levels of sickness.

In order to establish the number of staff required on each shift the trust commissioned the executive management team to support a review of staffing levels across mental health inpatients in May 2013. This information had been used to inform staffing levels and skill mix. During our inspection we reviewed the staffing rota's across all wards. They confirmed managers adjusted staffing levels to take into account patient mix, for example, at times when increased observations were needed or days when there were team meetings. The numbers of staff on duty on each shift matched that of the establishment set for each ward. In addition to this the staffing levels for the trust are published every month on the trust website which the general public can view. This is broken down by ward so that people using the service and their relatives can look at the staffing levels for their particular ward.

A weekly ward managers meeting at Moorside unit in Trafford monitored staffing, sickness rates and use of bank and agency staff by the service. It also planned for the week ahead taking into account leave and activities. Staff were moved around to other wards if required.

All the wards used bank and agency staff. The total number of shifts covered by bank and agency staff across the service was 233. This was highest on Holly ward at 63 shifts. Staff told us that when bank and agency staff were used these were staff that knew the ward and worked there on a regular basis. There was a local induction for bank and agency staff if it was the first time they were working on a particular ward and this was completed by the nurse in charge. During our inspection we saw evidence of completed induction checklists on each ward and staff completing them with staff on duty. The ward manager was always supernumerary on the staffing rota. This meant that if there was short notice sickness they were able to work on the ward until a staff member to cover was found.

All ward managers were clear that they had sufficient authority to increase staffing levels dependent on patient need.

The communal areas had sufficient staff available and they would assist patients with activities of daily living and ward based activities on all five of the wards. Staff and patients told us that they spent regular one to one time together. During our inspection we saw staff sat with patients for most of the day engaging with them and providing support. We also saw documented evidence of one to one time spent with patients in the care records we reviewed.

There were always enough trained staff to carry out interventions safely and all staff were trained in management of violence and aggression for older adults. Within all of the buildings where these wards were located there was an identified response team who would attend the ward where the alarm was raised to assist.

The medical cover differed between the two sites out of hours. At Greenway and Bollin wards, there was access to an on call junior doctor and a consultant psychiatrist on call at all times via a duty system. If there was a medical emergency then the wards would access the crash team at the acute hospital on the same site by dialling 2222 on the ward telephone. The physical health nurse for the unit was also part of the crash team. At Woodlands hospital, junior doctors and consultants were based on each ward during core hours. Outside of these times, a locum medic was employed to cover weekends and bank holidays for mental health related problems. There was also cover by the second tier on-call psychiatrist would attend the unit as required through the night for any psychiatric emergencies. For physical health related problems, there was a hospital at night service. This was staffed by advanced practitioners from 17:00 to 09:00, seven days per week. There was also a GP out of hour's service for any physical health related issues. In a medical emergency staff would use 999 to contact an ambulance.

The average mandatory training rate for staff in Older People Inpatients is 77%, which was below the trust standard of 85% compliance. The trust provided us with data for mandatory training. Of the 12 courses that the trust lists as mandatory for staff, only four met the trust target of 85%. Delamere ward was the only ward that was compliant and above 75% in every area for all twelve courses. Records showed levels of compliance were below 75% in the following areas;

Bollin/Greenway Ward

Basic Life Support 44%

Requires improvement

Are services safe?

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

Fire safety 73%

Immediate Life Support 67%

Infection control level 1 0%

Infection control level 3 52%

Positive Management of Violence Aggression 50%

Hazelwood Ward

Basic Life Support 63%

Immediate Life Support 18%

Infection control level 3 42%

Information governance 63%

Holly Ward

Fire safety 54%

Immediate Life Support 20%

Infection control level 3 54%

Information governance 69%

During our inspection we saw records that showed that all ward managers were working to ensure the courses that fell below 75% were improved. We saw evidence of forward planning for booking on courses prior to them lapsing in order to maintain compliance. Some of the mandatory training had been changed to an e-learning style of training. When we spoke to staff they told us it was difficult to complete these courses as they had to do it on the ward during working hours. This meant that if anything happened on the ward they had to leave the course to help other staff and the course would "time out" losing the work they had done. Ward managers told us they were planning to give staff time out of the staffing establishment to complete e-learning in order for staff to be able to complete the course away from the ward area.

Assessing and managing risk to patients and staff

In the six months leading up to our inspection, there were no episodes of seclusion. There were 62 episodes of restraint across the five wards with Greenway ward being the highest at 35. Of these episodes of restraint, 11 were recorded as prone restraint and none of the reported prone restraints resulted in rapid tranquilisation. When we spoke to staff about prone restraint they reported that they never used it. We asked about the 11 reported incidents of prone restraint and it was explained that this could have been an error by the inputter as staff on older adults wards are not taught prone restraint techniques. There is a specialised PMVA later life training course that teaches safe holds in a seated or standing position only. All staff on the older adult wards are required to attend this training and there was 100% compliance at the time of our inspection..

