Good

5 Boroughs Partnership 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)
RTV06	Hollins Park	Austen ward	WA2 8WA
RTV06	Hollins Park	Sheridan ward	WA2 8WA
RTV04	Wigan (Leigh Infirmary)	Lakeside unit	WN7 1SD
RTV04	Wigan (Leigh Infirmary)	Cavendish unit	WN7 1SD
RTV04	Wigan (Leigh Infirmary)	Rivington unit	WN7 1SD
RTV51	Knowsley Resource and Recovery Centre	Grasmere ward	L35 5DR

Summary of findings

RTV51	Knowsley Resource and Recovery Centre	Coniston ward	L35 5DR
RTV02	Peasley Cross	Taylor ward	WA9 3DE
RTV02	Peasley Cross	Iris ward	WA9 3DE
RTV03	Brooker Centre	Weaver ward	WA7 2DA
RTV03	Brooker Centre	Bridge ward	WA7 2DA

This report describes our judgement of the quality of care provided within this core service by 5 Boroughs Partnership 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 5 Boroughs Partnership NHS Foundation Trust and these are brought together to inform our overall judgement of 5 Boroughs Partnership 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

Contents

Summary of findings

Overall summary

We rated the service as good because:

- There were care plans in all of the care records that we reviewed. Three of the wards were completing the 'my recovery story' with patients with the aim of setting goals and the patient having more insight into the reason for their admission and focus on their recovery.
- The ward environments were clean and in good repair.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. Regular clinical supervision was being undertaken on all wards except Coniston ward.
- A clear admission process was in place to ensure admissions to the PICU were appropriate. There were good working links with the community mental health teams (CMHT) to facilitate discharge from the wards.
- The acute and PICU wards used a number of measures to monitor the effectiveness of the service provided. 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. Most of the acute and PICU wards were accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS.
- Staff reported that morale was generally good. Staff spoke positively about their roles and told us they felt supported by managers across the services we visited.
- Patients were treated with compassion and empathy. Feedback received from patients was mostly positive about their experiences of the care and treatment provided by the staff. Patients were actively encouraged to participate in a wide range of activities. Patients' diversity and human rights were respected. Patients were supported by advocacy services. Complaints and concerns were taken seriously and responded to in a timely way.
- The trust's vision and strategies for the service were evident and most staff considered they understood the vision and direction of the trust.

However:

- Lessons learnt from serious incidents were not routinely shared with ward managers and their teams. The timely and appropriate dissemination of learning following a serious incident is core to ensuring that incidents are not repeated. We were not informed of any clear and timely trust-wide dissemination or action planning following a serious incident.
- Attendance at medicine management training was low and incidents relating to medicines management were high. The high temperature in the storage of medicines on Weaver ward compromised the stability of the medicines.
- The seclusion rooms in the Taylor, Grasmere and Coniston wards did not meet the Mental Health Act (1983) code of practice requirements. Also, the lack of toilet facilities in the seclusion room on Taylor ward compromised patient dignity.
- Environmental difficulties and blind spots were noted in all ward areas and mitigation was in place in an attempt to address these difficulties. Stand-alone ligature risk assessment was only completed in one ward area following a high volume of ligature incidents. These identified risks had been awaiting resolution for over 6 months. We found that staff were unable to locate environmental risk assessments in some of the ward areas presenting a risk to patient safety.
- Blanket restrictions were in place on Austen and Sheridan wards where patient bedrooms were routinely locked without individual risk assessments taking place. In response to a serious incident relating to ligature risks, for instance from grab rails, accessible bathrooms were locked across all the wards. However, Austen, Sheridan, Cavendish and Grasmere wards routinely locked not only the accessible bathrooms, but also all shared toilets in communal areas.

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:

- Learning from serious incidents was not routinely shared with ward managers and their teams.
- On Weaver ward medicines were not stored safely and staff attendance at medicines management training was low. Three wards; Austen, Cavendish and Sheridan ward had had over 100 medicine incidents in the last year.
- The seclusion rooms for three locations did not meet the MHA code of practice requirements.
- Only one ward had a completed assessment of the environment for points to which patients might tie a ligature with the intention of hanging or strangling themselves. Environmental risk assessments had been completed for each ward. However, they were not accessible to ward staff.
- Mandatory training attendance was below the trust target of 85%
- There were risk assessments in place that stated the date they were completed and the presenting risks to and from patients. However, there were no risk management plans for patients. The documents did not provide direction of how to support an individual with managing or reducing their risks.
- Blanket restrictions were in place. Austen and Sheridan wards locked the patient bedrooms and Austen, Sheridan, Cavendish and Grasmere ward locked the toilets.
- Post seclusion reviews were not routinely completed with patients.
- We could not find any risk assessments in relation to patients going on section 17 leave within the care records we reviewed.
- On Lakeside ward, two patients who were admitted voluntarily were trying to leave the ward and were being refused.
- Cavendish ward and Grasmere did not have a notice displayed advising informal patients of their right to leave the ward.

However:

- Most staff had attended training on safeguarding adults that focused on identifying abuse and how to report abuse.
- Staff were confident of the process of making a safeguarding referral.
- All of the wards were clean and presented to a high standard.
- Staff were confident at reporting incidents and completing the datix entries on the electronic monitoring system.

Summary of findings

Are services effective?

Good

We rated effective as good because:

- There were care plans in all of the care records that we reviewed. Three of the wards were completing the 'my recovery story' with patients with the aim of setting goals and the patient having more insight into the reason for their admission and focus on their recovery.
- Cognitive behaviour therapy was offered by psychologists in addition to group therapy and skill development sessions.
- The teams consisted of a variety of disciplines including psychologists, occupational therapists and pharmacists. The multidisciplinary team met daily to review patients and their changing needs and presentation.
- Staff had annual personal development reviews and team meetings with the opportunity for reflective practice and group supervision.
- There was good MDT working with daily meetings and detailed reviews for patients.

However:

- Training was offered in MHA and MCA. However, staff attendance was below the trust target of 85%.
- Staff were not receiving regular supervision on Coniston ward.
- In six of the wards, the care plans had standardised information in. This had also been highlighted in MHA reviewer visits.

Are services caring?

Good

We rated caring as good because:

- Staff were kind and respectful to patients and recognised their individual needs.
- Staff were caring and compassionate to patients' needs and treated patients with dignity and respect.
- Staff respected the privacy and confidentiality of patients at all times.
- People had access to an advocate if they needed one.
- People who used the service told us they feel supported and staff care about them.

However:

- Ten of the 51 patients we spoke to reported not being involved in the creation of their support plans. They stated they did not have a copy or had just seen the care plan before the inspection.

Summary of findings

Are services responsive to people's needs?

Good

We rated responsive as good because:

- Patient care and recovery was discussed daily with input from various professionals including community mental health teams ensuring people were supported throughout their time on the ward through discharge planning and following discharge.
- There was a variety of organised activities on all the wards. Occupational therapists and activity coordinators were present on all wards including weekends. All wards allowed access to secure outside areas.
- There were good facilities for carer and child visiting.
- Complaints were recorded and dealt with in an appropriate and timely manner.
- Where transfer to the PICU unit from an acute ward was required, a clear PICU transfer process was in place.

However:

- We found that some of the wards had some difficulty in their design, there was limited space for activities and meetings. The seclusion room on Taylor ward was not conducive to the dignity of patients when in use.
- Patients could not make a private phone call on Lakeside ward.

