Good

Greater Manchester West Mental Health NHS Foundation Trust

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

Quality Report

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Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RXV60	Rivington Unit	Beech Ward Birch Ward Maple House	BL4 0JR
RXV17	Meadowbrook Unit	Eagleton ward Keats ward Chaucer ward	M6 8HG
RXV80	Moorside Unit	Brook ward Medlock ward Irwell ward	M41 5SL

Summary of findings

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.

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	Good
Are services safe?	Requires improvement
Are services effective?	Good
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 acute wards for adults of working age and psychiatric intensive care units as good because:

- There was effective and timely discharge planning at Meadowbrook and Moorside units. This meant that patients did not have to stay in hospital longer than necessary.
- Physical health checks were in place for all patients. This was achieved by using a physical health intervention tool. Staff were specifically trained in delivering this aspect of care. This meant that patients being admitted to the service had their physical health needs met.
- Risks assessments were in place for all patients. These were regularly reviewed and updated when necessary. This meant that staff were aware of risks and that patients and staff safety was managed well.
- There was effective multidisciplinary team working. A range of professionals had input into patient reviews and other ward meetings. This meant that patient care was holistic and barriers to recovery and discharge were challenged and overcome.
- The psychology provision at the Rivington unit was embedded in the ward culture and was well resourced. There were daily patient sessions available that focussed on relapse prevention and staying well.
- The service had an efficient system in place regarding bed management. Patient admissions were not unnecessarily prolonged and patients were rarely placed out of area. This enabled new patients being admitted to stay in their local area.
- All wards had access to occupational therapy. This meant that patients needing support with independent living skills or other needs could have this support whilst an inpatient.
- The food provided to patients was of good quality and variety. Patients had a choice of healthy meals and dietary or religious requirements were catered for.
- The senior management team were a visible presence on all wards. This meant that patients and staff were aware of whom the managers were and that they were accessible.

However:

- Environmental difficulties in observation/clear lines of view and ligature risks were evident in each ward area. Staff described mitigating environmental risks with increased observation of patients.
- There were inconsistencies in application of the environmental assessment tool used on wards with similar risks and patient populations, particularly the window design which was identified on the trust's risk register but not in the environmental assessment of risk.Six wards had environmental assessments with action planning in place and three had none. Patients may be exposed to unidentified risks if these tools are not applied consistently over all areas.
- Not all staff had the opportunity to access supervision or appraisal.
- Mandatory training levels were low for basic life support and immediate life support, with three wards with no staff trained in immediate life support. Checks on life support equipment had failed to identify out of date oxygen on two wards. Lack of training in life support and faulty equipment could compromise the safety of patients.
- De-stimulation rooms were used to calm patients on some wards. However, patients were prevented from leaving due to behavioural disturbance. Staff were also not following the checks and safeguards of the MHA Code of Practice.
- Staff were not adequately trained in the MHA or Mental Capacity Act. This meant that patients' rights could be compromised.

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**:**

- all acute wards and psychiatric intensive care units (PICU) had difficulties with clear lines of vision because of the ward lay out making it difficult for staff to observe all areas of the wards. Staff managed this by increasing observation levels which meant that some patients could be placed on a higher level of observation level than was clinically required
- environmental risk assessments identified ligature risks which were evident in all areas of the ward environments. Action planning was in place. However, risks remained on these assessments for lengthy periods of time and there were inconsistencies in the recording of risks and subsequent action planning across services
- environmental risks impacted negatively on patient care as nursing observations were increased to prevent risks posed by the environment
- staff described busy environments and acknowledged that activities and leave were cancelled due to lack of available staff
- checks on medical equipment failed to identify out of date oxygen cylinders on two wards. this meant that in an emergency staff would not have access to equipment that was in date and safe to use
- seclusion management plans were not completed or incorporated into patient care plans. There was a lack of de-brief following patients' being secluded
- mandatory training levels were significantly low for basic life support and immediate life support. Three wards had no staff trained in immediate life support. This meant that in a medical emergency staff were not aware of the correct and most effective lifesaving skills which could compromise the safety of patients
- de-stimulation rooms which were used to calm patients, prevented patients from leaving due to behavioural disturbance. Confinement in this room amounted to seclusion. Staff did not record this as seclusion or follow the correct procedures outlined in the Mental Health Act, (MHA), Code of Practice

However:

- all patients we spoke with described having regular one to one time with their named nurse

Summary of findings

- there was evidence of good discharge planning on the Meadowbrook Unit and Moorside Unit
- all wards had access to the physical health intervention tool, to ensure all physical health
-

checks were completed as necessary

- recognised risk assessments were used and regularly reviewed

Are services effective?

Good

We rated effective as good because:

- the wards had good multidisciplinary reviews of patients care, and good attendance from a range of professionals
- ward reviews and board rounds, (daily meetings of professionals to discuss how to progress patient care), were observed and demonstrated good involvement of the patient in the care planning process
- psychology input on the Rivington unit was well resourced and embedded throughout the unit. Patients were accustomed to attending group therapy and talking about their emotions and coping strategies

However:

- MHA and Mental Capacity Act, (MCA) training was not provided to all staff. There were plans in place to review the training programme and include MHA and MCA training to the mandatory training schedule
- not all staff had received an appraisal and supervision as per trust policy
- recording of patients capacity was inconsistent
- section 17 leave recording was inconsistent

Are services caring?

Good

We rated caring as good because**:**

- all patients and carers we spoke with told us that staff were supportive and treated them with respect
- patients spoke very highly of the care given by ward staff and detailed good relationships with all members of the ward team
- when staff spoke about patients they used respectful language and demonstrated a good understanding of their individual needs
- the service had a carer strategy in place and initiatives to involve relatives/carers

Summary of findings

- the service had good initiatives to involve patients in the delivery of the service

Are services responsive to people's needs?

Good

We rated responsive as good because**:**

- bed occupancy was high however bed management was good and every effort was made to ensure patients remained in their catchment area
- patients were only moved when there was a sufficiently good clinical reason to do so
- from July 2015 to January 2016 there were five identified delayed discharges, these were explained as awaiting specialist and social care placements
- the wards had ample space for therapeutic activities and treatment
- patients on each ward had access to a private telephone, or could use their own mobile phones
- hot drinks and snacks could be prepared at any time on the wards
- patients had access to occupational therapy
- staff respected patients diversity and rights, and every effort was made to meet patients individual needs
- a choice of meals was available with a varied menu
- spiritual support was available from a variety of different spiritual leaders
- patients had access to advocacy services
- there were quiet areas on each ward where patients could meet visitors and relatives
- child visiting arrangements were in place

Are services well-led?