The trust was in the process of implementing the "safewards" model of care across all of the older adult wards. This is about reducing restrictive practices in mental health settings by using positive language to reduce conflict, in particular the use of restrictive practices such as restraint. This was undertaken following the Department of Health (2014) guidance "Positive and Proactive Care" which aims to reduce restrictive practice in particular prone restraint. We saw evidence in the care records we reviewed that staff were working with patients and their families to create a holistic care plan for patients which identified potential triggers for aggressive behaviour. It also identified ways in which the patient could be engaged to reduce this behaviour at these times. For example at Woodlands patients had memory boxes in their bedrooms filed with things they enjoyed doing that staff could use with a patient who they identified was becoming agitated or upset. It was evident from reading patients care plans and notes that restraint was only used as a last resort and this was carefully risk assessed on a patient specific basis.

We reviewed 37 care records of patients. In all of the records we saw patients had a completed risk assessment that was updated weekly by the named nurse. We also saw evidence that risk assessments were updated after incidents and this was reflected in the patients care plans. The trust uses the risk version 2 (STAR) risk assessment tool.

We did not see any evidence of restrictive practice on the wards we visited. However, all of the wards we visited were locked. There was no information displayed as to how informal patients or others could leave the ward or seek assistance with doing so. We were informed by staff that these doors were electronically locked for patient safety reasons, however they were unsure how the locked door policy/procedure was reviewed stating that the doors were locked all the time

The trust had policies for observations of patients and staff were able to explain these to us. This included staff observing patients generally at all times to react to any risks, patient need and monitor patient interactions.

Requires improvement

Are services safe?

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Searching of patients did not happen and staff told us they had never searched patients. However, there was a trust policy for search of patients and their belongings. Staff were able to show us where this was located should they need to use it.

On all of the wards we visited we found evidence that National Institute for Health and Care Excellence (NICE) guidance was not being followed in relation to rapid tranquilisation. On Bollin and Greenway wards staff we spoke to were not aware of the trust policy in relation to physical health monitoring following rapid tranquilisation. Therefore they were not using the trust approved rapid tranquillisation physical observations chart. In all three examples we reviewed there was no documented evidence of patients physical observations being monitored following administration of rapid tranquilisation. There were also differing time frames given by staff on when the physical health of patients should be monitored following administration of this type of medication. On the three wards at Woodlands hospital one patient on each that had received rapid tranquilisation, for all of these the physical health monitoring of patients was being correctly followed and this was clearly documented in patients' notes. However, one of these episodes of rapid tranquilisation had not been logged as an incident on the trust incident reporting system. This is a requirement in the trust policy for rapid tranquilisation and therefore the policy had not been followed on this occasion.

Staff had a good understanding of safeguarding and were able to explain the safeguarding procedure to us. Safeguarding training is mandatory and all five of the wards were above the trust target for this training. Incidents were reported via an online form and all staff were able to tell us the name of the safeguarding lead for their area. They also told us they could ring them for advice around safeguarding if they needed it.

The trust had a medicines management policy and there were effective medicines management procedures in place. The pharmacist for all wards visited most days and was available for telephone calls during working hours for any questions or medication reconciliation. The trust had a NICE and quality standards policy which sets out responsibilities at a local level for staff regarding implementation and distribution of any new or updated guidance produced. On the older adult wards we saw evidence of staff engaging in clinical audit around NICE guidance relating to older adults with mental health problems. For example, monitoring of pain management and analgesic prescribing in on a dementia ward and antipsychotics for inpatients with dementia.

All patients were assessed on admission for pressure areas. If any were identified (at any level) this would be reported as an incident on datix and a safeguarding referral made. There were good links with tissue viability and access to pressure relieving equipment such as mattresses and cushions.

All falls resulting in a fracture were investigated by the trust. There was a falls groups that met monthly to discuss any incidents, training and new research in relation to falls. This group comprised of different members of the multidisciplinary team including nurses, physiotherapists, physical health nurses and mental health nurses. During these meetings incidents relating to falls were discussed and learning shared across the trust. All falls were recorded as an incident on the datix system.

There were facilities in place for child visiting to occur. This usually happened off the ward area to ensure the safety of the children. If children visited on the ward this was risk assessed before the visit occurred.

Track record on safety

There were six serious incidents in the 12 months leading up to our inspection. Four of these related to patients falling and sustaining fractures and two were relating to patient on patient violence.