Are services well-led?

Good

We rated the acute and PICU wards as good because:

- The trust's vision and strategies for the service were evident and most staff considered they understood the vision and direction of the trust.
- There were local meetings for managers to discuss quality and safety issues.
- The wards had governance systems in place that enabled them to monitor and manage the ward and provide information to senior staff in the trust.
- Data was collected regularly on performance. Each acute ward compiled performance data that recorded their performance against a range of indicators/thresholds which were reported monthly. The ward team were able to submit risks to the trust risk register.
- Staff reported that morale was generally good. Staff felt supported and received regular supervision and appraisals.
- They spoke positively about their roles and the teams they worked in.

However:

Summary of findings

- There was no clear system in place to indicate lessons learnt from serious incidents were being actioned and monitored on the wards.

Summary of findings

Information about the service

5 Boroughs Partnership NHS Foundation Trust has 10 acute wards across five hospitals for adults who require a hospital admission due to their mental health needs, either for assessment or treatment, or under the Mental Health Act.

The wards are:

- Cavendish Unit is a ward for women at Leigh Infirmary with 25 beds.
- Lakeside Unit is a ward for men at Leigh Infirmary with 25 beds.
- Bridge Ward is a ward for men at the Brooker centre, Halton hospital with 14 beds.
- Weaver Ward is a ward for women at the Brooker centre, Halton hospital with 14 beds.
- Grasmere Unit is a ward for women at Knowsley resource and recovery centre, Whiston hospital with 15 beds.
- Coniston Unit is a ward for women at Knowsley resource and recovery centre, Whiston hospital with 18 beds.
- Iris Ward is a ward for women at St Helens hope and recovery centre, Peasley Cross with 15 beds.
- Taylor Ward is a ward for men at St Helens hope and recovery centre, Peasley Cross with 17 beds.
- Sheridan Ward is a ward for women at Hollins park hospital, Warrington with 16 beds.
- Austen Ward is a ward for men at Hollins park hospital, Warrington with 17 beds.

5 Boroughs Partnership NHS Foundation Trust also has a unit which provides intensive care services for people who present more risks and require increased levels of observation and support:

- Rivington Unit is a ward for both men and women at Leigh Infirmary providing psychiatric intensive care and has eight beds.

There have been seven inspections at six sites registered to 5 Boroughs Partnership NHS Foundation Trust. One inspection covered Fairhaven, Halton, Knowsley, St Helens and Wigan in 2013 and 2014. All of the sites were inspected under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and were compliant with these regulations.

Hollins Park, Warrington has had two visits, one in 2012 and one in 2013. In the report published on 6 February 2013, the site was found to be compliant.

This inspection is the first one for the trust under the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

Our inspection team

Chair: Kevin Cleary, medical director and director for quality and performance, East London NHS Foundation Trust

Head of Inspection – Nicholas Smith, Care Quality Commission

Team leaders: Sarah Dunnett, inspection manager, Care Quality Commission

Patti Boden, inspection manager, Care Quality Commission

The team inspecting acute wards and psychiatric intensive care units comprised: five CQC inspectors, an assistant inspector, a consultant psychiatrist specialising in inpatient mental health services, two Mental Health Act reviewers, a mental health nurse specialising in inpatient mental health services, two occupational therapists specialising in activities within inpatient services, a social worker and an expert by experience with lived mental health experience.

Due to the number of the acute wards, the team split into two sub-teams, one of the sub-teams inspected four acute wards and the psychiatric intensive care unit. The other sub team inspected six acute wards.

Summary of findings

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 and carers by leaving comments boxes at all sites.

During the inspection visit, the inspection team:

- Visited all 11 of the wards at the five hospital sites;
- Looked at the quality of the ward environment and observed how staff were caring for patients;
- Spoke with 51 patients who were using the service and collected feedback from 18 patients using comment cards;
- Spoke with 11 carers;
- Spoke with the managers or acting managers for each of the wards;
- Spoke with 52 other staff members, including doctors, nurses and occupational therapists;
- Attended and observed 22 meetings, including 13 reviews with patients, a clinical supervision meetings and eight hand-over meetings and multidisciplinary meetings;
- Reviewed 58 care records of patients;
- Reviewed 130 prescription cards;
- Carried out a specific check of the medication management on four wards, including observing a medication round;
- Looked at a range of policies, procedures and other documents relating to the running of the service, including minutes of meetings, seclusion logs and supervision records.

What people who use the provider's services say

- We spoke to 51 patients who were using the service and collected feedback from 18 patients using comment cards. We spoke to 11 carers.
- Feedback from patients was that the wards were better environments than other establishments they have experienced.
- Patients reported staff were caring, friendly, approachable and polite.
- Patients did not have keys to their bedroom. However, they reported that staff would open the door for them when they wanted to use it.
- Patients reported feeling safe on the wards and that their mental state had improved during their hospital admission.
- Information on how to complain and the advocacy services was displayed on the notice boards. However, patients had not always been given the information verbally or in writing.
- Ten patients reported not being involved in the creation of their support plan and did not have a copy or had just seen the care plan before the inspection.
- Patients reported and we observed that staff were mainly based in the office on Cavendish ward and were not available to patients.
- Positive feedback was given regarding activities available including the gym at Hollins Park which patients accessed and valued the opportunity.

Summary of findings

- Patients reported receiving information about the medication they were prescribed.
- Patients felt able to voice their opinions and views at the weekly community meetings and had seen positive change as a result.
- Overall the feedback from carers was positive, they have seen positive progress in their loved ones and their physical health needs have been met too.
- Carers suggested areas for improvement were communication and the activities offered. Two carers were concerned as the leave arrangements were not clear to them or their son, the consultant within the review meetings directs all conversation at the parents not the patient.

Comment cards were overall positive from eight patients and four carers.

Good practice

The "my recovery story", was a person centred document was being used on Lakeside unit, Coniston and Iris wards. The document was aimed at patients for their completion. It included sections on mental health confidence scale, my story and this admission, my recovery journey and action plan.

We saw examples of local initiatives such as the advancing quality alliance which was an NHS health and care quality improvement organisation. Work funded by a grant from the health foundation was ongoing in some ward areas to reduce the use of physical restraint over a two year period.

A local initiative to support patients who self-harm was led by a ward manager. He had introduced a self-harm pathway on one ward area, which resulted in reduced incidents; he had recently moved wards and was planning to introduce this in another ward area.

Areas for improvement

Action the provider MUST take to improve

- The trust must ensure that the blind spot in the seclusion room in Taylor ward is mitigated and there is access to toilet and washing facilities for patients that are secluded.
- The trust must ensure that medicines are administered safely. It must resolve the unsafe storage of medicines on Weaver ward. The ambient room temperature in the clinic room was regularly in excess of 25 C. It must also ensure that staff attend the medicines management training.
- The trust must resolve the identified ligature risks on Sheridan ward.
- The trust must complete a comprehensive ligature risk audit for each ward and address the findings.
- The trust must ensure that the seclusion room at Taylor, Grasmere and Coniston wards meet the requirements of the Mental Health Act code of practice.