Good

We rated well led as good because**:**

- we found that the senior management team within all units were a visible presence on the wards and staff said they were approachable and supportive
- units demonstrated team working amongst wards and sharing of resources
- staff could input into services via the “dragons dens” initiative and new ideas and services could develop
- wards were involved in the “safe wards” programme
- there was an effective bed management system

However, we also found that,

Summary of findings

- the trust did not have a clear overview of mandatory training as training figures on the wards did not always match those generated by the trust systems
- management oversight for ensuring information from audits was acted upon was poor. This was evident in emergency equipment checks and ligature point audits
- compliance with supervision and appraisals was significantly low

Summary of findings

Information about the service

Greater Manchester West Mental Health NHS Foundation Trust had six acute wards for adults of working age and three psychiatric intensive care units (PICU), (wards that provide intensive care services for the most unwell patients who present higher risk), spread across three hospital sites. These wards provided care for patients aged predominantly between 18 and 65 who require hospital admission for their mental health problems.

These were based at the following locations,

- Salford Royal Hospital, Meadowbrook Unit.

Eagleton ward, 23 bed male acute ward.

Keats ward, 22 bed female acute ward .

Chaucer ward is an eight bed mixed gender PICU.

- Royal Bolton Hospital, Rivington Unit.

Beech ward 18 bed mixed gender acute ward.

Birch ward, 24 bed mixed gender acute ward.

Maple House, six bed mixed gender PICU.

- Trafford General Hospital, Moorside Unit.

  Brook ward, 22 bed male acute ward.

  Medlock ward, 21 bed female acute ward.

  Irwell ward, six bed mixed gender PICU.

All of the PICU wards had seclusion rooms within the ward.

The acute care pathway had recently made significant changes to the way care was delivered to patients when they were acutely unwell. The service had further developed the community and crisis care pathways to enable patients to remain at home for longer when their mental health had deteriorated. This meant that when patients were admitted to the service the acuity of patients was much greater than it had been previously. The trust had anticipated this and increased staffing levels to reflect this change. However, the trust had underestimated the acuity of patients and the staffing levels needed to provide adequate care. During the inspection process this was being reviewed and plans were being developed for staffing levels to be increased.

The CQC undertakes regular Mental Health Act monitoring visits to all hospital wards where patients may be detained for care and treatment. We carry these out at least once every eighteen months. During this inspection a Mental Health Act monitoring visit was undertaken on Keats ward. We had visited all of the acute admission wards within the previous eighteen months and were able to review the action plans for each ward to monitor progress the service had made against the action plans.

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, Care Quality Commission

The team comprised of two CQC inspectors, one CQC Mental Health Act reviewer, one CQC pharmacist, four specialist advisors, (two mental health nurses, one consultant psychiatrist and one trainee consultant psychiatrist), and one expert by experience. An expert by experience is someone who has gained expertise through using services or through contact with someone who has used them for example, as a carer.

Why we carried out this inspection

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

Summary of findings

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 three focus groups.

During the inspection visit, the inspection team:

- visited all nine of the wards at the three hospital sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 38 patients who were using the service
- spoke with eight carers of patients who were using the service
- spoke with the managers or acting managers for each of the wards
- spoke with 39 other staff members; including doctors and nurses
- attended and observed two hand-over meetings and 12 multidisciplinary meetings
- attended and observed one patient led activity group

We also:

- collected feedback from patients using comment cards
- looked at 20 treatment records of patients
- carried out a specific check of the medication management on one ward
- carried out a Mental Health Act monitoring visit on one ward
- held focus groups with staff and patients

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 patients and their relatives/carers. Patients described positive nursing interventions. They were positive about the care they received on the acute wards and psychiatric intensive care units. They detailed good interactions with staff who they found to be caring and supportive; they felt engaged and listened to.

Although all patients described having good one to one time with their named nurse, patients also told us that leave was not always available to them because of staffing issues and complained they couldn't always get cigarette breaks.

Carers/relatives described staff as helpful and respectful although the relatives we spoke with suggested that they would like more information about the service and involvement in their relatives care.

Good practice

Across all wards we found evidence of excellent interagency working. For example at Medlock ward pregnant patients and new mothers were often supported by midwives and specialists such as breast feeding specialists.

The psychology input across the three wards based within Bolton Royal Hospital had a particularly robust provision for psychological interventions. We observed and reviewed ward based psychological groups that were

Summary of findings

provided to patients on a daily basis, (except weekends). We found that these were well attended by patients and that the psychological ethos was embedded in the ward culture.

We also found that despite a high bed occupancy rate on each ward, there was an effective bed management system in place which ensured patient flow was not hampered by external or internal obstacles. We observed the daily board round meetings where patient's needs were discussed and barriers for potential progress and discharge were delegated for action. This enabled patients to be discharged in a timely way with the correct support in place.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that all relevant staff have the necessary training in order to safely perform their roles and protect patient safety.
- The trust must ensure that equipment and medical supplies are replaced when necessary in order for safe care and treatment to be delivered to patients in an emergency situation.
- The trust must ensure that environmental checks are completed in a consistent way and that improvements are made in a timely manner.
- The trust must ensure that staff do not seclude patients without the correct checks and safeguards being in place in respect of the Mental Health Act code of practice and trust policy.

Action the provider SHOULD take to improve

- The trust should continue to ensure that staffing levels reflect the acuity of patients and that there is an appropriate skill mix within all wards.
- The trust should ensure that patients who are detained under the Mental Health Act can clearly understand their Section 17 leave entitlement.

Greater Manchester West Mental Health NHS Foundation Trust

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

Detailed findings

Locations inspected

Name of service (e.g. ward/unit/team)	Name of CQC registered location
Beech Ward Birch Ward Maple House	Rivington Unit
Eagleton ward Keats ward Chaucer ward	Meadowbrook Unit
Brook ward Medlock ward Irwell ward	Moorside Unit

Mental Health Act responsibilities

We do not rate responsibilities under the Mental Health Act, (MHA), 1983. We use our findings as a determiner in reaching an overall judgement about the Provider.