There were clear processes set out by the trust following on from a serious incident. An incident form was completed by the staff member and the team manager reviewed this. The manager and senior team would then have a period of three days to review high level incidents. A root cause analysis would take place to identify factors that contributed to the incident and enable the wards and the trust to learn from incidents. This would in turn prevent further incidents of a similar nature occurring. A positive learning event would take place following on from this. This was a meeting where staff could discuss the incident and any learning or changes that could be made following it. An example of a change following an incident was the introduction of a "safety huddle" on the wards at

Requires improvement

Are services safe?

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

Woodlands Hospital. This was a short meeting where staff discussed patients that were at risk of falls. Physiotherapists would be present and give advice around how staff could manage these patients.

Reporting incidents and learning from when things go wrong

The trust had an electronic incident reporting system in place called datix. All staff we spoke to were aware of this system and how they would access it to report an incident. Staff were aware of duty of candour and the need to be open and transparent when an incident occurred.

Staff told us they learnt outcomes from incidents in a number of ways. This included feedback at staff meetings, in supervision, the internal intranet system and via email from the manager. The ward manager also ensured that debriefs happen following incidents. This was to ensure patients and staff felt supported following a serious incident. This involved a discussion of what happened, what could have been done differently and also supporting the staff with their emotions around this. On Bollin and Greenway wards the ward manager chaired positive learning events. This was a meeting where a particular incident was discussed with the team in order for them to identify what had gone wrong and how this could be avoided in the future. All staff we spoke to reported that these were a positive idea and that they felt this was an opportunity for learning without fear of blame.

Are services effective?

Requires improvement

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Our findings

Assessment of needs and planning of care

We reviewed 37 sets of care records during our inspection. In all of these a care plan and risk assessment had been formulated within the first day of admission. All care records showed evidence of physical health being reviewed on admission and that this was ongoing throughout admission. This included regular blood pressure checks, monitoring of bloods and weights being monitored. Patients told us they found the physical healthcare on the unit to be excellent, readily available and easily accessible.

We found the majority of care plans to be patient centred and there was evidence of patient and carer involvement in these. However, three care records one on each ward across Delamere, Greenway and Bollin wards where care plans were formulaic rather than patient centred and did not involve the patients' views. We saw evidence on all wards of patients being offered a copy of their care plan and there were folders in all patients' bedrooms that contained a copy of their care plan.

At the time of our inspection the trust had recently implemented a new electronic record system (PARIS). This meant that staff could access patients' records from previous admissions and from other mental health professionals easily. Staff told us they were still in the early stages of using this system and more training was needed. The trust had implemented "super users" who were experts in the PARIS system, to be available for staff to ask questions to in order to make the change process smoother.

Best practice in treatment and care

There is best practice guidance provided by the Royal College of Psychiatrists for older people's mental health services. The focus of this guidance relating to inpatient care is the importance of a multidisciplinary approach in relation to physical and mental health. This also stresses the importance of joint working between inpatient and community services to ensure continuity of care. During our inspection we found some good examples of joint working in these areas. Ward rounds were inclusive of a multidisciplinary team including speech and language therapy, physiotherapists and the physical healthcare nurses so there was advice about physical healthcare available immediately. This joint working also included voluntary organisations such as Alzheimer's Society.

The wards followed national guidance relating to the care and treatment of older adults. The Advanced Quality Alliance (AQuA) has developed seven measures that, when applied at the appropriate time, can greatly increase the outcomes for patients. AQuA uses these measures to monitor the quality of care given to patients across the North West with the aim of improving standards and reducing variation in care. These measures included a cognitive assessment, nutritional assessments, functional assessments, depression assessments and pain assessments. The measures also incorporate discharge care planning and physical health monitoring. The trust had fully adopted and implemented these standards across each of the wards.

On all of the wards there was good access to physical healthcare. This included specialist care when required. At the time of our inspection we saw evidence of referrals to services such as podiatry, tissue viability, phlebotomy and physiotherapy. If patients had an appointment at the general hospital staff would escort them to the appointment and back or family would do this if they were able.

We saw patients being encouraged to drink and eat plenty during our inspection. On Bollin ward there was an hourly "comfort round" where staff would offer drinks and snacks to patients. Diet and fluid charts were part of the admission process to monitor a patient's intake in the first three days of their stay. If there were any issues surrounding this they would be kept on the chart until staff were happy with their intake or a specialist such as a dietician was involved and a care plan in place. Patients' were weighed at a minimum of weekly to monitor their weight during their admission.