Action the provider SHOULD take to improve

- The trust should ensure that patients are involved in the creation of their care plans and that care plans reflect their preferences.
- The trust should ensure that there are facilities on Lakeside ward for patients to make a private phone call.
- The trust should ensure that staff attend mandatory training courses at the trusts' target level of 85% attendance.
- The trust should ensure that there is a system in place to share the learning and actions from serious incidents with ward managers and their teams.
- The trust should follow the National Institute for Health and Care Excellence (NICE) guidance NG10 by completing the post seclusion review with patients. The review will discuss reasons and possible triggers for the behaviour presented from a patient, which resulted in seclusion.

Summary of findings

- The trust should ratify the Mental Capacity Act policy and procedure, which is currently in draft, and disseminate to all staff.
- The trust should ensure that staff on Cavendish and Grasmere display a poster that advises informal patients of their right to leave the ward.
- The trust should develop a system for recording the risk assessment in relation to patients going on section 17 leave.
- The trust should ensure that staff follow the supervision policy and ensure that staff receive regular supervision on Coniston ward.
- The trust should review the blanket restrictions in place on Austen and Sheridan wards whereby staff were locking the patient bedrooms and on Austen, Sheridan, Cavendish and Grasmere ward whereby staff were locking the toilets. The restrictions should be individually risk assessed.

5 Boroughs Partnership 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
Austen ward	Hollins Park
Sheridan ward	Hollins Park
Lakeside unit	Wigan (Leigh Infirmary)
Cavendish unit	Wigan (Leigh Infirmary)
Rivington unit PICU	Wigan (Leigh Infirmary)
Grasmere ward	Knowsley Resource and Recovery Centre
Coniston ward	Knowsley Resource and Recovery Centre
Taylor ward	Peasley Cross
Iris ward	Peasley Cross
Brooker Centre	Weaver ward
Brooker Centre	Bridge ward

Detailed findings

Mental Health Act responsibilities

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

MHA training was offered as a mandatory e-learning course for staff. Attendance was 77%, which was below the trust target of 85%.

All of the wards visited had had MHA reviewer visits completed between January 2014 and July 2015.Findings from the reviewer visits included: two wards did not have facilities for patients to make a private phone call. There were issues with the cleanliness of the seclusion facilities and ability to protect people's privacy and dignity when being secluded on some of the wards. Some patients did not have care plans in place or were not involved in the care planning process. Consent to treatment was not being recorded within files. Section 17 leave forms were not being given to patients and historic section 17 leave forms not being crossed through.

Several patients we spoke to had leave in the grounds for a maximum of 10 minutes or supervised leave; however, their MHA status was informal. On Lakeside ward, there were two patients who were admitted voluntarily who were trying to leave the ward and were being refused. This was raised with the ward manager who arranged for a MHA assessment to be completed. The patients were then detained by the nurse under the nurses holding powers, section 5(4) of the MHA.

Staff and patients reported that in the past their section 17 leave had been cancelled due to staff shortages, However, the situation had improved by the time of the inspection.

Prescription charts had the relevant T2 or T3 form attached to them where needed, which were fully completed, regularly monitored by the pharmacist and medicines were administered in line with relevant mental health legislation.

Patients on all wards except Lakeside were able to tell us about the advocacy service and how they would access it. However, advocacy information was on display on the notice boards in the Lakeside unit.

Toilets were locked on Austen, Sheridan, Cavendish and Grasmere wards. Patients had to ask for the toilets to be opened. When we explored with the staff, this was due to the nature of the patients admitted and this was not individually risk assessed and was a blanket restriction.

Bedrooms were locked on Austen and Sheridan wards, patients had to ask staff to enable access to their room, and this was not individually risk assessed.

We could not find any risk assessments in relation to patients going on section 17 leave within the care records we reviewed.

The patient phone on Lakeside was broken. It was situated in the middle of the corridor, resulting in patients not being able to make a private phone call. The phone in Coniston ward was in the dining room, which did not enable a private phone call for patients.

Mental Capacity Act and Deprivation of Liberty Safeguards

MCA training was offered to staff: 80% had attended, this was below the trust's target of 85%.

There were no patients detained under a deprivation of liberty safeguards (DOLS) and there were no pending DOLS applications.

The trust had a draft MCA policy and procedure. The policy linked to the MCA code of practice. The documents were due to be ratified in June 2015.

The staff that we interviewed had a basic understanding of the five statutory principles of the MCA.

Staff's understanding of assessing capacity was that it was the doctor's responsibility to assess capacity.

Ward managers gave two examples where they were involved in best interests meetings regarding patients in relation to their physical health needs.

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

The design of the wards meant there were many blind spots, which hindered observation of patients. This could result in unwitnessed incidents occurring. Concave ceiling mirrors were in place in an attempt to mitigate against this risk. Increased staff supervision was also provided for patients with an increased level of risk.

Only Sheridan ward had completed a ligature assessment. This had been prompted by the number of incidents where patients had tied a ligature with the intention of hanging or strangling themselves. A comprehensive ligature point audit had been completed on Sheridan ward with a high number of ligature risks identified. The trust had not completed any of the building works to resolve the risks at the time of inspection. Action to minimise the risks was for the security nurse to conduct hourly checks of the ligature points to ascertain if they had been tampered with. Staff on the ward felt frustrated and concerned about the risks in the environment. Staff had been told that the trust were exploring a capital bid for the works.

All of the acute wards were single sex. The PICU (Rivington ward) was a mixed ward. All of the bedrooms on the PICU had en-suite facilities. There was a female only lounge on the PICU. This meant that the trust were meeting the guidance on same sex accommodation.

All of the clinic rooms were safe and clean, with appropriate records showing regular checks taking place to monitor the fridge temperatures for the storage of medicines. In addition, the controlled drugs book was in use and up to date. Emergency drugs were all within date. However, medicines were not stored safely on Weaver ward because the ambient room temperature in the clinic room was regularly in excess of 25 C, the maximum room temperature recommended for the storage of medicines. Ward and pharmacy staff told us they were aware of this and action was planned but no timescale was known.

Resuscitation bags were regularly checked by staff and records showed they were up to date. Staff were able to explain how to order a replacement if the equipment had been used.

The seclusion rooms on Austen, Sheridan and Iris wards were clean, had access to natural light and a clock was visible from each room. For patients who needed a low-stimulus environment, safe care areas were available. Patients on Lakeside and Cavendish wards had to use the seclusion facilities on Rivington ward, the PICU. This impacted on patients' privacy and dignity, and increased risk to others as they were escorted off the ward and, in Lakeside's case, upstairs to the seclusion facility.

Patients on Coniston and Grasmere wards shared a seclusion facility and safe care area. The seclusion room did not have a dimmer switch and the light within the room was bright. There was a clock on the wall outside. However, this was difficult to view due to the observation blind. There was air conditioning in the room. However, we noted that it was extremely noisy after spending some time in the seclusion room.

Bridge ward has an extra care area situated next to the seclusion room. The extra care area was used as a bedroom at the time of inspection. Due to the noise from occupants of the seclusion room, patients sleeping in the extra care area experienced noise and disruption to their routine.

Taylor ward had a seclusion room, which was off the ward adjacent to the main entrance of the building. To access this, patients would have to pass the family room, kitchen and offices. There was a blind spot in the seclusion area, a person could not be seen through the viewing panel if laid next to the mattress. The room had no clock, toilet or washing facilities. To relieve themselves, patients had to use bedpans or urine bottles. There was a public toilet next to the seclusion room.

The trust's procedure for placing patients in seclusion, dated October 2014, states that, "the patient must be able to see a clock from within the seclusion room in order to maintain his/her time orientation."