None of the staff working on the acute wards and psychiatric intensive care units had received any training on the new MHA Code of Practice or were aware of any significant changes following its introduction. We were told that training on the MHA was not mandatory within the trust.

Wards at Salford and Bolton had rooms described as destimulation/de-escalation areas. Staff described these as

areas where patients were given time to calm away from other patients. We found that patients were prevented from leaving these rooms. This amounts to the seclusion of the patient, but had not been recognised as such by staff so that patients were denied the safeguards set out in the Code of Practice.

We carried out a formal MHA monitoring visit on Keats ward as part of the comprehensive inspection of the trust, and checked adherence to the MHA and Code of Practice. In most of the case records reviewed, relating to the detention, care and treatment of detained patients, we found that the principles of the Act had been followed and the Code of Practice was adhered to. However we found a number of issues relating to some patients records.

We found that where the MHA was used, most patients were detained with a full set of corresponding papers. However, in one instance some statutory documentation could not be located. We looked for evidence that a copy of the approved mental health practitioner (AMHP) report was available to staff and found these were not always available.

In the majority of records we found that patients had had their rights whilst detained explained to them. However, there was a degree of inconsistency with late explanations on a number of case files. Subsequent attempts were not always undertaken at appropriate times.

For section 17 leave we found inconsistent evidence of any clear link between risk assessments and the facilitation of section 17 leave. We also found inconsistent recording of the outcome of leave, particularly the views of patients as to how their leave had gone. We found the recording of section 17 leave on the PARIS electronic patient record was confusing, as all previously agreed leave was shown at the same time as current leave. The copy of authorised leave given to patients also outlined all previously agreed leave arrangements. Not all patients were given a copy of the leave that had been agreed.

We looked for evidence that a patient's wishes or desires in relation to treatment were routinely captured, either through the use of advance statements or other means, and found that such evidence was rarely present.

We found that the vast majority of patients had an appropriately completed form T2 or T3 in place relating to consent to treatment and authorising medication that was being administered. However, we found one where a patient who was deemed to have consented to electroconvulsive therapy (ECT) when, the previous day they had been determined to be lacking capacity to consent.

Although we observed discussions in ward reviews and board rounds relating to patients capacity, the recording of patients' capacity to consent was very inconsistent and not always undertaken when medication was first administered or when a form T2 or T3 had become necessary. We reviewed the medicine cards for detained patients and found two patients were subject to the three month rule which meant that a certificate to authorise mental health treatment was not required. However, we were unable to find evidence of their consent, refusal to consent, or a lack of capacity to give consent recorded in their case notes.

We were aware that the introduction of a new electronic record system PARIS had taken place some months before our visit and we found that the level of awareness amongst staff as to how to locate important statutory documentation was very inconsistent, with many staff unable to find documents when asked to do so.

Mental Capacity Act and Deprivation of Liberty Safeguards

We were told that there had been a recent online module added to the staff training resources relating to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. Training in this area was not mandatory and an average of 48% staff have had training in the MCA.

There were no Deprivation of Liberty Safeguards applications made in the six months prior to inspection.

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

We visited all nine acute and psychiatric intensive care units (PICU) wards**.** All ward layouts made it difficult to observe large areas on each ward location. This meant that nurses could not clearly see patients due to a network of corridors and blind spots. Therefore, if an incident occurred, nurses would not immediately know where this was.

We reviewed the environmental risk assessments dated September and October 2015 and found that they were not completed in a consistent way to ensure all risks were clearly identified. On the Meadowbrook Unit the ligature point audit did not list the windows as being a high risk factor despite being on the trusts risk register. There were inconsistencies as the action plans did not always match the audit results and on the Moorside and Rivington units no action plans were completed on three wards. We also found that the quality of the audits differed such as the detailed description. On Brook Ward ligatures had been assessed in rooms where patients had no unsupervised access which is not in keeping with the audit policy. We also found that whilst in some instances, ward managers were looking to replace items with anti-ligature fixtures, others had actioned that risks should be operationally managed and patients supervised. We found that this impacted negatively on patient care as many patients were on a high level of observation which could be avoided if environmental risks could be minimised. We spoke to ward managers, nursing staff and patients who confirmed that patient leave and ward activities are frequently cancelled due to short staffing.

The senior management team held quarterly ligature risk meetings trust wide in order to identify and rectify ligature risks. We examined the minutes of these meetings and found action plans were in place. However; some identified risks remained on these plans for some time, such as unsafe window frames in patient bedrooms at Meadowbrook which posed a ligature risk had been on this list since 2012. This risk was being mitigated by the use of risk assessments and increased observation of patients at risk of using a ligature point to self harm. The trust had developed an action plan to replace these windows in 2016/17.

The wards complied with guidance set out in the Mental Health Act (MHA) Code of Practice on same-sex accommodation. There was mixed gender accommodation in all three PICU's. The Bolton acute wards at the Rivington Unit were also mixed gender although there were plans to reconfigure these wards. Birch ward was to be moved and both acute wards were to become single gender wards. All wards had male and female only lounges, toilets and bathrooms. Bedroom corridors could be sectioned off for female admissions. The majority of bedrooms were not ensuite and patients shared bathrooms. There were approximately four bathrooms/shower areas per acute ward. Each ward had an accessible bathroom for patients requiring disabled access.

All wards were locked and had access to outside spaces/ courtyards; these were mainly used as smoking areas for patients. Some ground floor wards had open access to these areas whilst on other wards particularly the second floor wards, patients had to be escorted dependent on risk. Patients detailed hourly slots to go outside for a cigarette. There were notices on only two of the nine ward exits to inform patients who were informally admitted that they could leave the ward and how to do this.

None of the wards we visited had nurse call alarms or systems in use for patients to alert staff to their personal safety. This was problematic due to the difficult ward layout, lack of staff in communal areas and lack of other mitigating features such as mirrors to aid observations of blind spots. This meant that if an incident occurred, patients would be expected to seek assistance themselves by approaching nursing staff directly. This placed a high degree of reliance on patients who could be unlikely to seek help.

There were fully equipped clinic rooms on each ward with accessible resuscitation equipment and emergency drugs. These were checked regularly. However, on Keats and Eagleton wards at Salford we found the oxygen in the

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emergency resuscitation equipment to be out of date. This meant that in an emergency situation, the emergency equipment was not reliable or safe to use. Staff rectified this immediately during the inspection.