Staff on all wards were actively involved in clinical audits. They were able to tell us about these and changes that have been made following them. These included medication audits, mental health act audits and specialist audits by the quality lead around dementia care. Feedback from these audits was communicated via the ward manager to staff.

Skilled staff to deliver care

The wards were staffed by a multidisciplinary team with a dedicated consultant psychiatrist specialising in older adults with mental health problems for each ward.. There were registered mental health nurses, occupational therapists, physiotherapists, speech and language therapists, activity coordinators, support workers,

Are services effective?

Requires improvement

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consultant psychiatrists. There were student mental health nurses and occupational therapists who undertook placements on the wards. There were also domestic and admin staff allocated to each ward. The pharmacist visited most days and was available on the telephone for any queries.

There was a robust two week induction for new staff. This included mandatory training. We met some staff who were new to the wards and they reported the induction was helpful in understanding the trust and its values as well as their individual roles.

Supervision figures were at 22% at the time of our inspection. However, during our inspection we saw that ward managers had worked hard to get this number up. There was regular supervision in place at six weekly intervals for all staff. We reviewed staff files and found that this was up to date on all wards and that plans were in place for this to continue. Staff we spoke to told us that they felt this was a positive step and that they felt they were able to approach their manager for more informal supervision at any time.

For older peoples inpatient wards, the data provided to us by the trust showed the current appraisal rate was 68%. When we spoke to ward managers they were able to show us evidence that this had significantly increased since the submission of data.

There was a specialist dementia training course that was provided by the trust for staff working on the older adult wards.

There were structures in place for ward managers and their deputies to manage performance within the team. The manager and senior staff were confident in the way they would approach this. They could explain how this had been done and could give examples around staff sickness levels and managing these in accordance with the trust policy. We reviewed staff files and found evidence to support appropriate actions being taken when necessary.

Multi-disciplinary and inter-agency team work

There were regular and effective multidisciplinary meetings. The ward reported good working relationships with the community mental health teams. The wards always made sure that members of the community team were updated with any changes to a patient's treatment plan. Members of the community team attended the ward for meetings about the patients they were allocated to.

Handovers occurred at the change of each shift. They included everyone who was on duty including non nursing staff to ensure that information was provided to everyone working with the patients that shift.

Consultant psychiatrists and junior doctors reported that they felt included in the team and supported by the ward staff.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

At the time of our inspection 21% of staff had attended training in the Mental Health Act (MHA). This was highest on Bollin ward at 54% and lowest on Hazelwood and Holly wards at 9%. Staff had a general understanding of the MHA relevant to their role. However, we specifically asked staff what training or briefing they had about the expectations of the new MHA Code Of Practice and were told that although such training was planned none had been made available to date. Staff told us that MHA Training was not mandatory and some told us that it had recently become mandatory.

During our inspection a MHA reviewer looked specifically at the care records of people who were detained under the MHA. In total we reviewed 37 care records. During our inspection all patients' files included a record of the responsible clinicians assessment of capacity and their discussions with the patient. However, for one patient on Delamere Ward the assessment was dated seven weeks after the first administration of medication and for another the date of first administration did not take into account medication prescribed whilst the patient was subject to section 2.

The recording and reviewing of patients' rights was inconsistent across all five wards. Whilst there was good evidence of rights being read on admission and being repeated for patients who did not have capacity or were too distressed at admission. Rights were not reviewed at key points during their detention such as when patients' detention was changed from a section 2 to a section 3. We also found that the leaflets provided to patients detailing their rights under the MHA did not include the most up to date contact details for the Care Quality Commission (CQC) However, this information was clearly displayed on the notice boards and in the patient information racks on the ward. In relation to section 17 leave none of the wards completed risk assessments directly prior to patients going on leave or updated them on their return. This provided us with no evidence of a clear link between patients' current

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Requires improvement

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risks and the decision to agree leave. Similarly patients' views or that of their carers were not recorded on return from leave to assess whether the leave had been beneficial or not. We also found the electronic recording system (PARIS) caused some confusion with regards to current leave as all previous leave forms were recorded on the same page with no way of differentiating between current and past leave.

There was good evidence of an effective MHA administration system, which ensured the required documents were received and scrutinised in accordance with the MHA and Code of Practice (CoP). The legal section of each patient's file contained detention papers and medical recommendations. However, in three files the AMHP report was not present.

There was evidence that an independent mental health advocate (IMHA) was available for patients on the wards. When a patient was deemed to lack capacity a referral to the IMHA was made on their behalf by the MHA administrator.

Good practice in applying the Mental Capacity Act

At the time of our inspection 28% of staff had received training in the Mental Capacity Act (MCA). There were 20 Deprivation of liberty safeguards (DoLS) applications made in the last six months. These applications were made on Holly Ward (twelve12) and Delamere Ward (8).