All wards were clean and had a good standard of furnishing. Grasmere ward provided more of a homely environment than others did. Cleaning rosters were on display in the offices and were up to date. The décor in Lakeside and Cavendish units needed updating. Paint was coming off the walls in the toilet in Lakeside unit and there

Requires improvement

Are services safe?

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

was an odour in the toilets. Both Lakeside and Cavendish wards had dormitories, which do not enable patients to hang their clothes up or put their belongings out of view as the doors of the wardrobes had been removed for safety reasons. The trust was aware of the need to modernise the facilities and there was a new build underway where they would be new wards with en-suite rooms and a separate ward for older adults with mental health needs.

There were dispensers at the entrance to all wards with hand sanitizer. All staff observed during the inspection were bare below the elbows as is trust policy.

Although ward managers advised that they had been involved in the completion of environmental risk assessments, these had been submitted centrally and some wards did not have their own copy or access to them on the ward. As a result, some staff within the teams were not able to access the risk assessments. Upon request, the trust provided copies of all of the environmental risk assessments, which included hazards, levels of risk, controls in place and an action plan.

Safe staffing

Establishment levels qualified nurses (WTE)

Austen Ward 12.8, Bridge Ward 15, Cavendish Unit 16.6,

Coniston Ward 13.8, Grasmere Ward 14, Iris Ward 15.6,

Lakeside Unit 16.2, Rivington Unit 13.8, Sheridan Ward 13.8,

Taylor Ward 14, Weaver Ward 14

Establishment levels nursing assistants(WTE)

Austen Ward 15, Bridge Ward 13, Cavendish Unit 16.6,

Coniston Ward 14.56, Grasmere Ward 14.64, Iris Ward 12.6,

Lakeside Unit 17, Rivington Unit 16.46, Sheridan Ward 12.6,

Taylor Ward 12, Weaver Ward 12

Number of WTE vacancies qualified nurses

Austen Ward 1, Bridge Ward 3, Cavendish Unit 1,

Coniston Ward 1.13, Grasmere Ward 1, Iris Ward 2.6,

Lakeside Unit 2, Rivington Unit 1.8, Sheridan Ward 0.8,

Taylor Ward 0, Weaver Ward 1.8

Number of WTE vacancies nursing assistants

Austen Ward 1, Bridge Ward 0, Cavendish Unit +0.2,

Coniston Ward +0.04, Grasmere Ward +0.36, Iris Ward +0.8,

Lakeside Unit +0.4, Rivington Unit 1.8, Sheridan Ward 0.8,

Taylor Ward 1, Weaver Ward 1.2

Number of shifts filled by bank or agency staff from 1/ 2/15 to 30/4/15 were:

Austen Ward 113, Bridge Ward 162, Cavendish Unit 208,

Coniston Ward 141, Grasmere Ward 104, Iris Ward 234,

Lakeside Unit 205, Rivington Unit 154, Sheridan Ward 105,

Taylor Ward 194, Weaver Ward 154

Staff sickness rate and turnover from 1 April 2014 to 31 March 2015 was;

Austen ward had 32 substantive staff with 3 staff leaving in the last 12 months. They had 7 % vacancies and 6 % staff sickness.

Bridge ward had 30 substantive staff with 3 staff leaving in the last 12 months. They had 14% vacancies and 7% staff sickness.

Cavendish unit had 41 substantive staff with 1 staff leaving in the last 12 months. They had 8% vacancies and 6% staff sickness.

Coniston ward had 34 substantive staff with 1 staff leaving in the last 12 months. They had 7% vacancies and 7% staff sickness.

Grasmere ward had 32 substantive staff with 2 staff leaving in the last 12 months. They had 10% vacancies and 6% staff sickness.

Iris ward had 32 substantive staff with 3 leaving in the last 12 months. They had 7% vacancies and 9% staff sickness.

Lakeside unit had 40 substantive staff with 5 leaving in the last 12 months. They had 10% vacancies and 5% staff sickness.

Rivington unit had 31 substantive staff with 2 leaving in the last 12 months. They had 14% vacancies and 7% staff sickness.

Sheridan ward had 31 substantive staff with 3 leaving in the last 12 months. They had 5% vacancies and 3% staff sickness.

Taylor ward had 27 substantive staff with 6 leaving in the last 12 months. They had 10% vacancies and 8% staff sickness.

Requires improvement

Are services safe?

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

Weaver ward had 26 substantive staff with 2 leaving in the last 12 months. They had 16% vacancies and 10% staff sickness.

Bank staff used by the wards were staff employed by the trust who volunteered to work extra shifts. The patients knew the staff providing the additional staff in the majority of occasions. Austen ward submitted one incident due to safer staffing between 1 April 2014 and 31 March 2015 and Coniston and Bridge wards submitted two safer staffing incidents in that period. These highlighted that the full staff complement was not achieved on the shift, which could result in incidents occurring due to less supervision.

Due to levels of sick leave and human resource involvement, Cavendish ward reported using agency staff. Due to vacancies in the team and sickness Coniston, Lakeside and Weaver wards were using agency staff for several shifts per week. Staff at Coniston ward reported it being very difficult to find agency and bank staff to cover shifts. This was noted in their safety walkabout, where managers visit the ward to assess safety and create a report of their findings. Two patients on Coniston ward reported that the staff were mainly in the office and not providing direct care to patients. The safety walkabout notes for June for Weaver ward highlighted the challenges with recruitment.

Ward managers were able to adjust staffing levels depending on the needs of the patients. There was a list of approved agencies that ward managers could approach when required.

Patients and staff told us that they had their section 17 leave, the aim was for two sessions per week with their named nurse.

Mandatory training for the staff in the trust included fire safety (annual), infection control (annual), non-clinical infection control (two yearly), moving and handling (two yearly), safeguarding children Level 1(three yearly), basic life support (annual), immediate life support (annual) and Mental Health Act with attendance once. The trust target was for 85% of staff to have attended all mandatory training. Mandatory courses that were below the trust target were: fire safety at 74%, infection control at 78%, basic life support at 79%, immediate life support at 76% and MHA training as a mandatory e-learning course at 77%.

Updated training figures provided by the trust after inspection showed several wards with training attendance below their target of 85%. Iris ward with 83%, Sheridan ward with 84%, Weaver ward with 68%, Austen ward with 84%, Bridge ward with 75% and Cavendish unit with 85% attendance.

Assessing and managing risk to patients and staff

Number of incidents of seclusion in the last six months from 1 October 2014 to 31 March 2015.

During the period 1 October 2014 to 31 March 2015 Austen ward had 3 incidents of seclusion and 2 incidents of restraint. There were no incidents of restraint in the prone position or the use of rapid tranquilisation.

Bridge ward had 18 incidents of seclusion, 20 incidents of restraint, 2 of which were in the prone position and no rapid tranquilisation was used.

Cavendish unit had 10 incidents of seclusion, 41 incidents of restraint, 14 of which were in the prone position. They used rapid tranquilisation on 7 occasions.

Coniston ward had 11 incidents of seclusion, 9 incidents of restraint, 2 of which were in the prone position and no rapid tranquilisation was used.

Grasmere ward had 5 incidents of seclusion, 3 incidents of restraint. There were no incidents of restraint in the prone position or the use of rapid tranquilisation.

Iris ward had 9 incidents of seclusion, 11 incidents of restraint, 2 of which were in the prone position and 1 occasion where rapid tranquilisation was used.