Seclusion rooms were located on each PICU, all had two way communication and a clock was visible to patients to orientate them to time. All three seclusion rooms had temperature control and en suite bathrooms where the door opened from the outside that allowed for observation.

All the wards were clean and in good repair and the furniture and fittings were well maintained. All patients and carers we spoke with described the ward as always being clean and tidy. We had sight of cleaning rotas and records which indicated that staff monitored hygiene and tidiness daily. Staff adhered to infection control principles and mandatory training in infection control level one, was at 100%.

The trusts average score in 2015 for patient led assessments of the care environment was:

- cleanliness 100%
- food 94%
- privacy, dignity and wellbeing was rated at 95%
- condition, appearance and maintenance was at 99%.

In 2015 the Royal Bolton Hospital was above the trust's score and for other trusts in England for four of these indicators with the exception of food, where Royal Bolton scored 89%.

Safe staffing

The trust had carried out a review of nurse staffing. This had set staffing levels on the acute wards in response to the reconfiguration of the community teams. We reviewed the staffing records and saw that staffing levels were in line with the levels and skill mix determined by the trust. The only exceptions occurred in response to late notice sickness/absence where replacement staff could not be found in time. However, the senior management team were aware that the acuity of patients was higher than had been initially estimated and that this was impacting negatively on patient care.

On the acute wards the staffing levels was designated as:

- four staff on day shift (two qualified)
- four staff on late shift (two qualified)
- three staff on night shift (one qualified)

In addition to this, each ward should also have,

- dedicated qualified occupational therapist
- dedicated support time and recovery worker
- senior nurse practitioner for nursing resource
- senior nurse practitioner for physical health resource
- assistant practitioner for physical health resource
- psychology resource

From data provided by the trust for 1 January 2015 to 31 December 2015, the total number of substantive staff was at 217 of which 83 were qualified nurses and 99 were nursing assistants. Overall there were 18% vacancies, 26 vacancies for qualified nurses and 14 vacancies for nursing assistants, sickness was at 8%. Staff turnover was 15%.

Vacancy levels resulted in use of temporary staff to ensure there was enough staff on each shift to maintain standards of quality and safety. 428 shifts had been covered by bank and agency staff with 109 shifts not being covered in the 12 months from 1 January 2015. Managers told us that most temporary staff were bank staff who were familiar with the ward environment. The trust's induction and mandatory training policy stated that bank or agency staff employed for less than one week were required to complete a condensed local induction checklist prior to commencing a shift and managers were able to describe this orientation process for staff unfamiliar with the ward. Although we were told that there was difficulty in agency staff accessing the records system particularly out of hours, plans were in place to rectify this.

Staff we spoke with described busy ward environments with high levels of close observations of patients. They described the wards as being short staffed and patients described not being able to access leave because of low staffing. Ward managers acknowledged that some activities and leave were difficult to facilitate because of the lack of staff.

We found that this had impacted negatively on patient care as many patients were on a high level of observation which

could be avoided if the environmental risks were minimised. We spoke to ward managers, nursing staff and patients who confirmed that patient leave and ward activities were often cancelled due to pressures on staffing.

All patients we spoke with described staff support as being good and described regular one to one time with their named nurses. Managers told us they were able to obtain additional staff when required to ensure safety.

Medical staff told us that there was always adequate medical staff available to attend the ward. This included out of hours and emergency situations.

We reviewed the trust's induction and mandatory training policy which stated that all staff should have a corporate trust induction, a local induction and be compliant with mandatory training. During the inspection process we found that staff were receiving both corporate and local inductions. The overall compliance rate for mandatory training for acute wards for adults of working age and psychiatric intensive care units was 80%. However, compliance rates for training in basic life support and immediate life support were low. We found that some wards did not have any staff qualified to provide immediate life support these included Eagleton, Keats and Irwell wards. On these wards staff were restraining patients and using rapid tranquilisation.

There was a plan in place to increase the training that was available to nursing staff. However, at the time of the inspection there was not enough sufficiently trained staff on shift to provide emergency life support treatment. This meant that patients were not being cared for by staff with the appropriate levels of skills required for their role.

Assessing and managing risk to patients and staff

From the 1 July 2015 to 31 December 2015 there were 133 documented episodes of seclusion and one incident of long term segregation. Seclusion rates were highest in Chaucer Ward with 63.

There were 344 episodes of restraint. Chaucer Ward recorded the most with 107. There were 27 incidents of prone (face down) restraint. Of the prone restraints reported 10 resulted in rapid tranquilisation.

We spoke with 38 patients over all nine wards; all the patients described feeling safe and supported in the ward environments. We reviewed the trust's clinical risk policy which stated that inpatient staff should use the standardised tool for assessment of risk to assess a patient's risk. In addition to this staff could use the Beck Triad assessment tool to identify levels of depression, hopelessness or suicidality. During the inspection process, we found that staff were using the correct assessment tools.

The clinical risk policy also stated all patients should have a comprehensive risk assessment completed at initial referral or presentation to the service. We found that 95% of patients had an up to date risk assessment. The majority of these, (90%), had been completed within the last month.

Handovers occurred at the start of each nursing shift. A handover sheet was prepared at each occasion. We observed a staff handover and noted this included a discussion on the individual risks of patients.

We looked at the trust's observation policy which identified three types of observations levels and how to implement and record these details. Staff told us that when particular risks were identified, measures were put in place to ensure these risks were managed. During the inspection we found that clinical notes detailed observations in line with the trusts policy.

Between 4 December 2015 and 7 February 2016 there were 115 reported incidents of violence, aggression, abuse and harassment to staff across the acute wards and psychiatric intensive care units (PICU). Prevention and management of violence and aggression training rates were low on four wards, Medlock 58%, Eagleton 59%, Keats 62% and Irwell at 68%.

The trust's restraint policy stated that all staff that may need to use restraint techniques should be trained and updated on patient safety and advanced and basic life support training. However, basic life support training rates were low. Staff informed us that they felt they were sufficiently skilled to undertake life support if required and could always call assistance from other ward areas. However; the lack of basic life support training on these wards, meant there was a lack of assurance that staff were equipped to manage an emergency situation which could result in patients being placed at unacceptable and avoidable risk.