We reviewed 37 treatments cards of patients across the five wards. Staff we spoke to understood the principles of the MCA and were able to give us examples of how they had appropriately assessed people's capacity. Examples of this were around do not attempt resuscitation, covert medication and best interest decisions around future care settings. We spoke to patients relatives who were able to tell us their involvement in these meetings and that they understood the decisions that were being made and why. However, at both Greenway and Holly wards there was examples of these discussions not being documented in patients care records. This meant that it was difficult for staff to identify when these decisions would need to be reviewed and show evidence of this being done, as a baseline discussion was not recorded.

Good

Are services caring?

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

Our findings

Kindness, dignity, respect and support

During our inspection we saw interactions between patients and staff. We observed all of these to be respectful and kind, even when patients became agitated. Staff demonstrated skill when dealing with these situations. They used de-escalation techniques, such as verbal reassurance and appropriate distraction techniques, to effectively reduce patients' distress. Staff allowed the patients to move into a quieter area with less stimulation. The design of the wards meant that there was flexible space that patients could move into. We observed medication being administered by staff in a discreet manner, allowing the patients' time to ask questions about their medication. During mealtimes we observed that staff were responsive to patients' individual needs, providing assistance to patients who needed support to eat and drink. Staff were also mindful to maintain patients' independence as much as possible. Staff knew the patients well and we observed staff being caring towards relatives and carers during visiting times. For patients that needed support with intimate care their preferences were clearly care planned. This included for some patients family coming to the ward to assist if that was how the patient felt most comfortable. If patients were able to they were encouraged to choose their own clothing by the staff each morning. Patients that preferred to stay up later told us that this was respected and that staff would check on them regulary to see if they needed anything.

We spoke to 11 patients during our inspection. All patients commented that they felt safe and there was enough staff to meet their individual needs. Patients praised the staff for being available when they needed them and approachable. They told us they found staff caring, dedicated and professional.

Patient Led Assessment of the Care Environment (PLACE) is a system for assessing the quality of the patient environment. Local people go into hospitals as part of teams to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. It focuses entirely on the care environment and does not cover clinical care provision or how well staff are doing their job. Scores for PLACE data for privacy, dignity and wellbeing, were 95% for Holly and Delamere Wards, 95% for Hazelwood ward and 95% for Bollin and Greenway wards which are all above the England average of 89%.

The involvement of people in the care that they receive

The robust admission process ensured patients were orientated to the ward. However, this was difficult for some patients because of cognitive impairment. We saw evidence that for these patients staff tried their best to orientate them by making their bed area identifiable with photographs of the patient and their family on the bedroom doors.

Although the wards all had visiting times, the staff and carers told us that they welcomed relatives to come and assist their loved ones at any time with things such as feeding, shaving or washing. This was in order to maintain those relationships for when the patient returned home. For some patients this was because the patient would only do those things with a relative and this was also encouraged by staff in order to reduce agitation for the patient. The ward staff recognised that this could be a difficult time for relatives and did their best to reduce anxieties around this.

There were arrangements in place for carer support on all of the wards. At Bollin and Greenway there was a monthly carers meeting where the ward manager would discuss topics identified by the carers that they wanted to know more about. There had also been outside speakers coming in to talk about things such as dementia in the Muslim community, this was facilitated by the local imam. There were also events to mark special days in the year such as a valentines party, an event for carers week and Christmas parties. At Woodlands hospital there was bi-monthly carer's forum that begun in December 2015. Carers were given the opportunity to meet consultants, matrons and ward managers to discuss their experience of Woodlands. The trust also produced a quarterly magazine for carers information called "who cares?" This included lots of information to carers about ongoing events, research and national initiatives for carers of people with mental health problems. There was access to a "care hub" on the trust website where carers could read about carer champions, local carer groups and watch short films about caring for someone with a mental health problem.

Good

Are services caring?

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

All wards had access to an advocacy service and it was reported there were good links with them. They were usually able to respond to requests for support within 24 hours.

We saw good examples of patients being involved in decisions about the service. At Woodlands Hospital there was a service called "reach beyond". This was developed to break down some of the barriers around engaging patients with cognitive impairment. Greater Manchester West are the first NHS Trust to employ a person living with Dementia. The aim of this position was to guide, develop and engage with patients who are supported by the service. Patients are encouraged to put forward their opinions and be given a voice about the services they are receiving. Reach beyond employ two people living with Dementia, their individual roles has led to the development of forums and support groups to engage with patients and their carers. They have established two Support Groups a Dementia Café, weekly Dementia Book Club and will be launching a new Young Onset Dementia Dining Group in May 2016 aimed at supporting people still in employment who are living with Dementia.