Lakeside unit had 20 incidents of seclusion, 21 incidents of restraint, 9 of which were in the prone position. They used rapid tranquilisation on 4 occasions.

Rivington unit had 16 incidents of seclusion, 15 incidents of restraint, 2 of which were in the prone position and no rapid tranquilisation was used.

Sheridan ward had 6 incidents of seclusion, 18 incidents of restraint, 2 of which were in the prone position and no rapid tranquilisation was used.

Taylor ward had 12 incidents of seclusion and 12 incidents of restraint. There were no incidents of restraint in the prone position or the use of rapid tranquilisation.

Weaver ward had 5 incidents of seclusion, 30 incidents of restraint with 2 in the prone position. There were no incidents of the use of rapid tranquilisation.

Requires improvement

Are services safe?

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

We were advised by staff that the care and responsibility training for managing difficult behaviour included the practice of lowering patients onto their front (prone) to administer intramuscular medication and then turning them over. The attendance for the training in care and responsibility for the service was an average of 85%, which is at the trust's target.

There had been no incidents of long-term segregation reported by the trust.

Updated figures were provided by the trust, which showed that from April to the end of June 2015 Bridge ward and Lakeside unit had the highest number of incidents of use of seclusion. Lakeside did not have its own seclusion room and had to escort a patient requiring seclusion out of the ward and upstairs to use the facility on Rivington unit.

Restraint was highest on Cavendish unit and Weaver ward for the six months from October 2014 to March 2015. However, between April and June 2015, the use of restraint on Cavendish had reduced. Staff felt this was due to the introduction of the self-harm pathway, a recovery focused intervention where patients identified goals on admission and psychology provided sessions to explore reasons for self-harm and alternative strategies and responses to self harm.

We reviewed 58 care records, all of which had risk assessments in place. However, five had not been reviewed recently and one had not been reviewed since the patient's admission in April 2015 and did not include any risks identified since admission. Risk assessments included current and historic risks, the likelihood of risks occurring, a list of chronological incidents and a risk summary. However, there were no risk management plans providing guidance for staff on how to respond when a risk presented. We were told that instructions for how to respond to patients would be included in their care plans. However, this was not evident in the files we reviewed.

The trust used risk screening tools and risk assessment tools within their electronic record system.

We could not find any risk assessments in relation to patients going on section 17 leave within the care records we reviewed.

Toilets were locked on Austen, Sheridan, Cavendish and Grasmere, patients had to ask for the toilets to be opened. When explored with staff they told us this was due to the nature of the patients admitted and was not individually risk assessed and was a blanket restriction.

Bedrooms were locked on Austen and Sheridan wards. Patients had to ask staff to enable access to their room and this was not individually risk assessed.

On Lakeside unit, we observed two patients who had been admitted voluntarily and who were trying to leave the ward but were being refused. This was raised with the ward manager who arranged for a Mental Health Act (MHA) assessment to be completed to assess the possibility of detention under the MHA. The patients were then detained by the nurse under the nurses holding powers, section 5(4) of the MHA.

Cavendish and Grasmere did not have a notice displayed advising informal patients of their right to leave the ward.

Patients and staff across all wards and units confirmed that restraint was only used when de-escalation was not successful.

Once in seclusion, patients were secluded for the minimum amount of time. Reviews of the seclusion logs showed that the trust was acting in accordance with the MHA code of practice and NICE guidance (NG10 Violence and aggression: short-term management in mental health, health and community settings including the medication used for rapid tranquilisation). However, there was one incident where the records were not completed for the observations after the rapid tranquilisation of the patient.

We could not find evidence that the service was consistently completing the post-seclusion review with patients. Post-seclusion reviews are meetings with patients to explore the reason for seclusion and identify triggers. Of the six seclusion packs reviewed on Lakeside, only one patient had had a post-seclusion review.

There was 82% attendance at safeguarding children training and 92% attendance at the safeguarding adults training. Staff had a good understanding of the safeguarding process and made use of the centralised safeguarding team for advice and guidance. Staff were also aware of the out of hours contact number for safeguarding referrals.

Requires improvement

Are services safe?

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

Ten of the 11 clinics were safely storing their medicines and had systems in place for controlled drugs. The controlled drugs books were up to date. From observations and meetings with the pharmacy team, we learnt that the medicines management team reconciled all patients' medicines on admission and assessed the suitability of patients' own medicines for use where necessary. A pharmacist regularly attended ward rounds where clinical teams discussed the ongoing treatment of each patient, and actively contributed to the safe management of their medicines. Pharmacy staff carried out regular checks on all prescription and administration records and alerted medical staff if patient safety-monitoring checks were due or had been overlooked, or if a person's medication required review. Pharmacy staff also monitored medicine omissions and ensured that these were followed up and reported via their electronic incident recording system, datix where appropriate.

Pharmacy staff audited medicines security and the management of controlled drugs.

Staff on Coniston ward told us that on occasions there was a lack of privacy and dignity when staff needed to access medicines while patients were in the clinic room for ECGs or suture removal. The wards based at Leigh hospital had challenges with the supply of medicine, as the service was outsourced. Records showed and staff confirmed that antibiotic medication that had been prescribed on the Monday had not been received by the Wednesday, which could be detrimental to patients' health and recovery. The medicine had to be reordered. The in-hospital provision was reported to be too expensive for the trust to access, as the hospital was not part of 5 boroughs and was a separate trust.

Track record on safety

From 1 May 2014 to 30 April 2015, there had been 10 serious incidents across the 11 wards. The nature of the incidents were two fires, one absconsion, two suicides, one serious self-injury, two unexpected deaths, one serious injury sustained from a traffic accident and one attempted suicide. On inspection, we were alerted to a recent incident on Bridge ward where a bedroom had caught fire and was under investigation as a suspected arson. The trust had completed the initial 72-hour review and was in the process of fully investigating the incident.

In response to a serious incident that occurred within an accessible toilet, the trust locked all accessible toilets. In some wards, all of the toilets had been locked but there was no evidence of individually risk assessing the decision for this.

From April to July 2015, there were 943 incidents across the core service; 85 absconsions, 221 medication incidents, 287 were classified as violence or aggression and 150 were incidents of self-harm.

Reporting incidents and learning from when things go wrong

Staff knew how to report incidents and were confident at recording information on datix.

Medication incidents were reported via datix. From July 2014 to end of June 2015, the highest incidents were 151 incidents reported at Austen ward, 145 at Cavendish ward and 109 at Sheridan ward.

The trust offer training in medicines management, which had a low attendance, Austen at 58%, Cavendish at 8%, Sheridan at 16% with an average attendance of 22% attendance across the core service.

The learning from serious incidents was not routinely disseminated to the ward managers and their staff teams. Ward managers had not been provided with copies of the review or the actions and learning from the incidents.

There had been a serious incident at Austen ward in March 2015; at the time of inspection no actions or lessons learned had been shared with the ward manager or team. Sheridan ward walkabout notes from July 2015 highlighted a lack of formal feedback following serious incidents. Since June 2015 the patient safety alerts had been introduced which were emailed to all staff to highlight areas they need to be more vigilant of or changes in practice as a result of a serious incident investigation.