Rapid tranquillisation according to the National Institute for Health and Social Care Excellence, (NICE, NG10 Violence and aggression: short-term management in mental health, health and community settings, 2015) refers to the use of

Requires improvement

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medication by the parenteral route, (usually intramuscular or, exceptionally, intravenous), if oral medication is not possible or appropriate and urgent sedation with medication is needed. Following rapid tranquilisation NICE recommend that monitoring for side effects should occur every hour until it is deemed as no longer required. We found that staff were following this guidance in relation to both the administration and monitoring of rapid tranquilisation.

Wards at Salford and Bolton had rooms described as destimulation/de-escalation areas. Staff described these as areas where patients were given time to calm away from other patients. One patient on Maple ward described being physically restrained by staff in this room, with staff holding both their arms. A discussion with staff and examination of the patient's records found that staff were clearly preventing patients from leaving this room. We spoke to staff on other wards who also described similar situations. This amounts to the seclusion of the patient, but had not been recognised as such by staff so that patients were denied the safeguards set out in the Code of Practice.

Staff, relatives and carers told us that there was a problem with illegal drugs coming into the acute wards and an increasing use of 'legal highs'. A banned list of items was in place for all acute and PICU wards, this information was given to patients and relatives. To combat this issue, sniffer dogs have been used in the service but infrequently. Suspicion of drug use would prompt the use of the trusts policy to search the premises, patients and their property.

The trust's safeguarding policy states that all safeguarding notifications should be recorded on the datix electronic reporting system and to the national patient safety alert system. We found good examples of staff initiating safeguarding alerts. All the staff we spoke with were aware of the trusts safeguarding policy and referral process. Staff training in safeguarding adults and children was good at 86% and above for each ward. Safeguarding was a standard agenda item at reviews and meetings.

Patients were provided with information about their medicines and they described being given information leaflets which they told us they found helpful. We also observed discussions in ward reviews with patients and relatives/carers relating to medicines.

Appropriate arrangements were in place for the management of medicines. Medicines were stored securely on the wards. Clinic room and fridge temperatures where medicines were stored were recorded. Medicines reconciliation was undertaken by the pharmacists and medical team.

During inspection we reviewed the medicines administration records for 38 patients. We found that not all prescription cards had a photograph attached and some signatures were also missing on the administration of medication.

Track record on safety

There were six recorded serious incidents from October 2014 to November 2015. One suspected suicide, one suicide by a patient discharged the day before, two unexpected deaths of an inpatient. One fire incident in April 2015, and one allegation/ incident, of physical abuse and sexual assault or abuse. A fire had also occurred on one ward two days prior to our visit; an investigation into this was underway.

One of these incidents had occurred the day after a patient had been discharged which prompted an enquiry. One of the initial findings suggested risk reviews prior to discharge were not fully implemented. Staff working on the ward at the time of this incident which happened in July 2015 were aware of the initial findings. Staff on the other wards were unaware of this serious incident. A learning event was scheduled for March 2016. During the inspection we found that risk assessments were completed prior to discharge and that learning from this incident had occurred.

Reporting incidents and learning from when things go wrong

The staff used an electronic system to record and monitor incidents. Between 1 January 2015 to 3 December 2015, the trust reported 3087 incidents for acute wards for working adults and psychiatric intensive care units, (PICU) locations. Of the 3087 incidents, 780 of them were for 'violence / aggression / abuse / harassment to staff'; 'violence / aggression / abuse / harassment to patients' with 385; 'missing patient' with 348 and 'patient care' with 329.Chaucer Ward recorded the highest number of incidents with 572, this was followed closely by Birch Ward with 524. This tells us that 35% of reported incidents were for violence, aggression or harassment to either patients or staff.

Use of this system meant that the trust was alerted to incidents promptly. Staff we spoke with on all acute and

Requires improvement

Are services safe?

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

PICU wards knew how to recognise and report incidents on this system. Incident analysis took place by the trust governance team who had trust wide oversight of the incident analysis and produced regular reports on trends and monitoring of serious incidents. Incidents were categorised in relation to degree of harm.

Staff described good debriefing and support for staff and patients when incidents occurred such as the recent fire on Birch ward. Staff also described good examples of duty of candour. Staff were able to describe an open and honest approach when things went wrong.

Ward managers told us how they maintained an overview of incidents reported on their wards. Incidents were investigated and managers told us of the systems in place to learn when things go wrong in other areas within the trust. They received regular newsletters and team briefing and learning events were organised to discuss the findings of serious event investigations.

Knowledge of serious incidents was variable. Managers were aware of serious incidents in their own areas but not always from other areas of the trust. We had sight of a newsletter produced after a serious incident and lessons learnt, although staff commented that the learning of lessons was not put into context of the actual event and therefore reduced the impact of the learning. Staff told us that feedback from incidents could take some time and changes in practice therefore had not been made in a timely manner.

Are services effective?

Good

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

Care planning was in place within 72 hours of admission; this was monitored for all new admissions. We examined an audit of admission procedures at Meadowbrook unit for July 2015. We found that compliance with trust procedures was good in all areas including assessments and physical examinations and that appropriate timescales were met.

We attended ward reviews and board round meetings, (meetings with key people to ensure patient needs were being met without delay), which had good multidisciplinary representation. Observations from these demonstrated a holistic approach to care planning and discharge.

The trust had recently changed their electronic record systems and therefore the format of the records. The care plan format was holistic. However, we noted that there was very little information included in the majority of the records we looked at, with some sections being left blank.

Physical health assessments were in place which was undertaken by a team of physical health practitioners associated with each ward. They used a physical health improvement tool (PHIT) to document physical health assessment and well-being needs. PHIT incorporates alcohol abuse identification and signposts practitioners to deliver brief interventions and motivational interventions to patients.

All information was stored electronically and was available to staff when they needed it. Paper records were scanned into the electronic system. Information governance training levels were good on seven of the nine wards. Compliance with mandatory training in information governance was good with the exception of Beech ward 73% and Maple ward 70%. Staff we spoke with described a good knowledge of information governance.

Best practice in treatment and care

National Institute for Health and Care Excellence guidelines, CG76, Medicines adherence: Involving patients in decisions about prescribed medicines and supporting adherence, 2009, was followed when prescribing medication. Exceptions to this were clearly discussed by the multidisciplinary teams and reasons for this documented in the patients records. We observed patients discussing their medication with the relevant professionals in ward reviews and patients told us they had enough information available to them relating to their medication in the form of patient leaflets. Pharmacy support was also available.