Patients are able to sit on interview panels when the older adult service recruits staff. The recruiting process is split between two interview panels (Professional Panel & Reach Beyond Panel) that each holds their individual interviews. The Reach Beyond interview questions have been put together in consultation with patients and carers to address what they feel they would like to ask the potential applicants with regard to patient care, carer involvement, diversity, dignity and respect. Both respective panels then meet together to discuss and agree the successful applicant

At Trafford Hospital where Greenway and Bollin wards are based there is a monthly patient council meeting. The purpose of this meeting was to give service users the chance to be heard and put their opinions across with regards to ways the service can be improved. We saw minutes of these meetings during the inspection. Examples of topics discussed include alternative food for the menu and access to a hairdresser.

Are services responsive to people's needs?

Good

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

Our findings

Access and discharge

The bed occupancy for the trust for the six months leading up to our inspection was 96%. The average bed occupancy over the last six months for older peoples inpatient wards was 95%. All older peoples wards were over the 85% national average for bed occupancy.

The number of out of area placements attributed to this core service in the last six months was zero. This meant that patients could access a bed in their locality when they needed it. Leave beds were never used so patients always had a bed to return to when they had been out on leave.

In the six months leading up to our inspection, there was had been two delayed discharges from inpatient facilities. These were both for Delamere ward. In the last six months, there had been eight readmissions within 90 days. The wards with the highest number of readmissions within 90 days was Bollin Ward with five and Holly, Delamere , Hazelwood wards with one each.

Patients were only moved between wards based on clinical need. This was done in conjunction with the relatives and staff team. If patients required a higher level of care there were psychiatric intensive care facilities within the trust that patients could access. These were available in the respective boroughs so patients still had access to visits from family and carers.

Patients discharge was planned in advance and staff ensured that this happened at an appropriate time of the day for both the patient and the family.

The facilities promote recovery, comfort, dignity and confidentiality

The older adult wards differed in their setup. The wards at Salford (Holly, Delamere and Hazelwood) were new and spacious with lots of lounges and quiet rooms for patients to sit in. At Trafford (Bollin and Greenway) the wards were much smaller with only one lounge on each. This meant that the wards felt crowded at times and patients did not have a quiet space to go to apart from their bedroom. There was no private room on the ward where patients could sit with visitors. This was done in the main lounge area or family would take patients off the ward if they were able to. There was dementia friendly signage of each of the ward showing words and pictures in clear bright colours for areas such as bedrooms, toilets and bathrooms.

There was access to an outdoor space on all of the wards. On wards for patients with a diagnosis of dementia the doors were usually kept locked. However, this was due to the fact patients needed observing by staff in the garden area due to the risk of falls. Patients could go out in the garden whenever they wanted and staff would facilitate this for them.

Patients and carers reported that food was good. The catering department were able to prepare food for a wide range of tastes as well as those who needed specialist diets as prescribed by speech and language therapists, these included finger foods for patients who struggled to eat with a knife and fork to maintain their independence. The ward had a range of aids to assists patients who need support with eating. These included plate guards, easy grip knives and forks and non slip mats for tables. There was also access to special diets such as vegetarian, gluten free and diets for specific religious groups such as kosher or halal.

There were facilities for patients to make hot drinks and snacks on all wards. On Holly and Greenway ward these were offered by staff on an hourly basis due to the cognitive impairment of some patients.

Patients were able to personalise their bedrooms. On all wards this was actively encouraged. Patients showed us their rooms and they had pictures of themselves and family on their doors and walls. Patients also had pictures they had made during art and crafts sessions as well as memory boxes containing items that reminded them of home or work.

There were secure spaces in the bedrooms for patients to store personal belongings. This was in the form of a lockable drawer or cabinet and differed across the five wards.

There were a range of activities seven days a week on all five wards. This included weekends. There was access to arts and craft materials, quizzes and board games. There were also activities provided by outside agencies that visited the wards such as "singing for the brain" which we observed during our inspection. This was a reminiscence type singing group which encouraged patients with cognitive impairment to engage and remember songs from the past. Other activities included beauty sessions, walking groups and baking.

Are services responsive to people's needs?

Good

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

Meeting the needs of all people who use the service

The five wards were all on the ground floor and had full disabled access. The showers were all wet rooms style so accessible for people in a wheelchair or with impaired mobility. There were also larger assisted bathrooms that contained baths with seats that lowered so patients who could not mobilise well were able to bathe with support of staff if required.

Patient information leaflets were available about a range of treatments, mental health illnesses and medications. These were obtainable in different languages and formats if they were required. The wards all had access to interpreters via an online booking system.