Lakeside gave examples of staff being offered debriefing sessions by a psychologist following serious incidents and additional training was explored for staff in relation to the incident, for example packing wound training. The ward manager also reported the sharing of information and lessons learnt from serious incidents at the local quality and risk management meetings. Minutes from February

Requires improvement

Are services safe?

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

2015 recorded the sharing of two serious incidents from the ward that had occurred and the lessons learnt from these. However, we were not informed of any clear trust-wide action planning following a serious incident.

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

We reviewed 58 care records, all of which had a care plan in place. All were up to date except one. This was for a patient who historically had a fluid intake chart in place, which was included in the care plan. The patient was no longer on a fluid intake chart and the care plan had not been amended. On six wards, care plans contained standardised information with no evidence that the views of patients were sought as part of the care planning process. This was also highlighted from previous MHA reviewer visits. Care plan headings included mental health, physical health and accommodation. We found for one out of the four records we reviewed on Sheridan ward where a patient had a health condition requiring staff support and this was not captured in the care plan. However, care plans on Grasmere, Iris, Lakeside, Rivington and Taylor wards were holistic, patient centred and recovery orientated.

Lakeside, Coniston and Iris wards were using the "My recovery story" booklet. Patients completed on admission where they rated themselves on the confidence scale and then gradually during their admission with their named nurse they completed the rest of the booklet with the aim of setting goals and the patient having more insight into the reason for their admission and have a focus on their recovery.

Assessments completed on admission include malnutrition screening, falls risk assessment, health of the nation outcome scales and a physical health assessment. Six of the records reviewed did not have evidence of a physical health examination completed on admission.

The wards had a mixture of electronic and paper records, the recovery story booklets were kept separately to other records. Austen and Sheridan wards were piloting an electronic interactive dashboard entitled "patient status at a glance" board, which stored dates of completed documentation and dates for review. It also showed the number of patients, if they were out of borough, their MHA status, risk screening, safeguarding concerns, delayed discharges, the dashboard also linked to the electronic reporting system. Links were in the dashboard to relevant NICE guidance and this was being developed further as the trust identified on their risk register that there was the possibility of noncompliance with NICE guidance. The dashboard was used at every handover and risks were reviewed as part of the process. The front page did not contain any confidential information to respect patients' information. There was a large screen to access this in the nurse's office and smaller versions in the ward manager's office. All other wards had a white board, which closed to protect patient confidentiality. There were frosted windows and blinds in offices to protect confidential information too.

Best practice in treatment and care

NICE guidance CG123 "common mental health disorders: Identification and pathways to care" and CG178 "psychosis and schizophrenia in adults: treatment and management" recommends the psychological therapies of cognitive behavioural therapy (CBT), interpersonal psychotherapy are available for patients. Psychologists confirmed they offer one to one CBT to patients and also enhance staffs skills to offer psychological intervention too. The psychologist and occupational therapist working across Austen and Sheridan wards worked jointly with the activity coordinators to facilitate a coaching group, lifestyle group and life skills group. The psychologist working on Iris and Taylor wards facilitated groups on mindfulness, anxiety management, recovery, wellbeing and self-esteem.

In addition to the my recovery story where patients rate themselves on the confidence scale the service used the model of human occupation related assessments. Including outcome measures, the health of the nation outcome scale, also the rate your mood and Rosenberg self-esteem scale which is a ten-item Likert scale with items answered on a four point scale from strongly agree to strongly disagree. The occupational therapists are also involved in the falls assessments for patients.

The trust had completed an audit against the guideline for bipolar disorder NICE CG185 which concluded in March 2015. With the findings of the difficulties in obtaining a pure sample and the challenges in clinical coding in the trust. Only three of the 14 patients with bipolar depression were offered psychological interventions and only 22% of patients were offered a psychological therapy. Thirty-six out of 58 patients had their physical health handed back to their GP.

Skilled staff to deliver care

Within each of the wards, the teams consisted of consultant psychiatrists, nurses, part time occupational therapist and

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psychologist, pharmacist and at least one activity coordinator in each team. Grasmere and Coniston ward also had a housing officer linked to their wards to assist with housing applications for discharge.

Inductions for new staff included training in: basic life support, infection control, safeguarding, care and responsibility, bullying and harassment, care programme approach, clinical supervision, customer care, MCA, equality and diversity, fire, health and safety, information governance and conflict resolution. The ward managers were responsible for completing the ward based local induction to orientate the staff member in the ward and advise of ward specific information. An induction checklist was completed and submitted centrally. However, the checklist did not include environmental risk. Coniston unit was using a higher number of bank and agency staff than most wards. The ward manager had created a staff orientation leaflet for new staff onto the ward which included; observation, telephone, location of the ligature knife, fire safety, identification of shift coordinator and location of emergency equipment. This leaflet had to be signed by the staff member and manger to confirm they had covered and understood the topics.

The trusts' supervision policy advised that staff receive management supervision every eight weeks, staff we spoke to and records confirmed that this was happening on all wards except Coniston ward. This was raised with the modern matron on the day who agreed to address the issue. Psychologists and occupational therapists also had clinical supervision with a senior clinician in their discipline. Group supervision was also offered by psychologists.

The appraisal rates for the teams from 1 April 2014 to 31 March 2015 were:

Austen ward had 32 staff, 13 had not had an appraisal, (41% without an appraisal in the last 12 months).

Bridge ward had 27 staff, 23 had not had an appraisal, 85%.

Cavendish unit had 40 staff, 12 had not had an appraisal,30%.

Coniston ward had 33 staff, 8 had not had an appraisal, 24%.

Grasmere ward had 31 staff, 6 had not had an appraisal, 20%.

Iris ward had 31 staff, 4 had not had an appraisal, 13%.

Lakeside unit had 40 staff, 7 had not had an appraisal, 18%.

Rivington unit had 29 staff, 25 had not had an appraisal, 86%.

Sheridan ward had 30 staff, 16 had not had an appraisal, 53%.

Taylor ward had 26 staff, 10 had not had an appraisal, 38%.

Weaver ward had 26 staff, 8 had not had an appraisal, 31%.

An average of 40% of non-medical staff had not had an appraisal within the 12-month period. However, information shown when visiting the wards was that the majority of staff had been appraised in June 2015 prior to our visit. The appraisals covered the review of the previous year's objectives and set new objectives with a development plan. Both the employee and manager had to rate their contribution on a scale of one to five as part of the process.

Team meetings were held in some wards weekly where they had then opportunity to reflect on difficult incidents, fortnightly in other wards where they discussed the new build, pending CCQ visit, professional development reviews and feedback from safety walkabouts. The longest gap between meetings was six weeks. Topics discussed included lessons learnt from incidents, training and policies and procedures.

Poor staff performance was noted to be managed on two of the wards that we visited. Staff had been suspended on one of the wards pending a disciplinary investigation. On another ward, a member of staff had made a number of medication errors, they had been removed from administering medication in the interim while they completed a medication administration assessment and a reflective analysis. They were also being offered additional training and supervision.

Multi-disciplinary and inter-agency team work

There were daily multidisciplinary meetings, these included planning meetings, morning reviews and handovers. The meetings had attendance from consultant psychiatrist, pharmacist, occupational therapist, nurses and psychologist. The aim of the meetings was to have a brief review of all patients, Austen and Sheridan ward used the patient safety at a glance (PSAG) electronic board for the morning review where tasks were identified to be

Are services effective?