Patients' access to psychological therapies was for assessment only at Meadowbrook and Moorside with no psychological input into the ward reviews and board rounds. However, psychologists were part of the staff team at the Rivington Unit and psychological therapies were more accessible. They were provided individually and in group sessions.

Multidisciplinary working was effective on all wards. This included both internal and external staff and agencies. This was evident in board rounds, hand over meetings and patient reviews.

All wards were supported by a team of physical health practitioners who led on patient's physical health needs. They undertook health checks and physical health care planning. We observed one practitioner supporting a patient with physical activities as part of their ongoing health requirements. The physical health improvement tool was used to record physical health issues which was located in the electronic records system.

Staff engaged in local clinical audits such as controlled drugs audit, handwashing techniques, safe staffing, safeguarding children, infection prevention and control, discharge planning, capacity assessment and psychology referrals for assessment.

Skilled staff to deliver care

The staff working on the wards included nurses, medical staff, occupational therapists and physical health practitioners. The pharmacy team visited the wards regularly.

All staff had a period of induction prior to commencement on the ward. The nursing team on each ward area had a number of newly qualified nurses who detailed good preceptorship from their team.

There was access to specialist training and support for ward staff. There were six patients with an identified learning disability across the service at the time of the inspection. Some nurses were trained learning disability nurses who supported their colleagues when patients with

Are services effective?

Good

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learning disabilities were admitted. Staff told us that they could also contact the dedicated learning disability teams including consultants for advice and support. Autism training was available to staff.

The trust standard for supervision and appraisals was that staff should undertake six episodes of clinical supervision per year. Appraisal and supervision enables managers to review competency and support staff development needs. Supervision rates on some wards were significantly low: Beech ward 30%, Birch ward 17%, Irwell ward 43%, and Medlock was reported to have no appraisals supervision in that period. The average supervision rate across the acute and psychiatric intensive care unit, (PICU) wards was 59%. Nursing staff we spoke with told us that because of the demands on staff time it was not possible to access supervision. This was confirmed by ward managers and the senior management team who described a higher than expected patient acuity rate.

Policies were in place to address staff performance and poor staff performance was addressed promptly and effectively. There were six staff across the acute and PICU wards currently under suspension with investigations ongoing.

Multi-disciplinary and inter-agency team work

Ward handovers took place at the change of every shift, notes were taken and attention was paid to patient's current risks and support needs.

We attended twelve multidisciplinary meetings on the wards. Reviews and board rounds were held regularly to review each patient's care. We saw a good representation of professionals in attendance at these meetings. We found these effective in sharing information about a patient's care needs and advice was sought from different professionals across the service dependent on individual need.

We observed interagency work taking place with representation from the community teams and care coordinators as part of the patients' admission and discharge planning.

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

Mental Health Act (MHA) training was not mandatory. The figures in percentage for staff trained in use of the MHA per ward in the last six months were,

Beech 50

Birch 38

Brook 60

Medlock 40

Eagleton 64

Keats 82

Chaucer 29

Irwell 13

Maple 27

This meant that not all staff had received up to date MHA training and therefore were not aware of changes to the MHA Code of Practice.

We reviewed the seclusion policy and found this complied with the MHA Code of Practice. The service completed an audit of the seclusion records in November 2014 and was compliant in most areas in line with the MHA Code of Practice. However, the audit did identify areas of improvement (where compliance was below 90%) that included:

- evidence of four-hourly doctor's reviews
- multi-disciplinary discussion regarding review arrangements
- independent multi-disciplinary reviews after eight hours consecutively or 12 hours over a period of 48 hours
- seclusion documentation being completed fully
- reporting of the seclusion event on the trust's incident reporting database
- post seclusion briefing for patient's and consequently an update to their care plan

The trust had developed an action plan to address these issues. We found that there was evidence of appropriate doctor's reviews, seclusion documentation being completed fully and corresponding entries into the electronic incident management system. However, although risk assessments were reviewed after an episode of seclusion, specific care planning for seclusion or care planning reviews/post seclusion briefing was not evident in patient's care planning records.

We found that where the MHA was used most patients were detained with a full set of corresponding papers. In the

Are services effective?

Good

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majority of records we found that patients had had their rights whilst detained explained to them. Staff were aware of the need to explain patients' rights to them. The explanation of rights was audited regularly which ensured that patients understood their legal position and rights in respect of the MHA. Patients we spoke with on the whole confirmed that their rights under the MHA had been explained to them.

For section 17 leave we found inconsistent evidence of any clear link between risk assessments and the facilitation of section 17 leave. We also found inconsistent recording of the outcome of leave, particularly the views of patients as to how their leave had gone. Records systems were difficult to navigate and the information contained in the leave forms were difficult to understand because of the current leave entitlement was not clear.

Completed consent to treatment forms were attached to the medication charts of detained patients. Although we observed thorough discussions in ward reviews and board rounds relating to patients capacity, the recording of patients' capacity to consent was very inconsistent, and not always recorded when medication was first administered or when a form T2 or T3 had become necessary.

Information on the rights of patients who were detained was displayed on the wards and independent advocacy services were readily available to support patients, although not all wards had visible information on the rights of informal patients to leave the ward. Staff knew how to contact the MHA administrators when needed.

Good practice in applying the Mental Capacity Act

Across the service an average of 48% staff had training in the Mental Capacity Act (MCA) with Beech ward at 44%, Birch ward 46%, Brook ward 60%, Medlock ward at 45%, Eagleton ward at 75%, Keats ward at 73%, Chaucer ward 33%, Irwell ward at 25% and Maple House at 33%.

During our inspection we found that staff lacked an awareness of the basic principles of the MCA and Best Interests procedures.

There were no Deprivation of Liberty Safeguards applications made in the six months prior to inspection.

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

All patients and carers we spoke with told us that staff were supportive and treated them with respect. Patients spoke very highly of the care given by ward staff and detailed good relationships with all members of the ward team.

We observed staff interactions with patients on the ward and in review meetings which were conducted in a caring and compassionate way. Patients who appeared distressed were responded to in a calm and respectful manner. We witnessed situations on the wards being de-escalated well. Staff remained calm and made every effort to engage patients in regulating their own behaviours whilst ensuring other patients were safe and supported in these interactions. Staff engaged with patients well and were consistently respectful under all situations we observed.

When staff spoke about patients they used respectful language and demonstrated a good understanding of their individual needs.