Patients were encouraged to maintain links with their own religious networks as much as possible. However, if patients were too unwell to leave the wards then religious leaders were arranged to visit the ward. There was a multi faith room at each site which gave patients access to their own religious book and other materials required to pray.

During our inspection we saw information explaining to patients how to complain if they wanted to. There was information about their rights under the Mental Health Act 1983, and the internal complaints process for the trust. Patients and carers we spoke with knew how to complain and felt they would feel confident to do so if they had an issue to raise.

Listening to and learning from concerns and complaints

In the twelve months leading up to our inspection there were 11 complaints across the service. Of these 11 complaints two were upheld and six were partially upheld. None were referred to the ombudsmen.

Patients and carers we spoke with told us they were given information on admission about how to complain and we saw evidence of this in the admission information pack. However, all patients we spoke with said that they found the staff approachable. They told us that should they have a problem they would feel at ease talking to the staff about this and were confident their issue would be listened to and resolved.

Staff we spoke with were aware of the complaints procedure and could explain this to us. Staff told us they encouraged an open culture and that their relationships with the patients meant they could discuss issues in an open and honest way. If a patient raised a concern this would be discussed in the patient meeting if it were appropriate. We saw evidence of this in the minutes from the meetings, for example people asking about different activities and these being implemented into the activity plan. Staff were given feedback via supervision and staff meetings from the ward manager.

Are services well-led?

Good

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

Our findings

Vision and values

The trust values were "caring and kind, going that extra mile, value and respect, welcoming and friendly and working together". The staff we met all had the trust values on the lanyard that held their identification badge. The values were developed in collaboration with staff and patients through an initiative called values into action. This was a piece of work where patients and staff worked together to develop values and behaviors that were put into practice each day.

Team objectives reflected the organisations values. This was done in a number of ways. For example during supervision ward managers used the trusts values to encourage staff to reflect on the values and how they were displaying them during their work.

Staff knew the most senior managers in the trust. They were able to tell us their names and roles. Staff reported that senior managers were visible on the wards on a regular basis. They told us they felt they could approach them if they had any worries or problems and that they felt they would be listened to.

Good governance

Staff could access their compliance with mandatory training on the trust intranet. This showed courses that were out of date or would be out of date soon. This system also allows managers to see what staff were compliant with and when training is due. Mandatory training was below the trust target of 85% across the older adult wards. We spoke to staff and managers about this and asked why this was the case. Staff told us that lots of the mandatory training had now become e-learning. They reported that they were not given supernumerary time to complete training and therefore when it was busy on the ward they would have to go and help. The course would then time out and they would have to start again. Managers told us that eLearning was still quite new and they had realised this was an issue. All ward managers were beginning to plan in supernumerary time on their rotas for staff to complete the training and not be disturbed.

Appraisals were undertaken annually. At the time of our inspection the trust provided us with data which showed only 60% of staff on the ward had received an appraisal in the 12 months leading up to our inspection. Staff supervision was ongoing every six weeks for staff at all levels and records we looked at during our inspection showed this was up to date. All staff we spoke to told us they now had regular supervision with some informal supervision happening weekly.

The trust commissioned the executive management team to support a review of staffing levels across mental health inpatient wards in May 2013. This information had been used to inform staffing levels and skill mix.

When we spoke to patients they told us they spent one to one time with staff on a regular basis. We reviewed 37 sets of records during our inspection and all of these evidenced staff spending therapeutic time with patients on a daily basis.

There were many clinical audits happening across the older peoples wards. These included antipsychotic prescribing for those people with dementia, depression in older adults, safeguarding, and controlled drugs. Staff on the wards told us they were involved in these and that they received updates from the ward manager of outcomes.

Staff told us they knew how to report incidents and records showed they did this in accordance with policy. Staff learnt from incidents via staff meetings and one to one supervision. Information was also sent out via emails to people who were not on duty at the time to receive the feedback. Staff and patients told us they were aware of the process they needed to complete should they wish to complain.

All the ward managers felt they had sufficient authority to run their own wards. They told us that they could increase staffing levels should this be required. There was were monthly meetings for ward managers where they could meet peers and discuss any issues or incidents on their respective wards. Ward managers were aware of the trust risk register and could escalate items to be added to it via meetings with senior management.

Leadership, morale and staff engagement

The sickness level for the ward at the time of our inspection was 11%. This is above the national average of 5%. During our inspection we reviewed staff files on each of the wards. We saw that managers were using the trust policy to manage any sickness absence that triggered their internal procedures. We saw evidence of staff being supported to return to work via phased returns and occupational health referrals. There is a staff wellbeing academy where

Are services well-led?