Good

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completed that day. Positive feedback was received from staff regarding the use of PSAG, as it was always current as it was updated within the meeting. Within the meetings there was a summary given of risk, safeguarding and mental state for each patient. Within one of the planning meetings observed, a member of staff from the home treatment team was present.

The reviews that we observed included consultant psychiatrist, nurses, care coordinators from the community teams, support time and recovery workers and the patient. Professionals were aware of physical health needs of patients and discussed discharge plans. Three of the reviews were very person centred and created a clear action plan of increased time in the community with the aim of discharge. An independent mental health advocate was present at one of the reviews who was liaising with other professionals involved. In two of the reviews, we observed the patient was not provided with information about their medication they had been prescribed. In one of the reviews the patients parents attended, the consultant only spoke to the parents and did not involve the patient in the meeting. When the patient attempted to speak the consultant spoke over them.

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

MHA reviewer visits had been completed on all of the wards. Two wards did not have facilities for patients to make a private phone call. There were issues with the cleanliness of the seclusion facilities and ability to protect people's privacy and dignity when being secluded on some of the wards.

MHA training was offered as a mandatory e learning course for staff. Attendance was 77%, which was below the trust target of 85%.

Several patients we spoke to had leave in the grounds for a maximum of 10 minutes or supervised leave; however, their MHA status was informal. On Lakeside ward, two patients who were admitted voluntarily were trying to leave the ward and were being refused. This was raised with the ward manager who arranged for a MHA assessment to be completed. The patients were detained by the nurse under the nurses holding powers, section 5(2) of the MHA.

We were shown a form on Austen ward, which explained to informal patients the expectations of their admission, and the restrictions on the ward. The other wards did not use the form. However, the information was clearly written in the information packs which were available in all of the wards. There was trust leaflets available and on display in communal areas for topics including your rights, care reviews, child visiting, compliments and complaints, PALS, service user and carer involvement.

Staff and patients reported that in the past their section 17 leave had been cancelled due to staff shortages; however, the situation had improved by the time of the inspection.

Prescription charts had the relevant T2 or T3 form attached to them where needed, which were fully completed, regularly monitored by the pharmacist and medicines were administered in line with relevant mental health legislation.

Patients on all wards except Lakeside were able to tell us about the advocacy service and how they would access it. However, advocacy information was on display on the notice boards in the Lakeside unit.

Toilets were locked on Austen, Sheridan, Cavendish and Grasmere wards, patients had to ask for the toilets to be opened. When explored with the staff, this was due to the nature of the patients admitted and this was not individually risk assessed and was a blanket restriction.

Bedrooms were locked on Austen and Sheridan wards, patients had to ask staff to enable access to their room, and this was not individually risk assessed.

Within the case notes we could only find evidence in one person's file that there had been a discussion or assessment of their capacity to consent to treatment or evidence of capacity being assessed upon admission or regularly thereafter.

Good practice in applying the Mental Capacity Act

MCA training was offered to staff. 80% had attended, this is below the trust's target of 85%.

There were no patients detained under a deprivation of liberty safeguards (DOLS) and there were no pending DOLS applications.

The trust had a draft MCA policy and procedure. The policy linked to the MCA code of practice. The documents were due to be ratified in June 2015.

The staff that we interviewed had a basic understanding of the five statutory principles of the MCA.

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.

Staff's understanding of assessing capacity was that it was the doctor's responsibility to assess capacity.

Ward managers gave two examples where they were involved in best interests meetings regarding patients in relation to their physical health needs.

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

Staff were able to describe the culture of care. Patients said staff treated them with dignity, respect and kindness and relationships with staff were good. A patient said: "staff have been amazing, very genuine and caring attitude." In addition, another said: "really caring because they go the extra mile to get involved with the patients."

There was access to appropriate spiritual support. Patients told us they were supported to access appropriate spiritual help when needed.

Patients felt safe and comfortable. Patients said staff were visible and asked about their wellbeing. One patient said: "staff are always there for you."

Staff spoke about patients in a respectful manner and demonstrated a good understanding of their individual needs. Patients said staff were interested to talk to patients with time for individual 1.1 discussions.

The involvement of people in the care that they receive

When patients arrived, they were shown around and given information about the ward.

Details of local advocacy services were displayed. Patients told us they were supported to access an advocate if they wished.

Details of how to complain were displayed. Leaflets were available and patients told us they knew how to complain if necessary.

Patients were involved in decisions about care on the ward. We saw records of community meeting minutes and observed those meetings taking place. Patients said staff ask their opinion about what happens on the ward. We saw an example of menus being changed following patient feedback.

People and those close to them were involved as partners in their care. Some patients said they were involved in developing their care plans and knew their named nurse. We saw evidence of patient involvement in developing their care plans. However ten of the 51 patients we spoke to reported not being involved in the creation of their support plan and stated they did not have a copy or had just seen the care plan before the inspection. We could not find evidence that all patients had been offered a copy of their care plan. Patients were encouraged to involve relatives in their care if they wished. Carers said they were invited to review meetings and we attended meetings where relatives were actively involved.

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 assessment service was the single point of access for referrals of adult age to secondary care mental health services at the trust with access 24 hours a day, 365 days per year. The home treatment team acted as gatekeepers for admission to acute inpatient services. Mental Health Act assessments were conducted in collaboration with the local authority. There was a clear process in place for admission to wards with leaflets available to all patients and carers explaining the process. The adult care pathway model launched in 2012 for the trust was recovery focused and aimed at preventing people coming into hospital and promoting early discharge.

In common with many mental health trusts, there were issues related to bed availability and patient flow. The inpatient occupancy target for the Trust was 85%, and occupancy levels at the time of the inspection had exceeded this percentage over a sustained time period. Within the acute and PICU wards we noted constant pressures around bed availability. Where patients had left the hospital on leave there were times when their beds were filled with new admissions. Beds were regularly over occupied and the wards had to put up extra beds in clinical areas and use private beds across the country.

Bed occupancy from October 2014 to March 2015 was: Bridge Ward 103%, Sheridan Ward 101%, Iris Ward 100%, Grasmere Unit 100%, Weaver Ward 100%, Cavendish Unit 98%, Rivington 85%, Coniston Unit 91%, Taylor Ward 94%, Lakeside Unit 93% and Austen Ward 94%. Bed occupancy was managed by a dedicated bed management team.

We found that staff and patients did not have access to designated extra care areas as these were occupied as bedrooms.

We were informed that local provision of community rehabilitation services which ensures that service users with complex needs do not become held in acute mental health inpatient wards were at times difficult to access leading to delayed discharges and readmissions across the acute services or placements outside the local area. Accommodation and community support was highlighted as a reason for delayed discharge from the acute wards.

However, there were good links between staff on the wards and community mental health teams, with representatives attending meetings to plan and discuss treatment and discharge plans.

Where transfer to the PICU unit from an acute ward was required, a clear PICU transfer process was in place. Difficulties in this transfer process were highlighted by the acute ward MDT's. Where patients were identified as requiring PICU support by the acute ward MDTs, a further tier of assessment from the PICU team was described. The PICU team would often recommend further treatment options to prevent inappropriate transfers. High bed occupancy on the acute wards also meant that transfer from the PICU to acute was sometimes delayed.

Although adult inpatient occupancy was high and above the trust target threshold, the indicators of clinical quality were positive. Readmission rates were within the trust target threshold limits. Bed occupancy, length of stay, unplanned readmissions and delayed discharge were monitored at business stream level through a monthly operational performance report, which was then reported to the trust board.