The involvement of people in the care that they receive

There was good orientation to the wards for new admissions with welcome packs in place for patients. Information leaflets were available however the relatives/ cares we spoke with were not always given this information.

Approximately half of the patients we spoke with detailed involvement/awareness of the care planning process, although others appeared to have little or no awareness of their care plans. Carer's views were also mixed with some having more involvement in the care planning process than others. We spoke to eight carers who all stated that they were not involved as much as they would have liked in their relatives care. For three carers, this was dependent on the patients consent to their relative's involvement.

The service had good initiatives to involve patients. Patients were invited to public board meetings and shared their experiences of care. Regular community meetings were held on the wards where notes were taken and fed back into the trusts governance structure. Patients were involved in training staff and the development of information resources as part of the recovery academy.

We noted 'you said we did' posters on the wards in response to feedback from patients. There was an annual carer's event where carers could share their experiences of care at the trust and a quarterly carer's newsletter.

Patients have been involved in the buildings design and refurbishments planned at the Rivington Unit in Bolton. The trust held a dragons den initiative and one staff described being awarded £3000 to purchase extra activity resources for the ward.

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

There had been a change in acute care pathway provision involving a reduction in beds and an increase in provision of home services with the introduction of a 24/7 home based treatment team. This change was being monitored by the trust in relation to any possible increase in the requirement of out of area beds and impact on patient experience.

Bed occupancy trust-wide was 96.30%. The average bed occupancy from July 2015 to January 2016 months for acute wards and psychiatric intensive care units (PICU) was 98.55%. Brook ward, Eagleton ward and Maple were over 100% occupancy for this period of time. Research undertaken by the Royal College of Psychiatrists indicates that where wards are running at over 85% bed occupancy, this can have a negative impact on patient care.

The number of out of area placements attributed to acute and PICU wards from July 2015 to January 2016 was nine. Eight patients remained in the Manchester region and one patient was placed in the North East of England. In this period there was one under 18 admission on Beech ward for a period of three days.

Bed management was good and every effort was made to ensure patients remained in their catchment area. Few patients were admitted for long periods out of area and if a bed out of area was necessary they were repatriated as soon as reasonably possible. Leave beds were used but we were informed that the majority of patients returned to the same ward on return from leave.

Patients were only moved when there was a sufficiently good clinical reason to do so. Staff provided us with an example of when it had been necessary to separate three patients on one ward. The rational for moving the patients was based on clinical risk assessment and to promote the safety of the patients. We were told that PICU access for patients who required more intensive care was good and transfers between wards were usually negotiated in a timely manner.

From July 2015 to January 2016 there were five identified delayed discharges from acute and PICU inpatient facilities. One from Birch ward and four from Medlock ward. These were explained as patients awaiting specialist and social care placements.

In this time period there were also 98 readmissions within 90 days. The wards with the highest number of readmissions within 90 days were Brook Ward (22) and Eagleton Ward (20).

We observed good multidisciplinary team (MDT) discussions relating to discharge planning and notes could be found in the MDT review notes. Discharge care planning was recorded as a discharge road map. This was a comprehensive form in the new records system. Those that were completed in full were being done collaboratively with patients. However, the information contained in most discharge care plans did not reflect the detailed information collated within the road maps.

An audit of evidence of discharge planning in February 2016 detailed all patients on five of the nine wards had evidence of a discharge plan in place. Beech ward achieved 50%, Birch ward 90%, Brook ward 72% and Medlock ward 86%.

However, we were informed of three incidents of patients being transferred from general wards and the discharge information regarding medication was not available to psychiatric ward staff. This caused patients to not receive the correct medication for their illnesses.

The facilities promote recovery, comfort, dignity and confidentiality

The wards had ample space for therapeutic activities and treatment. All wards offered outdoor space for patients although this was limited and tended to be used for smoking. Patients could personalise their rooms and had secure storage for valuables.

There were quiet areas on each ward where patients could meet visitors and relatives. The Meadowbrook and Rivington units had designated rooms off the wards for child visiting. Moorside child visitors were accommodated in the ward areas. Protocols were in place to ensure the safety of child visitors.

Patients on each ward had access to a private telephone, or could use their own mobile phones. If access by a patient to mobile phones was restricted this was included in the risk assessment and care planning process. Staff and patients also told us that calls could also be made from the nursing office relating to legal support if they were struggling to pay for the calls on the payphone.

Are services responsive to people's needs?

Good

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

Feedback regarding food was good from the patients we spoke with. Patients described the food as being of good quality and choice with the exception of one patient who described the halal choices as limited. Although a patient led assessment of the care environment, undertaken in 2015, showed the Rivington Unit at Bolton scored below the trust and England averages for food. Hot drinks and snacks could be prepared at any time on the wards.

On inspection we noted patients engaged in activities such as art projects, card playing, and group activities. Meetings were held on the wards to discuss activities and weekly activity programmes were advertised on the information boards of all wards. All wards had dedicated activity workers and health care assistants were also designated to lead activity sessions. Staff told us that planned activities were sometimes cancelled at busy times because of a lack of staff available to run them. All patients we spoke with said there were enough activities on the wards. They spoke about the available activities in a positive way, although they confirmed that activities were cancelled at times because of the availability of staff.

A range of activity spaces were available off the wards such as gym facilities, activity/recreation room, computer room/ internet cafes. Wifi was not available to patients on the wards.

Patients had access to occupational therapy. An occupational therapist was assigned to each ward and conducted individual assessments of patients' needs.

Meeting the needs of all people who use the service

Staff respected patient's diversity and rights, and every effort was made to meet patient's individual needs. Cultural, language and religious needs were considered. A choice of meals was available. A varied menu enabled patients with particular dietary needs connected to their religion, and others with particular individual needs or preferences, to eat appropriate meals.

There were multi faith rooms located off the wards. Regular weekly services were held for a variety of different faiths. We were informed that spiritual leaders sometimes visited the wards to introduce themselves and let patients know what spiritual support was available to them.

Patients had access to an Independent Mental Health Advocate who visited the ward on a weekly basis.

Information about advocacy was displayed on the unit. There was a range of helpful information displayed on notice boards throughout the ward and in patient information leaflets and welcome packs.

We noted the presence of interpreters in multidisciplinary team meetings for patients whose first language was not English. Leaflets explaining patients' rights under the Mental Health Act were also available in different languages.