Good

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

counselling and other support is offered. We saw evidence that when staff had high levels of sickness this was managed with support from human resources for the ward managers. In order to offer incentives for staff there was an annual prize draw for staff who had no sickness over the 12 month period. The people included would get a letter signed by the chief executive of the trust thanking them for the hard work. Last years prize was an iPad.

There were no ongoing bullying and harassment cases at the time of our inspection. However, staff told us they were aware of the trust whistleblowing policy and how to report this should they need to. All staff we spoke to told us they felt confident to raise concerns to their managers if they had a problem. They felt they would be listened to and would have no fear of any comeback from this.

All staff we spoke to told us that they were happy in their job. They felt they made a difference to patients' lives and enjoyed coming to work. The senior team had all been encouraged to attend some form of leadership training and reported this had helped them in carrying out their job. Staff told us they were able to give feedback about the service in which they worked via team meetings and supervision.

Commitment to quality improvement and innovation

None of the older adults wards were accredited by AIMS (Accreditation for Inpatient Mental Health Services) at the time of our inspection. However, all the wards were benchmarking the service against the AIMS with a view to seeking accreditation in the future.

The older adult wards were heavily involved in the trust research and development programme. There was a dementia research event at the trust headquarters In November 2015. This was in order to raise awareness of current dementia research available both in the trust and outside the trust. The trust had an opt out policy for research in order to boost research participants within the trust. On all the wards there was information about this on notice board and in welcome packs for patients and their families to read about.

At both sites there was a room to provide end of life care for patients. The wards had good links with the local hospice and Macmillan nurses to ensure that patients were looked after in the best possible way in the final weeks of their life. There was an end of life care lead who provided staff with training in relation to end of life and any issues surrounding this. This person was available on site whenever a patient was nursed to end of life and on the ward each shift to see if they needed any extra advice or assistance.

The wards were in the process of rolling out the "safewards" initiative at the time of our inspection. This is about reducing restrictive practices in mental health settings by using positive language to reduce conflict, in particular the use of restrictive practices such as restraint. This was undertaken following the Department of Health (2014) guidance "Positive and Proactive care" which aims to reduce restrictive practice, in particular prone restraint.

The wards were all taking part in Advancing Quality (AQ) dementia measures programme. This quality standard covered care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings. A Q aims to give patients a better experience of the NHS by making sure every patient admitted to a north west hospital was given the same high standard of care no matter which hospital they attended. This standard was recommended by the National Institute for Health and Care Excellence.

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 must be provided in a safe way for service users **How the regulation was not being met** On all of wards evidence that National Institute for Health and Care Excellence (NICE) guidance was not being followed in relation to rapid tranquilisation. Staff were not monitoring and recording physical observations after the use of rapid tranquilisation. On Bollin and Greenway wards, staff we spoke to were not aware of the trust policy in relation to physical health monitoring following rapid tranquilisation. On Holly ward, one incident had not been logged on the trust incident reporting system. This is a requirement in the trust policy for rapid tranquilisation. Records did not show that leave was routinely risk assessed prior to authorisation or that the outcome of any specific period of leave was reviewed consistently. The layout of the wards did not allow staff clear lines of sight. This risk was not mitigated on any of the wards by the use of mirrors, risk assessments or staff observations. **This was a breach of regulation 12(2)(a)(b)**

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect Service users must be treated with dignity and respect **How the regulation was not being met**

This section is primarily information for the provider

Requirement notices

Both Bollin and Greenway wards did not comply with the Department of Health's guidance on eliminating mixed sex accommodation. On Bollin ward there was no clear signage to indicate where members of the opposite sex should not enter.

On Greenway ward there was only one bath which was at the end of the female corridor. This meant that males using the bath would have to pass by female bedrooms to get to it.

There was a designated female only lounge but on the day of our inspection this was used for a singing group which was attended by both males and females.

This was a breach of regulation 10 (2)(a)

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 must enable the registered person to maintain securely and accurate, complete and contemporaneous record in respect of each service user, including decisions taken in relation to the care and treatment provided. **How the regulation was not being met** At both Greenway and Holly wards discussions around capacity and best interest were not being documented in patients care records. This meant that it was difficult for staff to identify when these decisions would need to be reviewed and show evidence of this being done, as a baseline discussion was not recorded. The recording and reviewing of patients' rights was inconsistent across all five wards for people detained under the Mental Health Act

This section is primarily information for the provider

Requirement notices

On Holly ward there was one example of a patient who had a do not attempt resuscitation form in place but no capacity assessment and best interest decision were recorded.

This was a breach of regulation 17 (2)(c)