The facilities promote recovery, comfort, dignity and confidentiality

The ward environments varied in their design. Sheridan and Austen ward had a reception desk on entry to the ward, this was welcoming and assisted with orientation. Sheridan ward clerk had a list of informal patients to enable those patients to leave at their will. Some wards were designed as rehabilitation wards and Lakeside and Cavendish wards were dormitory style wards. All wards were locked. We noted difficulties in observation on most wards with further difficulties highlighted by staff such as inadequate space for activities and meetings and seclusion room design. However, Austen ward had a well-equipped music room with evidence of patients recording and creating their own music.

Seclusion room design was highlighted as an issue on Taylor ward. The seclusion room was off the ward and by the entrance to the building. This required patients to be transferred past administrative and kitchen areas through locked doors. This room did not have any bathroom facilities and patients were using cardboard urine bottles and bedpans, which had an impact on patient comfort and dignity.

Are services responsive to people's needs?

Good

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

High bed occupancy often resulted in rooms designed as extra care areas being used as bedrooms and unavailable to patients and staff.

The PICU, Cavendish and Lakeside wards were earmarked to relocate from Leigh Infirmary to Atherleigh Park, a purpose built hospital development, due to open in Autumn 2016.

There was a room for family visiting off the wards, which was suitable for child visiting. All patients had access to outdoor areas/secure courtyards where there were dedicated smoking areas. There was a good range of information across the wards for patients on notice boards in communal areas and ward admission packs were available in patient bedrooms. Hot drinks and snacks were available. However, patients on Taylor ward were unable to access hot drinks after 9.30pm.

There were communal areas and activity areas on each ward. Multi-faith boxes, which have items relating to different faiths, for example a bible, were available on each ward. Activity programmes/plans were visible in each ward area and we noted activities being undertaken with activity coordinators. There was a range of therapeutic activities available and patients were actively encouraged to participate. Activities included: life skills groups, cooking groups, walking groups, exercise groups, anxiety management, relaxation and mindfulness, art and pet therapy. There was a gym at Hollins park and Whiston hospital, which patients could access too. Activities were available at weekends on some of the wards.

Not all wards had occupational therapy staff but we were told that these posts were under current development. All wards had activity coordinators. Staff told us that planned activities were rarely cancelled because of a lack of staff availability to run them.

Patients could not make a private phone call on Lakeside ward, the patient phone was broken and had been since the previous Mental Health Act reviewer visit.

Meeting the needs of all people who use the service

Patients' diversity and human rights were respected. Staff understood, promoted and supported patients and their differences. Staff working in the trust were aware of patients' individual needs and tried to ensure these were met. This included cultural, language and religious needs. Interpreters were available if required for people whose first language is not English.

All of the wards had welcome packs or introduction booklets which covered: welcome, aims, philosophy of care, care programme approach (CPA), what to bring to hospital, medication, personal property, electrical goods, mobile phones policy, your rights, second opinion, access to records, what to expect, dietician, acceptable behaviour agreement, smoking policy, violence and aggression, observation policy, reporting an incident, children visiting, hospital chaplaincy, patient advise and liaison service, advocacy, carers, suggestions comments and complaints, ward activities, visiting times, protected meal times, notice board, laundry, bus times, confidentiality, useful phone numbers, satisfaction survey. This was in accordance with NICE guidance CG136 "service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services"

A varied menu was available, which enabled patients with particular dietary needs connected to their religion or other particular preferences or individual needs, to eat appropriately.

Listening to and learning from concerns and complaints

The majority of patients' and carers we spoke with told us they knew how to make a complaint. We found posters, leaflets and admission packs on the wards informing patients how to raise a concern, complaint or compliment. We also saw information on how to access the patient advice and liaison service and advocacy services.

There was a clear policy in place and staff were able to describe the process clearly. Patients told us that their complaints were taken seriously. The trust had a system in place for monitoring complaints and the complaints procedure was discussed with patients during community group meetings.

There were 41 complaints across the service, with eight upheld. No complaints were referred to the ombudsman.

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 were on display in some ward areas, and were understood by the staff on the wards. We saw examples of local initiatives such as the advancing quality alliance, which was an NHS health and care quality improvement organisation. Work funded by a grant from the health foundation was ongoing in some ward areas to reduce the use of physical restraint over a two year period. A local initiative to support patients who self-harm was led by a ward manager. He had introduced a self-harm pathway on one ward area, which resulted in reduced incidents; he had recently moved wards and was planning to introduce this in another ward area.

Ward managers had regular contact with their managers and attended local team quality and safety meetings where quality initiatives were discussed.

Good governance

There was a clear governance structure where ward managers contributed to the trust's quality and safety meetings. Staff told us of specific initiatives and information sharing and input into national audits such as the national audit for schizophrenia.

Staff were in receipt of an electronic newsletter called In View, which detailed initiatives and lessons learnt across the trust. Mangers told us that they contributed to local quality initiatives and attended quality and safety meetings. A core brief was received monthly and lessons learnt were cascaded to their teams through supervision and ward meetings. Although the process for action planning and monitoring of lessons learnt from serious incidents was unclear.

Quality issues were regularly monitored and action plans were in place. Each acute ward compiled performance data that recorded their performance against a range of indicators where organisational effectiveness was reported to the director of strategy and onto the trust board. Key Indicators were used to assess performance these were: delayed discharges, inpatient activity, complaints and compliments, 72 hour and 7 day follow ups, readmissions. For patients on CPA the service also monitored HoNOS, timely assessment on admission, gatekeeping and discharge planning.

However, some of the ward staff were concerned and frustrated at the providers failure to mitigate ligature risks and other safety concerns over a 6-month period.

Ward managers were in regular contact with the team managers and detailed some visits from the senior team to the ward areas.

Leadership, morale and staff engagement

On the whole, staff reported that morale was good. Staff told us they felt supported by the management across the wards we visited. Supervision and appraisal rates were monitored and we saw evidence that staff at all levels had received regular supervision and appraisals.

Staff had clear roles and a management structure that was understood by staff. Staff spoke positively about their roles and their commitment to providing quality patient care. Most staff reported they liked working at the trust and had good relationships with their colleagues. Staff told us that they felt supported by their managers and peers. Most of the staff told us that senior managers were accessible, approachable and encouraged openness.

Commitment to quality improvement and innovation

All of the acute wards except Cavendish ward and Rivington, the PICU were members of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) accreditation scheme called AIMS. Taylor ward had been deferred. AIMS are an accreditation scheme working with psychiatric intensive care units to assure and improve their safety and quality of services, and their environments. It engages staff and service users in a comprehensive process of review, through which good practice and high quality care are recognised. Services are supported to identify areas for improvement and set achievable targets for change.

Ward managers detailed ongoing and proposed improvements to patient care with plans to introduce quality improvement and innovation. One ward manager detailed plans to introduce an innovative approach to working with women who self-harm by introducing a harm minimisation approach.

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 The seclusion facilities for Taylor, Grasmere and Coniston wards do not meet the Mental Health Act code of practice and there was a blind spot in the seclusion room at Taylor Ward. There were ligature risks which had not been identified by an audit and had no plans in place to manage them. The medicines were not being administered safely as they was unsafe storage of medicines on Weaver ward as the ambient room temperature in the clinic room was regularly in excess of 25 C. This was a breach of regulation 12(2)(d)(g)