All ward environments had adjustments for disabled access with wide door frames and disabled access bathrooms. Wards on the first floor had lift access.

Listening to and learning from concerns and complaints

A complaints policy was in place which included being open and following the duty of candour protocol. Complaints were monitored through the trust's governance structure and reviewed for themes and trends. An annual report was produced and monthly report to services was produced. Ward managers and nursing staff explained that they would try and resolve complaints informally with the patient or carer. Staff were also aware of how to escalate a complaint using the correct policy and protocol.

For the past 12 month period there were 48 complaints relating to the acute wards and psychiatric intensive care units, of which six were upheld, 13 had been partially upheld and 29 had not been upheld. One complaint had been referred to the Parliamentary and Health Service Ombudsman who upheld the complaint.

In the same period there were a total of 27 compliments made about the service. Ward managers were able to describe good examples of the use of duty of candour.

Complaints information was available to all patients in the form of leaflets and admission pack. We also noted information on each ward on the notice boards about the trusts complaints process. All patients we spoke with stated they knew how to make a complaint and of the complaints process.

Staff were aware of the formal complaints process and knew how to signpost patients as needed to patient advice and liaison service. Complaints were a standing agenda

Are services responsive to people's needs?

Good

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

item for discussion at staff meetings and on some wards was a regular feature on locally produced newsletters. Individual complaint feedback was addressed in the staff appraisal and supervision process.

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's vision and values for the service were evident and on display on the wards. Staff on all wards considered they understood the vision and direction of the trust. Almost all staff we spoke with pointed out that their visions and values were printed on their identity card lanyards.

Ward managers had contact with their modern matron. Senior trust managers were known to staff and came to the wards.

Good governance

The trust had recognised the challenges to the service with the change in the acute care pathway and it was on the trust risk register and the board assurance framework. The senior management team were aware of the difficulties regarding nursing skill mix and were rotating staff onto different wards to alleviate some of these pressures. There was a rolling recruitment programme to ease the problem of high staff turnover and the staffing levels were due to be reviewed in respect of the high patient acuity.

The wards had access to systems of governance that enabled them to monitor and manage the ward and provide information to senior staff in the trust. An annual trust wide audit calendar was in place and wards undertook their own local audits.

A dashboard system had recently been introduced to monitor key performance indicators. Data was collected regularly on performance for each ward. This was in its infancy and action planning from these dashboards was not evident at the time of the inspection.

There were systems in place, such as checks on medical equipment, which were not always effective. Not all staff had received mandatory training or had opportunity to access supervision or appraisal. Staffing vacancies existed and the current skill mix was variable.

There was a system in place to monitor and respond to incidents and complaints. Thematic analysis was conducted and information shared across the trust. For serious incidents comprehensive investigations took place, reporting undertaken and lessons learnt.

There were robust safeguarding procedures which were followed by staff. There were some inconsistencies noted in the administration of the Mental Health Act and Mental Capacity Act.

Leadership, morale and staff engagement

Many staff told us that following significant changes in the acute care pathway, morale in the service had been quite low. However, they also felt that it was improving. Staff appeared highly motivated and caring despite their concerns.

There was evidence of clear local leadership on the wards we visited. Ward managers were visible on the wards during the day-to-day provision of care and treatment. They were accessible to staff and they were proactive in providing support. Staff on the wards described an open and supportive ward culture and staff felt encouraged to bring forward ideas for improving care.

Ward managers told us that they had access to leadership training and development as part of their appraisal process. They all stated they felt supported by their line managers.

The ward staff we spoke with were enthusiastic and engaged with developments on the ward. They told us they felt able to report incidents, raise concerns and make suggestions for improvements. They were confident they would be listened to by their line manager.

All staff we spoke with felt comfortable in raising concerns with their managers. Ward managers detailed good management of staff whose behaviours and performance were consistent with the organisations values. Staff were aware of the whistleblowing process if they needed to use it.

Commitment to quality improvement and innovation

At the time of this inspection the wards were not participating in a national quality improvement programme such as AIMS.

All of the wards were involved in Safewards initiative aimed at reducing conflict and containment and therefore improving patient and staff safety on the wards.

The Rivington Unit in Bolton had been accredited by the Electro-convulsive Therapy Accreditation Service, (ECTAS).

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 18 HSCA (RA) Regulations 2014 Staffing **How the regulation was not being met;** **We found that staff were not adequately trained in important elements of nursing care.** • A high proportion of staff were not up to date with training in immediate life support and basic life support. • A high proportion of staff were not up to date with training in the Mental Health Act and Mental Capacity Act. • Staff demonstrated a lack of understanding regarding the Mental Health Act and Mental Capacity Act. **This meant that staff were not aware of the latest guidance and best practice in relation to safe patient care and treatment.** **This was a breach of regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014**

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 **How the regulation was not being met;**

This section is primarily information for the provider

Requirement notices

We found that two of the wards we visited had out of date oxygen which had not been replaced despite regular audits which identified it needed to be replaced.

- Staff had checked the oxygen on a regular basis but had not acted on the findings of the checks.
- In an emergency patients would not have access to equipment that was suitable for use.

This meant that equipment and medical supplies needed in an emergency situation were not kept up to date and safe for patient use.

This was a breach of regulation 12 (2) (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 How the regulation was not being met;

We found that staff were secluding patients in the de-escalation room without following the Mental Health Act code of practice guidance and the trust's own policy.

- Patients were not permitted to leave the de-escalation room and were restrained and prevented from leaving by staff.
- Staff lacked awareness of the MHA and the safeguards that should be followed if patients are secluded in this way.

This section is primarily information for the provider

Requirement notices

- Patients were not aware of their rights or protections that the MHA provides to patients who are secluded.
- Staff did not document or report that an incident of seclusion had occurred.

This meant that secluded patients did not have their rights and safeguards under the Mental Health Act protected.

This was a breach of regulation 12(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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 How the regulation was not being met;

We found that environmental checks were not completed in a consistent way and that inappropriate fixtures and fittings were not replaced in a timely way.

- Ligature point audits were not completed in a consistent way on each ward.
- The findings of the ligature point audits were not acted upon without delay.

This meant that in order to mitigate the environmental risk factors, staff were required to increase patient observations and complete regular environmental checks.

This section is primarily information for the provider

Requirement notices

This was a breach of regulation 17 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014